District of Columbia

UNIFORM APPLICATION
FY 2020/2021 Block Grant Application

SUBSTANCE ABUSE PREVENTION AND TREATMENT
and
COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

OMB - Approved 04/19/2019 - Expires 04/30/2022
(generated on 08/30/2019 5.03.53 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

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

State Information

State Information

Plan Year

Start Year 2020

End Year 2021

State SAPT DUNS Number

Number 014384031

Expiration Date

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

Agency Name Department of Behavioral Health

Organizational Unit

Mailing Address 64 New York Avenue NE, 3rd FL.

City Washington

Zip Code 20002

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

First Name Barbara J.

Last Name Bazron

Agency Name Department of Behavioral Health

Mailing Address Department of Behavioral Health 64 New York Avenue, N.E. 3rd Floor

City Washington

Zip Code 20002

Telephone (202) 673-2200

Fax (202) 673-3433

Email Address barbara.bazron@dc.gov

State CMHS DUNS Number

Number 14384031

Expiration Date

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

Agency Name District of Columbia Department of Behavioral Health

Organizational Unit

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

City Washington

Zip Code 20002

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

First Name Barbara J.

Last Name Bazron

Agency Name Department of Behavioral Health

Mailing Address	64 New York Avenue, N.E., 3rd Floor
City	Washington
Zip Code	20002
Telephone	(202) 673-2200
Fax	(202) 673-3433
Email Address	barbara.bazron@dc.gov

III. Third Party Administrator of Mental Health Services

Do you have a third party administrator? ○ Yes ◉ No

First Name	
Last Name	
Agency Name	
Mailing Address	
City	
Zip Code	
Telephone	
Fax	
Email Address	

IV. State Expenditure Period (Most recent State expenditure period that is closed out)

From	
To	

V. Date Submitted

Submission Date	8/30/2019 5:02:18 PM
Revision Date	

VI. Contact Person Responsible for Application Submission

First Name	Jackie
Last Name	Richardson
Telephone	202-671-3152
Fax	
Email Address	estelle.richardson@dc.gov

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

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

Fiscal Year 2020

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
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As the duly authorized representative of the applicant I certify that the applicant:

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

to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
    a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
    b. Collecting a certification statement similar to paragraph (a)
    c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

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

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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

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

State: _____

Name of Chief Executive Officer (CEO) or Designee: Dr. Barbara J. Bazron

Signature of CEO or Designee[1]: _____

Title: Director

Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

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to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
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17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

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

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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

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

State: District of Columbia

Name of Chief Executive Officer (CEO) or Designee: Dr. Barbara J Bazron

Signature of CEO or Designee[1]: Dr Barbara J Bazron

Title: Director / SSA

Date Signed: August 29, 2019
mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

GOVERNMENT OF THE DISTRICT OF COLUMBIA

ADMINISTRATIVE ISSUANCE SYSTEM

Mayor's Order 2015-146
May 27, 2015

SUBJECT: Delegation of Authority to the Director, Acting Director, or Interim Director, the Department of Behavioral Health, or his or her Designee to Sign Documents Related to the Substance Abuse Prevention and Treatment (SAPT) Block Grant and to sign funding agreements with the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration for grants to be administered by the Department of Behavioral Health

ORIGINATING AGENCY: Office of the Mayor

By virtue of the authority vested in me as Mayor of the District of Columbia by sections 422(6) and (11) of the District of Columbia Home Rule Act, approved December 24, 1973, 87 Stat. 790, Pub. L. 93-198, D.C. Official Code § 1-204.22(6) and (11) (2014 Repl.), it is hereby **ORDERED** that:

1. **FIRST DELEGATION OF AUTHORITY:** The Mayor hereby delegates to the Director, Acting Director, or Interim Director of the Department of Behavioral Health, or his or her designee, authority to sign funding agreements and certifications, provide assurances of compliance to the Secretary of the U.S. Department of Health and Human Services, and to perform similar acts relevant to the administration of the Substance Abuse Prevention and Treatment (SAPT) Block Grant until such time as this delegation of authority is rescinded.

2. **SECOND DELEGATION OF AUTHORITY:** The Mayor hereby delegates to the Director, Acting Director, or Interim Director of the Department of Behavioral Health, or his or her designee, authority to sign funding agreements with the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration for grants to be administered by the Department of Behavioral Health.

3. **RESCISSION:** Mayor's Order 2013-228, dated December 5, 2013, is hereby rescinded.

4. **EFFECTIVE DATE:** This Order shall become effective immediately.

MURIEL E. BOWSER
MAYOR

ATTEST:
LAUREN C. VAUGHAN
SECRETARY OF THE DISTRICT OF COLUMBIA

State Information

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

Fiscal Year 2020

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

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

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
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b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
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The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
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This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

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

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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

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

Name of Chief Executive Officer (CEO) or Designee: Dr. Barbara J. Bazron

Signature of CEO or Designee[1]: _____

Title: Director

Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

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

Fiscal Year 2020

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

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

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

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

State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

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

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

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

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

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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

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

Name of Chief Executive Officer (CEO) or Designee: Dr Barbara J Bazron

Signature of CEO or Designee[1]: Dr. Barbara J Bazron

Title: Director

Date Signed: Aug 29, 2019

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

GOVERNMENT OF THE DISTRICT OF COLUMBIA

ADMINISTRATIVE ISSUANCE SYSTEM

Mayor's Order 2015-146
May 27, 2015

SUBJECT: Delegation of Authority to the Director, Acting Director, or Interim Director, the Department of Behavioral Health, or his or her Designee to Sign Documents Related to the Substance Abuse Prevention and Treatment (SAPT) Block Grant and to sign funding agreements with the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration for grants to be administered by the Department of Behavioral Health

ORIGINATING AGENCY: Office of the Mayor

By virtue of the authority vested in me as Mayor of the District of Columbia by sections 422(6) and (11) of the District of Columbia Home Rule Act, approved December 24, 1973, 87 Stat. 790, Pub. L. 93-198, D.C. Official Code § 1-204.22(6) and (11) (2014 Repl.), it is hereby **ORDERED** that:

1. **FIRST DELEGATION OF AUTHORITY:** The Mayor hereby delegates to the Director, Acting Director, or Interim Director of the Department of Behavioral Health, or his or her designee, authority to sign funding agreements and certifications, provide assurances of compliance to the Secretary of the U.S. Department of Health and Human Services, and to perform similar acts relevant to the administration of the Substance Abuse Prevention and Treatment (SAPT) Block Grant until such time as this delegation of authority is rescinded.

2. **SECOND DELEGATION OF AUTHORITY:** The Mayor hereby delegates to the Director, Acting Director, or Interim Director of the Department of Behavioral Health, or his or her designee, authority to sign funding agreements with the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration for grants to be administered by the Department of Behavioral Health.

3. **RESCISSION:** Mayor's Order 2013-228, dated December 5, 2013, is hereby rescinded.

4. **EFFECTIVE DATE:** This Order shall become effective immediately.

MURIEL E. BOWSER
MAYOR

ATTEST:
LAUREN C. VAUGHAN
SECRETARY OF THE DISTRICT OF COLUMBIA

State Information

Disclosure of Lobbying Activities

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

Standard Form LLL (click here)

Name

Barbara J. Bazron, Ph.D.

Title

Director

Organization

Department of Behavioral Health

Signature: Barbara J Bazron

Date: August 29, 2019

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

Disclosure of Lobbying Activities

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

Standard Form LLL (click here)

Name

Barbara J. Bazron, Ph.D.

Title

Director

Organization

Department of Behavioral Health

Signature: Date:

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

The executed document has been uploaded under the CEO Funding Agreement, Certification and Assurances, Letter Designating Signatory Authority_Mental Health section.

Planning Steps

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

Narrative Question:

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

FFY 20-21 MHBG and SABG Combined Application

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Executive Summary

The District of Columbia Department of Behavioral Health (DBH) is pleased to submit it first combined application of the Community Mental Health Block Grant (MHBG) and Substance Abuse Prevention and Treatment (SABG) Block Grants. DBH serves as the State Mental Health Authority (SMHA) and the District of Columbia Single State Agency (SSA) for substance use disorders.

This application describes the strengths and organizational capacity of the District's behavioral health service system to address specific populations, identifies unmet service needs and critical gaps in the current system, and outlines a plan to address these behavioral health system needs and gaps with MHBG and SABG 2020-2021 funding. To address mental health services and system gaps, the District will extensively and strategically utilize peer support services and expand and develop children services. To target substance use prevention and treatment unmet service needs and gaps, the District will focus on 1) providing and supporting community-wide training and implementation of evidence-based treatment models for co-occurring disorders, and 2) supporting evidence-based treatment and recovery models for youth and young adults. Service development, enhancement, expansion, coordination, and integration are strategic methods and approaches to ensuring timely access to mental health and substance use treatment, prevention, and recovery service for children, youth and adults.

In its combined 2020-2021 MHBG and SABG Application, the Department of Behavioral Health continues its commitment to ensuring access to high quality, accountable, a recovery-oriented behavioral health system that meets the needs of District residents. Further, the combined application advances our DBH mission: to develop, manage and oversee a public behavioral health system for adults, children and youth and their families that is consumer-driven, community-based, culturally competent and supports prevention, resiliency and recovery and the overall well-being of the District of Columbia.

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

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

The Department's organizational structure includes 1) the Behavioral Health Authority; 2) Accountability Administration; 3) Administrative Operations; 4) Clinical Services Administration; 5) Community Services Administration; 6) Consumer and Family Affairs Administration; 7) Systems Transformation Administration, and 8) Saint Elizabeths Hospital. The DBH leadership team includes the leaders of the administrations, divisions, and branches.

DBH's publically-shared values include:

- **Respect**. All persons who come in contact with the public behavioral health care system are treated with dignity and valued for their abilities and contributions.
- **Accountability**. DBH is responsible to consumers and family members for support and unobstructed access to services. The agency encourages all interested parties to participate in the planning, development, implementation, and monitoring of treatment, services, and policy.
- **Recovery**. DBH services are provided based on the belief that people can recover from mental and substance use disorders. Services and support for consumers, clients, and their families are tailored to:
    - Empower them to improve their quality of life
    - Address individual needs
    - Focus on strengths and resiliency
    - Provide choices and immediate access
    - Provide opportunities to participate in rehabilitation, regardless of disability
- **Quality**. The system is responsive, cost-effective, and incorporates high standards, best practices, cultural sensitivity, and consumer satisfaction. Service providers are committed to professional integrity, objectivity, fairness, and ethical business practices.
- **Education**. DBH takes the following actions to improve the service delivery system:
    - Shares information among consumers, family members, providers, and the public
    - Promotes prevention, wellness, and recovery
    - Reduces stigma
    - Recognizes the needs of others for information
    - Communicates in an open and candid manner
- **Caring**. DBH encourages genuine partnerships among consumers and clients, family members, providers, and others that foster unconditional positive regard for the concerns of those who seek and receive services.

Organizational Structure

Behavioral Health Authority
The Behavioral Health Authority plans and develops: 1) mental health and substance use disorder services; 2) ensures timely access to services; 3) monitors the service system; 4) supports service providers by operating the DBH Fee-for-Service (FFS) system; 5) provides grant or contract funding for services not covered through the FFS system; 6) regulates the providers within the District's public behavioral health system, and 7) identifies the appropriate mix of programs, services, and supports necessary to meet the behavioral health needs of District residents.

The Authority components are described below.
Office of the Director: leads management and oversight of the public behavioral health system; directs the design, development, communication, and delivery of behavioral health services and supports; and identifies approaches to enhance access to services that support recovery and resilience.

The Office of the Director includes the *Chief of Staff*, which oversees the Offices of the Ombudsman, Legislative and Public Affairs, and Communications and External Affairs.

- *Office of the Ombudsman*: identifies and helps consumers and clients resolve problems, complaints, and grievances through existing processes; educates on available services and helps to maximize outreach; refers individuals when appropriate to other District agencies for assistance; and comments on behalf of residents on District behavioral health policy, regulations, and legislation.
- *Legislative and Public Affairs*: develops, leads, and coordinates the agency's public education, internal and external communications, and public engagement and outreach initiatives; manages legislative initiatives and acts as the liaison to the Executive Office of the Mayor and the District Council; facilitates responses to constituent complaints and service requests; and provides information and support for special projects.
- *Communications and External Affairs*: develops, leads, and coordinates the agency's internal and external communications, public information program, and outreach initiatives.

General Counsel's Office: provides legal advice to the Director on all aspects of DBH operations and activities; drafts, researches, and reviews legislation, regulations, and policies that affect the DBH mission and programs; and formulates strategic advice on DBH program development, compliance and oversight activities. *Chief Clinical Officer:* supervises and sets standards for the provision of clinical care throughout the agency and public behavioral health system for children, youth, and adults; oversees community hospitals that treat consumers on an involuntary basis; serves as the petitioner in guardianship cases, and oversees the agency's disaster response for the District.

Accountability Administration

In FY20, the Accountability Administration will oversee provider certification; mental health community-residencal facility licensure; Medicaid claims audits; program integrity; quality

improvement; incident management; major investigations; and compliance monitoring. The Administration components are described below.

Division of Program Integrity- conducts claims audits, investigations of potential false claiming, monitors provider compliance with DBH regulations and policies, and issues and monitors corrective action plans for providers needing to remediate problems related to service provision or compliance concerns.

Investigations Division- conducts major investigations of complaints and specific unusual incidents and develops the final investigative report submitted to the agency Director, General Counsel, and other appropriate parties that include recommendations for remedial action.

Licensure Division- reviews and processes applications for licensure for Mental Health Community Residence Facilities (MHCRF) for approval; monitors MHCRF compliance with agency regulations and policies; and generates and enforces statements of deficiencies and corrective action plans when necessary.

Certification Division- reviews and processes applications for certification and recertification for behavioral health providers for approval, monitors provider compliance with certification regulations and policies, and generates and enforces statements of deficiencies and corrective action plans when necessary.

Administrative Operations Administration
Led by the Chief Operating Officer, Administrative Operations provides highly functioning administrative activities to support the vision and mission of DBH. The Administration is responsible for the business functions including budget and financial management; human resource management; property and space management; records management; and general administrative support. The Administration components are described below.

Office of the Chief Operating Officer- provides leadership, management, and vision necessary to ensure proper operational controls; administrative and reporting procedures; and people systems are in place to effectively manage day-to-day operations and to guarantee financial strength and operating efficiency of DBH.

- *Records Management Division*- manages the medical records program and maintains official medical records for DBH consumers and clients; oversees the development, implementation, maintenance, and adherence to DBH policies and procedures covering the privacy of and access to patient health information; in compliance with federal and state laws and provider information privacy practices.
- *Human Resources Division*- develops and administers human resource services including management advisory services; human resources policy development; position classification/position management; staffing and recruitment; employee and labor relations; performance management; benefits administration; records management; human resources information systems and human rights; and equal employment. This division also oversees risk management and compliance with Language Access requirements and the Americans with Disability Act.

Clinical Services Administration
The Clinical Services Administration supervises the operation of all clinical programs and sets standards for the provision of clinical care throughout the public behavioral health system. It includes all DBH directly provided assessment, referral, and clinical services; forensic services; the comprehensive emergency psychiatric program; and the disaster behavioral health program. The Administration 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 Administration components are described below.
Behavioral Health Services Division- directs and manages mental health services at two (2) DBH-operated locations, currently 35 K Street Northeast and 821 Howard Road Southeast.

- *Adult Services Branch*- provides clinical assessment and treatment for persons who are 18 years of age and older who present with urgent same-day mental health concerns and evaluation for persons, in crisis who do not need an emergency room visit.
- *Children's Services Branch*- provides urgent same-day service and clinical assessment and treatment for children up to 7 years old who present with challenging social, emotional and disruptive behaviors that cause impairment in functioning at home, school, daycare and the community.
- *Pharmacy Branch*- provides psychiatric medications for residents enrolled in the public behavioral health system who are uninsured and unable to pay for medications.

Comprehensive Psychiatric Emergency Program Division (CPEP)- provides emergency mental health services to adults 18 years of age and older, including immediate and extended observation care to individuals who present in crisis, as well as services in the community; and participates in the District's cold weather alert response.

Psychiatric Emergency Services Branch- provides immediate access to multi-disciplinary emergency psychiatric services 24/7; assesses and stabilizes psychiatric crises of patients who present voluntarily or involuntarily who live or visit the District, and formulates appropriate next level of care in the community or at other treatment facilities.

Community Response Team (CRT) - In July 2019, DBH launched the Community Response Team (CRT), which consolidates and expands our community-based direct service efforts—including homeless outreach, mobile crisis, and diversion—into one comprehensive, 24-7 integrated response team that provides assessment, referral, short-term care management, and follow-up for individuals with behavioral health support needs across the District. The community response team also provides community education, individual and neighborhood outreach, SUD specific outreach and behavioral health consultation, co-response, and intervention support to our partner agencies and community partners.

Program goals include:

- Improve access to behavioral health services
- Create 24/7 safe engagement sites for individuals experiencing behavioral health needs
- Improve and expand our Diversion partnership with MPD District-wide, and
- Increase community based behavioral health outreach and education to residents of the District.

Access HelpLine Division- enrolls consumers into services, authorizes appropriate units and duration of services based on the clinical review of medical necessity criteria and capacity limits; ensures District residents receive crisis services, as well as provides telephonic suicide prevention and other counseling as appropriate.

Forensics Division- provides and oversees a continuum of behavioral health and other services for justice-involved individuals from pre-arrest to post-incarceration to ensure their successful return to the community.

Assessment and Referral Center Division- assesses and refers adults seeking treatment for substance use disorders to appropriate services including detoxification, inpatient, medication-assisted treatment or outpatient substance use disorder treatment programs, or recovery support services. The Mobile Assessment and Referral Center (MARC), a mobile outreach vehicle, travels communities throughout the District to conduct assessment, referral, and HEP-C and HIV testing.

Community Services Administration
The Community Services Administration 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 support resiliency and recovery. The Administration components are described below.

Office of Community Services- leads oversight and management of the agency's integrated community-based, prevention, early intervention, and specialty behavioral health programs.

Prevention and Early Intervention Division- develops and delivers prevention and early intervention services, education, support, and outreach activities to help inform and identify children, youth and their families who may be at risk or affected by some level of mental health and/or substance use disorder. This division applies a public health and community-based approach to delivering evidence-based substance abuse prevention and mental health promotion programs. It includes the Early Childhood Branch, School Mental Health Branch, and a Substance Use Disorder Prevention Branch.

Early Childhood Branch- provides school-based and center-based early childhood mental health supports and child and family-centered consultation to staff and families to build their capacity to promote social and emotional development; responds to mental health issues and prevent escalation of challenging behaviors, and through screening and early intervention identify any children in need of more intensive services.

School Mental Health Branch- provides school-based, primary prevention services to students and school staff and consultation to schools, principals, teachers, and classrooms on early intervention and treatment to students and parents.

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

Specialty Care Division- develops, implements and ensures the sustainability of specialized and evidence-based behavioral health programs for adults, adolescents, transition-aged youth, children and their families, and new grant-funded initiatives that impact the well-being of individuals and communities. This division includes the Community- Based Services Branch and New Initiatives Branch.

- *Community-Based Services Branch*- oversees development, implementation and monitoring of community-based mental health, and substance use disorders services including evidence-based and promising practices, to address the needs of adults, children, youth and their families.
- *New Initiatives Branch*- provides overall technical direction and administration of a broad range of grant-funded projects and other new initiatives; tracks and monitors their progress and outcomes, and makes recommendations on integration into the agency and full-scale implementation.

Linkage and Assessment Division- provides community-based mental health and substance use disorder screening, assessments, and referrals for adults, children, youth and families, ensuring access to a full continuum of quality behavioral health services and supports. The Division includes the Assessment Center Branch, the Co-Located Program Branch, and the Psychiatric Residential Treatment Facility Branch.

- *Assessment Center Branch*- provides the Superior Court of the District of Columbia with court-ordered, high-quality, comprehensive, culturally competent mental health consultation, and psychological and psychiatric evaluations for children and related adults with involvement in child welfare, juvenile justice, and family court.
- *Co-Located Programs Branch*- Oversees the co-location of DBH clinicians at various District government agency and community-based sites who conduct behavioral health screenings, assessments and consultations, and make referrals to the behavioral health provider network.
- *Psychiatric Residential Treatment Facility Branch*- provides centralized coordination and monitoring of placement, continued-stay, and post-discharge of children and youth in psychiatric residential treatment facilities (PRTF), and oversees the coordination of the PRTF medical necessity review process.

Housing Development Division- develops housing options and administers associated policies and procedures governing eligibility, access to housing, and issuance of vouchers for eligible individuals enrolled with DBH. The division also monitors providers' compliance with contracts and provides technical assistance to providers on the development of corrective action plans; develops and monitors any Memorandum of Understanding or grant agreements related to housing development and funding of housing vouchers.

Residential Support Services and Care Continuity Division- Manages the housing program to support consumers based on housing needs and required level of support; provides referrals to landlords; assures properties are inspected and approved; monitors service provision according to individualized clinical treatment plans; assures coordination and resolves problems among landlords, tenants, and providers, and conducts regular reviews to transition ready individuals to more independent housing of their choice.

Consumer and Family Affairs Administration
The Consumer and Family Affairs Administration promotes and protects the rights of individuals with behavioral health disorders; encourages and facilitates consumer and client and family leadership of treatment and recovery plans, and ensures consumer and client voice in the development of the behavioral health system. The Administration also promotes consumer and client leadership, manages the peer certification training, and provides expertise on the consumer and client perspective. This Administration is made up of the following teams: Peer Support, Peer Operated Centers, Consumer Engagement, Consumer Rights, Quality Improvement, and Saint Elizabeths Hospital.

Systems Transformation Administration
The Systems Transformation Administration (STA) coordinates DBH's strategy development and performance improvement processes to help advance our mission: to develop, manage and oversee a public behavioral health system for adults, children and youth, and their families that is consumer-driven, community based, culturally competent and supports prevention, resiliency, and recovery and the overall well-being of the District of Columbia. This work involves building consensus among diverse stakeholders, implementing strategic priorities, and mobilizing the behavioral health system to take action.

STA's primary functions include:
- Strategic planning;
- Policy and regulatory analysis, development, and implementation;
- Data dissemination through reports and dashboards, and interpretation of findings to support performance improvement;
- Technical assistance and learning opportunities to support the provider network and advance system change;
- Management of Mental Health and Substance Use Disorder provider contracts;
- Strategy development and implementation around transitions; and
- Support for the Behavioral Health Planning Council.

The Administration components are described below:

Office of System Transformation- leads the development and implementation of programmatic, organizational, and system change management process.

Data and Performance Management Division- meets the agency's data reporting and analysis needs by working with staff to identify what information is needed, creates reports and dashboards that present and makes the information accessible, and helps staff understand what the data means and how it can be used to improve performance. Coordinate DBH's annual

Performance Accountability Report (PAR), which includes DBH accomplishments, reports, and measures.

Strategic Management and Policy Division- develops programmatic regulations, policies and procedures to support the agency's mission. Facilitates planning and implementation of special projects, and leads agency efforts to support behavioral health system redesign and payment reform efforts.

Network Development Division- monitors and provides technical assistance to individual providers and the provider network on emerging clinical, care coordination, administrative and organizational issues to ensure and enhance the provision of services. Also, the division supports the development of new providers interested in certification.

Training Institute Division- enhances the knowledge and competencies of the DBH provider network and internal and external customers through performance-based and data-driven learning environments.

Office of Change Management - provides leadership over DBH' engagement with Behavioral Health Planning Council; plans, develops and implements strategies for development of the DBH Strategic Plan; manages the coordination of special internal and external stakeholder engagement sessions; develops change strategies to facilitate project management of executive or program level projects.

Saint Elizabeths Hospital (SEH) – provides inpatient psychiatric, medical, and psycho-social person-centered treatment to adults to support their recovery and return to the community. The hospital's goal is to maintain an active treatment program that fosters individual recovery and independence as much as possible. Licensed by the District's Department of Health, the hospital meets all conditions of participation promulgated by the federal Centers for Medicare and Medicaid Services. This division contains the following activities:

Office of the Chief Executive – provides overall, executive management and leadership for all services and departments of Saint Elizabeths;

Office of Clinical and Medical Services – SEH – provides the clinical, operational, strategic, and cultural leadership necessary to deliver care that is high-value (in terms of cost, quality, and patient experience) to support their recovery and reintegration into the community;

Engineering and Maintenance – SEH – provides maintenance and repairs to ensure a functional, safe, and secure facility to maximize the benefits of the therapeutic environment;

Fiscal and Support Services – SEH– provides for the formulation, execution, and management of the hospital's budget, billing and revenue operations; approves and finances all requests for procurements; and oversees the overall financial integrity of the Hospital to ensure the appropriate collection, allocation, utilization and control of resources;

Quality and Data Management – provides quality improvement utilizing performance improvement techniques; uses data and research to guide clinical practices; provides oversight of reporting functions, and manages the reporting functions from the electronic medical record.

Housekeeping – SEH – maintains a clean and sanitized environment to enhance the therapeutic environment and level of clinical performance;

Materials Management – SEH– receives and delivers materials, supplies, postal and laundry services; maintains an inventory of goods, replenishes stock, and performs electronic receiving for all goods and services;

Nursing Services – SEH – provides active treatment and comprehensive, high-quality 24-hour nursing care through a recovery-based therapeutic program; establishes the training curriculum for all levels of hospital staff and ensures compliance with training programs for clinical and clinical support staff to maintain the health and safety of patients and staff;

Nutritional Services – SEH – provides optimum nutrition and food services, medical nutrition therapy and nutrition education services in a safe and sanitary environment;

Security and Safety – SEH – provides a safe and secure facility for patients, visitors, and staff to support a therapeutic environment;

Transportation and Grounds – SEH – manages the resources, administrative functions, contracts, and personnel; and provides transportation and maintenance services, including solid and medical waste disposal, and snow and ice removal;

Office of the Chief of Staff – SEH – primarily responsible for the organization, ongoing management, and oversight of key hospital administrative functions; regularly interacts and coordinates with medical staff and executive leadership; and serves as liaison with external partners including the Department of Corrections, DC Superior Court, and the District of Columbia Hospital Association;

Office of the Chief Operating Officer – SEH – provides the operational, strategic, and cultural leadership necessary to plan, direct, and manage major administrative functions. These functions ensure the provision of high quality services while also meeting the needs of individuals in care and external stakeholders. The Chief Operating Officer regularly interacts and coordinates with finance, information systems, human resources, performance improvement, and risk management;

Office of the Chief Clinical Officer – SEH – provides clinical leadership and interdisciplinary treatment teams; and ensures the provision of social work services, treatment programs, rehabilitation services, utilization review, and volunteer services; and

Revenue Management Division - plans, implements, and manages revenue cycle functions for patient care services provided at Saint Elizabeths Hospital. Ensures that charges for services are reimbursed in full amount allowable as quickly as possible.

Public Behavioral Health System Currently Organized at State Local Levels - Child System

Criterion 3- **Children's Services** describes services in great detail. An abbreviated summary is provided here.

Child/Youth services include:
1) Mental Health Rehabilitation Services
2) Early Childhood Interventions –
- Early Childhood Mental Health Consultation-
- Healthy Futures D.C. Social Emotional and Early Development Project,
- Parent-Infant Early Childhood Enhancement Program,
- Primary Project, Physicians' Practice Group,
- Child Urgent Same Day Services, and Co-Located Programs),

3) School Mental Health Program- Primary and Secondary Prevention Programs
4) Children and Adolescent Mobile Psychiatric Services,
5) Psychiatric Residential Treatment Facilities,
6) Functional Assessment Scales,
7) Evidence-Based Practices, and
8) Adolescent Community Reinforcement Approach (ACRA).

Transition age youth initiatives include:
1) Now Is The Time-Healthy Transitions/Our Time – focused on filling service and treatment gaps available for young adults 16-25,
2) Our Time Exploration - focused on filling service gaps that address the integration of substance use disorder and mental health treatment services specifically for young adults 16-25,
3) It's Time to Let Help In – focused on reducing stigma around MH,
4) First Episode Psychosis/Youth Blossom Program – early interventions to address first psychotic break for young adults 16-25,
5) Transition Age Youth Housing- supportive independent housing for young adults 18-25,
6) TAY Supported Employment – focused on connecting young adults 16-25 with career-focused employment,
7) TAY Professional training – focused on training DC providers who work with the TAY population to better connect and work with young adults,
8) Trauma, Intellectual Developmental Disabilities/Mental Illness, and
9) Proposed Projects (services, training, resources).

Prevention - There are four (4) D.C. Prevention Centers that each serves two (2) District wards. They were developed to strengthen community capacity, address needed community and system changes, reduce substance use risk factors, and achieve target outcomes for District children and youth. The Centers promote healthy children, youth, and families as well as a drug-free city.

In addition to the D.C. Prevention Centers, the Prevention team oversee four grantees conducting evidence-based programs within schools and community centers in each District ward. Along with facilitating drug prevention curricula, grantees implement environmental strategies, which are activities intended to educate and empower, DC residents to address substance use within their community.

Prevention activities also include the SUD social marketing campaigns presented from the perspective of youth and related adults. They include: 1) "*The Blunt Truth*" (addresses marijuana use), 2) *There's a Reason"* (addresses underage drinking), 3) *"More Harmful Than You Think"* (addresses youth opioid use), 4) *"Synthetics"* (addressing side effects of synthetic drugs), 5) *"Naloxone"* (addresses adult opioid use), and 6) *"K2 Zombie"* (addresses synthetic marijuana and other synthetic drug use among youth).

Evidence-Based and Evidence-Informed Curriculum - The DBH School Mental Health Program (SMHP) implements primary and secondary prevention programs that include evidence-based or evidence-informed programs. These programs include: 1) Violence Prevention, 2) Sexual Abuse Prevention, 3) Suicide Prevention, 4) Anger Management, 5) Parenting Program, and 6) Substance Abuse Prevention.

Early Identification - The organizational description of the Community Services Administration noted the purpose of early childhood interventions. A specific early identification project is the DC Mental Health Access Project (DC MAP). This project supports the integration of health and mental health by providing pediatricians with immediate access to mental health and/or psychiatric consultation as children/youth are identified as potentially needing behavioral health services. DC MAP is a team of psychiatrists, psychologists, social workers, and care coordinators who provide free mental health phone consultation for primary care clinicians in the District. In addition to phone consultations, referrals, face-to-face consultations as clinically indicated, education and training are offered to support primary care clinicians to address behavioral health concerns.

Treatment - DBH currently offers seven (7) evidence-based practices as part of the treatment process that includes: 1) Child-Parent Psychotherapy, 2) Trauma Systems Therapy, 3) Parent-Child Interaction Therapy, 4) Trauma-Focused Cognitive Behavioral Therapy, 5) Multi-Systemic Therapy; 6) Adolescent Community Reinforcement Approach (ACRA), and 7) Transition to Independence Process (an evidenced supported model).

Substance use disorder treatment and recovery services currently include a variety of strategies for adolescents and adults, such as 1) assessment (comprehensive, ongoing, brief), 2) drug screening, 3) clinical care coordination, 4) case management, 5) case management HIV, 6) crisis intervention, 7) counseling (individual, family, group, psycho-educational, and psycho-educational HIV), 8) medication management, 9) recovery support, 10) residential room and board, 11) recovery support evaluation, 12) recovery support management, 13) recovery mentoring and coaching, 14) life skills support, 15) spiritual support, 16) education services, 17) recovery social activities, and 18) environmental stability.

Recovery Support Services - In the District of Columbia non-clinical services are provided to an individual by a certified Recovery Support Services (RSS) provider to assist in achieving or sustaining recovery from a SUD. There are currently eight (8) billable recovery support services: 1) Recovery Support Evaluation, 2) Recovery Support Management, 3) Recovery Coaching (Recovery Mentoring and Coaching), 4) Recovery Support Service (Life Skills

Support Services), 5) Spiritual Support Services, 6) Education Support Services, 7) Recovery Social Activities, and 8) Environmental Stability.

Juvenile Justice Initiatives

Juvenile Behavioral Diversion Program (JBDP) - Operated within the D.C. Superior Court Juvenile Division, this program is intended for children and youth who are often served within multiple systems and who are at risk of re-offending without linkage to mental health services and other important supports.

Juvenile Adjudicatory Competency Program (JACP)- A partnership with Court Social Services to provide the District of Columbia Family Court with comprehensive, culturally sensitive and clinically appropriate competency evaluations to assist in the determination of a juvenile's capability to stand trial.

Alternatives to Court Experience (ACE) - The District's Department of Human Services operates this program. Juvenile prosecutors at the Office of the Attorney General (OAG) divert appropriate youth from the justice system to ACE, where program specialists comprehensively assess each child's needs for services and supports.

Behavioral Health Services Partners

Child and youth behavioral health service partners include but are not limited 1) the Office of the State Superintendent of Education, 2) D.C. Public Schools, 3) D.C. Public Charter Schools, 4) Child and Family Services Agency, 5) Department of Youth Rehabilitation Services, 6) Department on Disability Services, 7) Department of Human Services, 8) D.C. Superior Court Juvenile Division, and 9) Court Social Services, and many others.

Diverse Racial and Ethnic Initiatives

Services for Lesbian, Gay, Bi-sexual, Transgender, Questioning (LGBTQ) Youth and Young Adults

Wanda Alston Foundation (WAF) - advocates for increased resources for youth while providing programs including housing, life skills training, linkages to other social services, and capacity-building assistance for other community allies.

Supporting and Mentoring Youth Advocates and Leaders (SMYAL) - some of the services include: 1) case management (development of personal action plan, weekly check-in meetings, and crisis navigation), 2) supportive services (medical care, mental health services, and self-care support), 3) skill development (education, job readiness, and life skills such as cooking, budgeting, etc.), 4) social support (community outings and access to LGBTQ youth networking), and 5) after-care (open line of post-program communication between the youth and their case manager for up to 12 months).

Transgender Health Empowerment, Inc. (T.H.E.) - works to enhance the quality of life of the diverse transgender population by advocating for and supporting a continuum of health and

social services. In fulfilling their mission, T.H.E. is the home of the Tyra Hunter Drop-In Center for transgender, gay, lesbian and bisexual youth, providing showers, laundry, clothing, and food to the homeless. T.H.E. also operates transitional housing for gay, lesbian, bisexual and transgender youth.

Different Avenues **-** provides services to youth and young adults who are homeless or living in unstable housing. Many of the clients are transgender, gay, lesbian, or bisexual. The program also assists youth who are parents and their families. Services include a drop-in center, HIV/AIDS prevention education, sexual health education, access to drug prevention and mental health services, peer-based leadership training, and legal referrals.

Capital Center for Psychotherapy and Wellness - Named Washington Blade's 2016 Best LGBT Owned Business, the Capital Center for Psychotherapy and Wellness takes a holistic approach to health and wellness. They focus on using multiple modalities to treat all aspects of a person's health. They offer LGBT Therapy.

The DC Center for the LGBT Community- offers individual and group mental health support services for LGBTQ survivors of violence and crime in the District of Columbia. Any individual or couple may receive support services who have experienced any of the following types of victimization: intimate partner violence/domestic violence, sexual and/or physical assault, hate crime (racial, religious, gender, sexual orientation, and/or other types of hate crime), bullying, physical abuse/neglect, teen dating victimization, and family violence.

Youth Pride Clinic at Children's National - The Youth Pride Clinic provides primary and specialty care services to LGBTQ persons throughout the greater Washington, DC region. LGBTQ persons face unique health challenges, including higher rates of depression, suicide, sexually transmitted diseases, and HIV infection. This clinic provides comprehensive primary and mental health care to LGBTQ youth and young adults between the ages of 12 to 21.

Public Behavioral Health System Currently Organized at State Local Levels - Adult System

The Adult System is described in great detail under Criterion 1- **Comprehensive Community-Based Mental Health Service Systems**. An abbreviated summary is provided here. In its dual role as the State Mental Health Authority and the Single State Agency (SUD), DBH provides services and contracts with community providers for mental health rehabilitation services and supports and substance use disorder services and supports.

Adult clinical services include the following divisions:

1) Behavioral Health Services Division, which consists of three branches:
    - *Adult Services Branch* - provides same-day urgent care clinical assessment and treatment
    - *Children's Services Branch* –provides same-day urgent care clinical assessment and treatment

- *Pharmacy Branch* - provides psychiatric medications for residents enrolled in the public behavioral health system who are uninsured and unable to pay for medications

1) Comprehensive Psychiatric Emergency Program Division - provides emergency mental health services
2) Psychiatric Emergency Services Branch - offers immediate access to multi-disciplinary emergency psychiatric services 24/7
3) Access HelpLine - enrolls consumers into services and ensures District residents receive crisis services, as well as provides telephonic suicide prevention and other counseling as appropriate.
4) Forensics Division - Provides and oversees continuum of behavioral health and other services for justice-involved individuals from pre-arrest to post-incarceration to ensure their successful return to the community.
5) Assessment and Referral Center Division - assesses and refers adults seeking treatment for SUD to appropriate services, and the Mobile Assessment and Referral Center visits communities throughout the District to conduct assessments, referrals,, and HEP-C and HIV testing
6) Consumer and Family Affairs Administration - promotes the involvement of consumers, including family members and young adults, across the behavioral health system including a Peer Operated Drop-In Center and D.C. Certified Peer Academy.

Adult evidence-based programs include Assertive Community Treatment and the Supported Employment Program (partners include the Department of Human Services, Rehabilitation Services Administration, and Department on Disability Services).

Also, effective July 1, 2019, DBH established a 24/7 Community Response Team (CRT), which merges four existing community outreach teams (Homeless Outreach, Mobile Crisis, Pre-Arrest Diversion, and Crisis Outreach Services) to expand access to care.

The Community Response Team will:

- Provide low or no barrier assessment and referral for individuals presenting with developing or untreated mental illness and substance disorders;
- Engage with individuals who are connected to care, but not actively engaged with services due to other barriers; and provide short term support in resolving crisis to reduce barriers, and increase access to available care.

CRT deployment situations include community outreach and engagement, trauma events, and crisis assessment. Care Coordination will provide referral/follow up with identified resource or agency for case planning and consultation for individuals who are difficult to engage vs. new enrollments; support SUD treatment assessment, referral and support; support navigation within the criminal justice system, and facilitate Guardianship petitions.

The Department of Behavioral Health's (DBH) Assessment and Referral Center (ARC) is a point of entry for adults (21 and over) seeking publicly funded Substance Use Disorder (SUD) Treatment and Recovery. The ARC conducts nursing triages and comprehensive assessments

for substance use disorders and other health disorders including HIV/AIDS, Tuberculosis (TB), Hepatitis C (HEPC), and mental health. Additional access points of entry (co-located assessors, i.e., clinicians) are stationed at the various locations for any person to access to SUD treatment, including throughout the District at Child and Family Services Administration (CFSA) and DBH's Mobile Access van (i.e., social worker onsite). As well, starting 8/1/19, the first community providers started conducting SUD intake and referral on site. DBH is working to ensure that all certified SUD providers can enroll individuals on site. Additionally, DBH, the Family Treatment Court (FTC), and CFSA collaborate to improve the continuity of care and the quality of services for pregnant and parenting women with children. Access to Medication-Assisted Treatment (MAT) for this special population is achieved by decreasing any barriers to treatment and recovery services.

Women with children and pregnant women have priority access to SUD treatment and are given preference in admission to treatment facilities. In the event the treatment facility requested is at capacity and cannot accept an admission, the assessment center will refer the woman to another program that has the capacity. If no such facility can admit the woman, the assessment center will make interim services available no later than 48 hours after the woman seeks treatment. At the time of the assessment, women are referred to a primary care physician. Staff follows up to ensure service linkage. SUD services are provided to women and their dependent children under a trauma-informed lens to connect the family system. Each program incorporates evidence-based treatment models (e.g., Cognitive Behavioral Therapy, Motivational Interviewing, Motivational Enhancement Therapy, and A Women's Path to Recovery) to best support gender-specific Substance Use disorder Treatment.

DBH has one certified provider specializing in pregnant and parenting women with children treatment. Samaritan Inns provides 14 beds for women and 10 beds for children as a residential treatment program for women and children. Samarian Inn's Lazarus House is certified to provide Level 3.1 Clinically Managed Medium-Intensity Residential, and Mozart Inns is a Level 3.5, clinically Managed High-Intensity Residential and Medication Management Substance Use Disorder Treatment Services to Adults. To ensure the families stay together during the SUD treatment process, Samaritan Inns' has provided continuity of care with the Elisha House, a certified Recovery Support program to include Spiritual Support Services and Environmental Stability. An array of childcare and support services for women's children are included in the duration of SUD treatment services.

Prevention Activities

National Capital Region Compact to Combat Opioid Addiction - The Mayor of the District of Columbia and the Governors of Maryland and Virginia have pledged to work collaboratively to help stop the damaging effects of opioid addiction on the lives of those addicted, their families, law enforcement, health care providers, and the broader community. Their efforts to fight this public health and public safety emergency include: 1) a regional strategy to raise awareness of opioid and substance abuse, 2) curb stigmatization of addiction through regional communication strategies, 3) develop targeted messaging on the risks of synthetic opioid overdose and Fentanyl, and 4) convene the second Regional Summit in FY 2018. To monitor the success, the District, Maryland, and Virginia will share periodic updates about the efforts to fulfill these commitments. On behalf of the District of Columbia, DBH supported the Annual

Regional Summit and participated on the Planning Committee. Through the work of this body, a strategic plan "Live. Long. DC,[1]" was developed to guide the work of the District in addressing opioid use disorders.

Prevention Centers - The DBH funds four (4) D.C. Prevention Centers (DCPCs) that are designed to strengthen the community's capacity to reduce substance use and prevent risk factors. The DCPCs are dynamic, community-based hubs that serve two (2) wards each and include: 1) Latin American Youth Center (Wards 1 & 2); 2) National Capital Coalition to Prevent Underage Drinking (Wards 3 & 4); 3) Sasha Bruce Youthwork, Inc. (Wards 5 & 6); and 4) Bridging Resources In Communities (Wards 7 & 8).

The services include community education, community leadership, and community change. Community education focuses on current, relevant drug use/access information. Community leadership builds the prevention capacity of current and emerging leaders and identifies potential community prevention networks (CPNs) for data-driven planning. It also facilitates the CPNs in the 5-step Strategic Prevention Framework action planning (assessment, capacity building, strategic planning, implementation, and evaluation). Community change involves working with the networks in action plan development and implementation. The Centers address measures for three (3) outcomes: 1) changes in priority risk and protective factors; 2) community changes (e.g. new policies, programs, and practices that address the prevention needs assessment and action planning); and 3) behavioral outcomes.

Combating Opioid Misuse within the HEP-C/HIV Population - DBH substance use disorder staff attended this training event in September 2016. The presentations addressed the challenges in screening, treating and managing patient populations co-infected with Hepatitis-C, HIV, mental illness and opioid misuse.

Prevention Symposium - Originally implemented in October 2016, this symposium has taken place three (3) consecutive years (2016-2018). The participants included DBH substance use disorder staff, prevention center staff, and other participants. The session discussions included: 1) Under Age Drinking, 2) Use of Social Media for Prevention Messaging, and 3) Marijuana Use. This event aims to build the substance use prevention workforce within the District, and focuses on different areas of substance use prevention each year. With a desire to build upon the previous year's success, the planning committee researches national trends and successes in locations comparable to the District, from which lessons learned can be adopted.

D.C. Epidemiological Outcomes Workgroup (DC EOW) – Work efforts towards DC EOW goals are sustained through local and Strategic Prevention Framework Partnership for Success funds. They include: 1) continue updating District and Ward alcohol, tobacco and other drug data that includes consumption, consequences, risk and protective factors, demographics and health disparities; 2) develop a collaborative effort to build a common, systematic methodology for conducting prevention needs assessment based upon a risk assessment system to guide prevention policy, program planning, and resource allocation; 3) utilize risk and protective factor data, incidence and prevalence data to estimate service needs, target prevention

[1] https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/LIVE.%20LONG.%20DC-%20Washington%20DC%27s%20Opioid%20Strategic%20Plan-%20March%20Revision.pdf

resources, select appropriate preventive interventions, and evaluate the effects of the prevention system; and 4) develop District and Ward reports and resources for policy and program planners and community stakeholders. The emphasis on risk and protective factors increases an understanding that substance use and other aspects of behavioral health share many of the same risk and protective factors. Common risk factors predict diverse behavior problems including substance use, anxiety and depression, delinquency, violence, school dropout, and teen pregnancy. Because common risk factors predict diverse behavior problems, it is important to ensure that prevention efforts reach those young people exposed to many risk factors during their development.

The DC EOW was expanded in FY 2016 in an effort to have a more robust group of stakeholders. Membership is made up of representatives from the following agencies: 1) DC Health; 2) Department of Behavioral Health; 3) Child and Family Services Agency; 4) D.C. Metropolitan Police Department; 5) Criminal Justice Coordinating Council; 6) Alcohol Beverage Regulatory Agency; 7) Department of Consumer and Regulatory Affairs; 8) Children's National Health System; 9) D.C. Pretrial Services Agency; 10) Department of Transportation; 11) D.C. Hospital Association; 12) The Children's Trust; 13) Legacy Foundation: 14) DBH D.C. Prevention Center representative; and 15) Research Triangle Institute.

DBH supports the SAMHSA premise that the backbone of an effective prevention system is an infrastructure with the ability to collect and analyze epidemiological data and to use this data to identify areas of greatest need. DC EOW data sources will continue to include the D.C. Youth Risk Behavior Survey, National Survey on Drug Use and Health (NSDUH), Behavioral Risk Factor Surveillance System and archival indicators. In the fall of 2015, DC piloted a Ward level telephone survey, and re-administered this for the next three years, to address Ward gaps in youth and adult data, especially risk and protective factors. Through the work mentioned above of the DC EOW, collected data has been housed on an on-line data dashboard where the public can view data trends and also run various types of queries for data analytical purposes.

Recovery Coaching Training

In FY 2016, DBH substance use disorder staff developed a 36-hour Recovery Coaching Training curriculum. The proposed certification program began in FY 2017. The training prepares persons in recovery, recovery program staff, leaders of recovery provider organizations, peer specialists, and recovery coach candidates to implement recovery coaching skills and strategies within an array of recovery support services.

In April 2017, two (2) instructors conducted the Recovery Coaching Training with 18 Recovery Coaches (5 Peer Recovery Coaches and 13 Recovery Coaches). They completed the 40-hour course and received a training certificate. The course content included topics related to: 1) Using Strengths to Build Recovery Capital and Achieve, 2) Cultural Competence and Recovery Coaching in a Recovery Oriented System of Care, and 3) Recovery Support Services, Care Coordination and Recovery Coaches.

In Fiscal Year 2018 and 2019, two (2) instructors conducted the Recovery Coaching Training with 95 individuals. Participants completed the 30-hour course and received a training certificate.

The course content included topics related topics to: 1) Advocacy, 2) Mentoring/Education, 3) Recovery/Wellness Support and 4) Ethical Responsibility.

Adults, Young Adults and Youth Substance Use Campaigns

"The Blunt Truth" (addresses marijuana use) **2015** - The *Blunt Truth* campaign focuses on educating the public about the laws governing marijuana consumption in the District of Columbia. Materials point out the "cans" and "can nots," so that individuals can make informed decisions and stay within the realm of the law.

***"Adult Synthetics*" 2016** (addresses synthetic drug use among adults) - Building upon the K2 Zombie campaign, the Adult Synthetics campaign clarifies that the purchase, sale, and use of synthetic drugs are illegal in the District of Columbia. The campaign addressed designer drugs such as "Molly" and other drugs found to be popular among adults. The associated laws were made available through brochures, palm cards, and a website to inform as many adults as possible.

***"Opioid Awareness Campaign"* 2017** (addresses opioid use among adults, young adults and youth) - DBH Substance Use Disorder Services Prevention Division developed this campaign to raise awareness about the risks associated with opioid use and to direct individuals to help. Phase 1 targets adults, specifically older African American male heroin users age 40-69. It highlights increased health risks of using heroin, especially batches laced with other synthetic opioids such as fentanyl and carfentanil. It also promotes the use of Naloxone that can reverse an overdose resulting from heroin use. The emphasis will be on seeking medical attention following administration of the Naloxone.

***"More Harmful Than You Think"* 2017** - The More Harmful Than You Think campaign is an expansion of DBH's opioid awareness campaign which primarily targets youth. In focusing on youth, the campaign highlights the misuse of prescribed opioids such as pills and cough syrup. The campaign seeks to draw a contrast between how people "think" they look while misusing opioids (e.g., fun-loving, the life of the party, etc.) and how they may actually look while misusing opioids (e.g., disoriented, lethargic, drugged, etc.).

Beyond its initial launch, the campaign will continue targeting youth and young adults to shed light on how the misuse of prescribed opioids can lead to addiction, be a gateway to more potent variations of opioids, or result in death. Also, a focus will remain on addressing the notion that many individuals who are misusing prescription opioids are not knowledgeable of the risks and/or the class of drugs they are using (e.g., the same family as heroin).

Mayor's Office of Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) Affairs

This is a permanent, cabinet-level office within the Office of Community Affairs in the Executive Office of the Mayor, established by statute in 2006 to address important concerns of the District's LGBTQ) residents. The District has one of the highest concentrations of LGBTQ residents in the country with an estimated 7% to 10% of the population being LGBTQ. The

Office of LGBTQ Affairs works collaboratively with an Advisory Committee, appointed by the Mayor, to define issues of concern to the LGBTQ community and find innovative ways of utilizing government resources to help address these issues. This includes: 1) services are available for grant funding and business opportunities from the District Department of Small and Local Business Development; 2) community resources with links and publications including a directory of LGBTQ community organizations; 3) LGBTQ education and training; and 4) improving the treatment of LGBTQ residents by providing technical assistance.

Health Homes Initiative
The District Health Homes (HH) initiative is a joint effort by DBH and the Department of Health Care Finance. HH1 was launched in January 2016. HH2/ *MyHealth GPS* was launched in July 2017. The HH 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.

Community Residential Facilities (CRFs)
CRFs activities and residence include: 1) Mental Health Community Residence Facilities licensure; 2) Supportive Residence; 3) Supportive Rehabilitation Residence; Intensive Rehabilitative Residence; and 4) Transitional Residence.

Crisis Stabilization Beds
These beds provide a short-term, safe supportive living environment for consumers who do not require inpatient treatment for stabilization. DBH contracts with two (2) community providers for 15 crisis beds, including eight at Jordan House and seven at Crossing Place.

Housing Programs
DC's housing programs include: 1) Home First Housing Subsidy Program; 2) Supported Independent Living Program; 3) D.C. Local Rent Supplement Program; and 4) Federal Voucher Programs.

The Department of Behavioral Health's (DBH) Assessment and Referral Center (ARC) is a point of entry for adults (21 and over) seeking publicly funded Substance Use Disorder (SUD) Treatment and Recovery. The ARC conducts nursing triages and comprehensive assessments for substance use disorders and other health disorders including HIV/AIDS, Tuberculosis (TB), Hepatitis C (HEPC) and mental health. There are additional access points of entry, with co-located assessors (i.e. clinicians) stationed at the multiple locations for any person seeking access to SUD treatment. Various entries into SUD treatment are throughout the District at Child and Family Services Administration (CFSA) and DBH provides outreach to District residents that may need SUD services. Additionally, DBH, the Family Treatment Court (FTC), and CFSA collaborate to improve the continuity of care and the quality of services for pregnant and parenting women with children. Access to MAT for this special population is achieved by decreasing any barriers to treatment and recovery services.

Women with children and pregnant women have priority access to treatment and are given preference in admission to treatment facilities. In the event the treatment facility requested is at capacity and cannot accept an admission, the assessment center will refer her to another

program that has the capacity. If no such facility can admit the woman, the assessment center will make interim services available no later than 48 hours after the woman seeks treatment.

DBH has one certified provider specializing in pregnant and parenting women with children. Samaritan Inns provides 12 beds for women and 16 beds for children as a residential treatment program for women and children. Samaritan Inn's Lazarus House is certified to provide Level 3.5, Clinically Managed High-Intensity Treatment, and Clark Inns' is a Level 3.1, Clinically Managed Low-Intensity and 3.3 Clinically Managed High-Intensity Treatment. To ensure that families stay together during the SUD treatment process, Samaritan Inns' has provided continuity of care with the Elisha House, a certified Recovery Support program to include Spiritual Support Services and Environmental Stability. An array of supportive services for the women's children are included in the duration of SUD treatment services.

Planning Steps

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

Narrative Question:

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

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

In addition to in-state data, SAMHSA has identified several **other data sets** that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the **Healthy People Initiative**[16] HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

[16] **http://www.healthypeople.gov/2020/default.aspx**

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Footnotes:

FFY 20-21 MHBG and SABG Combined Application

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Executive Summary

The District of Columbia Department of Behavioral Health (DBH) is pleased to submit it first combined application of the Community Mental Health Services (MHBG) and Substance Abuse Prevention and Treatment (SABG) Block Grants. DBH serves as the State Mental Health Authority (SMHA) and the District of Columbia Single State Agency (SSA) for substance use disorders.

This application describes the strengths and organizational capacity of the District's behavioral health service system to address specific populations, identifies unmet service needs and critical gaps in the current system, and outlines a plan to address these behavioral health system needs and gaps with MHBG and SABG 2020-2021 funding. To address mental health services and system gaps, the District will extensively and strategically utilize peer support services and expand and develop children services. To target substance use prevention and treatment unmet service needs and gaps, the District will focus on 1) providing and supporting community-wide training and implementation of evidenced-based treatment models for co-occurring disorders, and 2) supporting evidence-based treatment and recovery models for youth and young adults. Service development, enhancement, expansion, coordination, and integration are strategic methods and approaches to ensuring timely access to mental health and substance use treatment, prevention, and recovery service for children, youth and adults.

In its combined 2020-2021 MHBG and SABG Application, the Department of Behavioral Health continues its commitment to ensuring access to high quality, accountable, a recovery-oriented behavioral health system that meets the needs of District residents. Further, the combined application advances our DBH mission: to develop, manage and oversee a public behavioral health system for adults, children and youth and their families that is consumer-driven, community-based, culturally competent and supports prevention, resiliency and recovery and the overall well-being of the District of Columbia.

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

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

District of Columbia Population Overview

Population Overview

Population: The following data is measured and reported by the Census Bureau. The 2017 U.S. Census Bureau American Community Survey (ACS) 5-year population estimate for the District of Columbia is **672,391**. Data on gender, age, and race/ethnicity, education attainment, housing and household composition is based on the U.S. Census Bureau 2013-2017 American Community Survey (ACS) 5-Year Estimates.

- ***Gender:*** 353,345 females represent 52.6% of the population, while 319,046 males represent 47.4% of the population.

- ***Age:*** The majority of the residents are age 25-64 (399,074) followed by those 65 and older (79,769).

Age	Number of People	Percent of Population
Total	672,391	100
Under-five years	43,607	6.5
5 to 9 years	33,366	5
10 to 14 years	25,534	3.8
15 to 19 years	37,168	5.5
20 to 24 years	54,873	8.2
25 to 64 years	398,074	59.1
65 years and over	79,769	11.9

- ***Race/Ethnicity:*** The majority of the residents are African American (321,062) followed by White alone (273,471).

Race/Ethnicity	Number of People	Percent of Population
Total	672,391	100
Black or African American alone	321,062	47.7
White alone	273,471	40.7
Some other race alone	30,961	4.6
Asian alone	25,558	3.8
Two or more races	19,293	2.9
American Indian and Alaska Native alone	1,757	0.3
Native Hawaiian and Other Pacific Islander alone	289	0

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

Educational Attainment	Number of People	Percent of Population
Population 25 years and over	477,843	100
Less than 9th grade	18,889	4
9th to 12th grade, no diploma	27,608	5.8
High school graduate (includes equivalency)	84,119	17.6
Some college, no degree	62,203	13
Associate's degree	14,601	3.1
Bachelor's degree	113,830	23.8
Graduate or professional degree	156,593	32.8

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

,	Number/Rate /Median	Percent of Population
Total Housing Units	308,161	100
Occupied Housing Units	277,985	90.2
Homeownership Rate	115,795	41.7
Housing Units in Multi-Unit Structure	193,901	63.1
Median Value Home Owner Occupied Units	$537,400	n/a

Median Household Income	$77,649	n/a

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

Family/Household Composition	Number of People	Percent of Population
Total households	277,985	100
Family households (families)	121,411	43.7
Married-couple family	70,359	25.3
With own children of the householder under 18 years	51,248	18.4
Male householder, no wife present	10,092	3.6
Female householder, no husband present	40,960	14.7
Non-family households	156,574	56.3
Householder living alone	121,126	43.6
65 years and over	29,851	10.7

Data Sources:
2018 Population Estimate:
https://www.census.gov/quickfacts/fact/table/dc/PST045218#PST045218
2013-2017 ACS 5-year estimates for Age, Race, Gender, Education, Housing and Household data: https://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml

Early Childhood and Children Unmet Needs

The Department of Behavioral Health (DBH) Continuum of Care is an important component of the District's early childhood and children services. DBH has a variety of services for young children that include:
1) Healthy Futures - provides mental health consultation services in Child Development Centers (CDCs)
2) Primary Project - provides early identification of student's level of social-emotional adjustment in the classroom and at CDCs, and
3) School Mental Health Program - provides prevention, early intervention and treatment services to young children and children in the District of Columbia schools. Young children can receive services at all levels of the continuum.

Most Important Early Childhood Unmet Service Needs or Critical Gaps

One of the unmet needs or critical gaps is that few individuals working with the early childhood population have received specific training in early childhood development. The D.C. Social Emotional and Early Development Project (D.C. SEED) is designed to provide Early Childhood training to a wide range of audiences (e.g., child development staff, Access Help

Line staff, and clinicians) to help increase knowledge regarding children birth to age six. The developmental progress of the children will be measured by changes in knowledge.

Another unmet need or critical gap is related to sufficient numbers of evidence-based treatment services for young children with mental health concerns. While DBH, specifically the Parent-Infant Early Childhood Enhancement Program and the School Mental Health Program, have been providing mental health services for young children for years; there are not enough services in District of Columbia for young children.

One of the goals of D.C. SEED is to support the expansion and strengthening of mental health services for children birth to age 6 who have been diagnosed with a serious emotional disturbance or are at risk for one. D.C. SEED will train providers on three (3) evidence-based programs which will increase the capacity for young children and families to receive services. Progress is measured through monitoring the number of children receiving services as well as looking at improvements based on their functioning (pre/post assessments).

In recent years there have been discussions on how DBH can better support both children in the District needing mental health services as well as children's mental health providers. In February 2019, the report "Behavioral Health in the District of Columbia for Children, Youth & Families: Understanding the Current System," by the Children's Law Center, Children's National Health System, and the District of Columbia Behavioral Health Association provided an in-depth look at the current system.

Transition Age Youth and Young Adults

The Department of Behavioral Health (DBH) offers a range of programs and services for children and adults but limited programs to address the needs of Transition Age Youth (TAYs) and young adults (YAs). There needs to be a seamless provision of mental health services, and recovery supports for TAY as they enter adulthood, particularly those who are at high risk and multi-system involved.

Most Important Unmet Transition Age Youth and Young Adults Service Needs or Critical Gaps

The current provider network is somewhat fragmented, causing a silo system of care that complicates access for individuals transitioning from adolescence to adulthood. The delivery of mental health services has been divided into two (2) systems: one serving children and one serving adults, with different eligibility requirements, health care providers, and funding streams. When a young person "ages out" by surpassing the DBH age-defined eligibility limit of 22, the services are discontinued and these young persons are referred to the adult mental health system. The lack of continuity of care is disruptive, as youth must adjust to a new culture of care, with new case managers, therapists, and treatments. Also, the services, in general, may not be age-appropriate or consistent with the kind of care or treatment plan customized for the youth up until this point.

Studies have found that this interruption in services, coupled with the abrupt discontinuation of regular contacts with peers in the child health system, may cause young people to adjust poorly to the new services or reject them altogether. DBH has found that this fragmented approach has led to an abandonment of mental health treatment by many TAY who start-out in the child mental health system and upon aging leave the system entirely.

DBH and its providers need to develop more training opportunities that focus on the needs of TAY and YAs.

Another service need or critical gap is related to substance use disorder (SUD) treatment for TAY and YAs. The system was set up to provide SUD services to youth ages 12-20. However, the 21 and above population was integrated with the adult SUD population. Findings show that the young adult population was not ready to be integrated with the adults, which caused their needs to be unmet. In response to the increasing need to expand SUD treatment and recovery services to transition-age youth, see Environmental Factors and Plan 4; Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI)[1].

Adult Unmet Needs

Clinical Care Coordination is a service available for substance use disorder treatment, and effective July 1, 2019, DBH established a 24/7 Community Response Team (CRT), which merges four existing mental health community outreach teams (Homeless Outreach, Mobile Crisis, Pre-Arrest Diversion, and Crisis Outreach Services to expand access to care.

The Community Response Team will:

- Provide low or no barrier assessment and referral for individuals presenting with developing or untreated mental illness and substance disorders;
- Engage with individuals who are connected to care, but not actively engaged with services due to other barriers, and short term support in resolving crisis to reduce barriers and increase access to available care.

CRT deployment situations include community outreach and engagement, trauma events, and crisis assessment. Care Coordination will provide referral/follow up with identified resource or agency for case planning and consultation for individuals who are difficult to engage vs. new enrollments; support SUD treatment assessment, referral, and support; support navigation within the criminal justice system; and facilitate Guardianship petitions.

Within the SUD network, care coordination is highly under-utilized. In FY18 of 4,208 SUD clients served, only 517 (12%) received a clinical care coordination service. In FY19 YTD, of 4,999 consumers served, 1689 (34%) received a Clinical Care Coordination service. Although there has been some improvement on the SUD side, there is still room for improvement. DBH sees this service as critical in helping to

[1] https://livelong.dc.gov/page/strategic-plan-0

ensure the consumer's full range of care needs are being addressed by both Substance Use Disorder providers and Mental Health Providers.

Outreach:

Goals of outreach are to connect those in need to available resources in the community, including mental health treatment, substance use treatment, housing, benefits, and primary care; thereby increasing health, safety, and quality of life of the District of Columbia residents. In a grant-funded pilot program, Cooperative Agreements to Benefit Homeless Individuals (CABHI) teams had nearly 20,000 face to face engagements with people on the streets, seeing 325 people housed and 74 people getting social security benefits as a result of the outreach and engagement efforts. DBH plans to extend these efforts to engage people in need of necessary behavioral health services in the District.

The District estimates that it will have the capacity to treat approximately 120 pregnant women and women with children in residential and 583 in outpatient services per year. It is estimated that 1,324 women will need these services. The District's system needs include services for youth in transition and residential programs for individuals under 21.

Data from a Districtwide telephone survey administered between 2015 and 2016 has assisted DBH with understanding the scope of the substance use problem among youth within the District by gathering responses related to ease of access to illicit substances, perceived risks associated with use, and the age of first use. As it pertains to ease of access, results show that 42% of respondents felt that alcohol was fairly easy to access, and approximately half reported that marijuana was easily accessible. When considering the risks associated with use, 36% reported a great risk of smoking marijuana regularly, and 44% about having one (1) to two (2) drinks of alcohol almost daily. Last, in accounting for the age of first use, the average ages for having the first drink of alcohol and first trying marijuana was 13 years old and 13.3 years old, respectively. It is important to note that 67% of respondents reported never trying alcohol, and 78% reported never trying marijuana. The analysis of survey responses guided DBH's substance use prevention efforts and further iterates the need to focus on preventing and delaying the onset of alcohol, tobacco, and other drug (ATOD) use.

Additionally, student self-reported data from the 2015 District of Columbia Office of the State Superintendent of Education's (OSSE) Youth Risk Behavior Survey (YRBS) show that 28.7% and 20.1% used marijuana or had at least one drink of alcohol within the past 30 days leading up to taking the survey. While this percentage is down from what was reported during the most recent administration of the survey in 2012, the legalization of marijuana for recreational use, albeit for those 21 years of age and older, is likely to impact use among adolescents. The 2015 YRBS shows how the percentage of use for a multitude of substances (e.g., marijuana, alcohol, synthetic marijuana, electronic vapor products, etc.) increases significantly as school performance worsens.

District of Columbia

Opioid STR Needs Assessment

See Attachment I (Page 117-138)

LIVE. LONG. DC. Strategic Plan

See Attachment II (Page 139-163)

Proposed Plans to Address Adult Needs and Service Gaps

MHBG

To address unmet mental health service needs and gaps, the District will increase its efforts in two primary areas: 1) more extensively and strategically utilize peer support services, and 2) expand and develop children's services.

Peer Services

The Centers for Medicare and Medicaid Services declared peer support an evidence-based practice in 2007. The role of peer support workers has expanded over the years from offering mutual support through self-help groups and peer-run programs (e.g., drop-in centers) to the provision of services. Peer-delivered services generate superior outcomes in terms of engaging "difficult to reach" individuals, reducing rates of hospitalizations and days spent as an inpatient, and decreasing substance use among persons with co-occurring substance use disorder. Literature informs us that when peers interact with someone in crisis, they can connect the individual to care 40% to 65% of the time; when a professional staff person does, the connection rate drops to 25%. It is clear of the critically important role that peers play in our system. As of June 2019, DBH has 158 certified peers in the behavioral health system and is committed to increasing this number. One of our KPIs for FY 19 tracks the number of new Certified Peer Specialists, including those in specialty tracks of family and youth.

Thirty-nine (39) states have Medicaid programs that cover peer support services for either individuals with mental illness, individuals with addiction disorders, or both groups. The Consumer and Family Affairs Administration has indicated that certified peer specialists are intent on becoming standalone Medicaid providers with their own National Provider Identifier (NPI), removing the requirement to work under anyone's supervision.

Peers have expressed that their work is hampered by documentation requirements. DBH staff have concerns that under the current Community Support Services (CSS) model, peers are under-utilized, due to some of the perceived provider barriers regarding supervision (where that supervision is not required of other personnel providing the same type of services). From the FQHC perspective, FQHCs are intent on being able to hire peers for services that fall outside CSS and Recovery Support Services.

Altogether, there is a very strong interest in thinking differently about how peers participate in our overall system of care and creating more symmetry between the SUD and MH-type peer supports. DBH staff is looking into these issues. For example, the DBH Consumer and Family Affairs Administration, working with other relevant DBH Divisions, is aiming to conduct an environmental scan of peer support services among behavioral health providers and Certified Peer Specialist/Recovery Coaches over the coming months. Additionally, DBH will seek support from national experts on how to incorporate best practices for a robust role for peers.

The Serious Mental Illness (SMI) portion of the 1115 waiver demonstration includes a requirement that the District meets certain milestones involving children and youth. The requirements include "Earlier Identification and Engagement in Treatment Including Through Increased Integration":

- Implementation of strategies for identifying and engaging individuals, particularly adolescents and young adults, with serious mental health conditions, in treatment sooner including through supported employment and supported education programs;
- Increasing integration of behavioral health care in non-specialty care settings, including schools and primary care practices, to improve identification of serious mental health conditions sooner and improve awareness of and linkages to specialty treatment providers; and
- Establishment of specialized settings and services, including crisis stabilization services, focused on the needs of young people experiencing SMI or SED.

Section 4.2.4 of the Mayor's recently released "Resilience DC" recommends providing a complete continuum of care for residents with severe mental health illness or substance abuse disorders. Tasks include reviewing the authorities that govern behavioral health services to identify gaps in DC's current service array; seeking to increase the number and type of mental health services billable to Medicaid, enhancing coordination, and supporting better data; and working with the Department of Healthcare Finance to establish new services and/or enhance those services currently available. [2]

SABG

The District proposes the following plan to meet unmet services needs for the substance use service and system gaps: 1) Provide and support community-wide training and implementation of evidence-based treatment models to address co-occurring disorders (substance use/mental health and behavioral health/primary care); and 2) support evidence-based treatment and recovery models for youth and young adults.

Co-occurring Treatment Models

Integrated treatment—treating both disorders (substance use and mental health disorders) at the same time—can stabilize the symptoms of co-occurring disorders and provide the foundation for lasting recovery.

As of May 2019, DBH has eight providers certified in both substance use disorder and mental health services (of 88 total DBH providers). To our knowledge, there are no providers that are implementing evidence-based co-occurring treatment models. DBH would like to train providers on co-occurring treatment models and support implementation. One model to explore is Seeking Safety, a present-focused therapy to help individuals attain safety from co-occurring PTSD, and substance use. The model has been conducted in group and individual format; for women, men, and mixed-gender; using all topics or fewer topics; in a variety of settings (e.g., outpatient, inpatient, residential); and for both substance use and dependence. It has also been used with individuals who have a trauma history but do not meet criteria for PTSD.

[2] https://resilient.dc.gov/

Evidence-based Treatment and Recovery Models for Youth and Young Adults

The District has a great need for adolescent/Transition Aged Youth (TAY) SUD and mental health treatment and recovery services. The Youth Behavioral Risk Survey (YBRS) indicates that of the 18,306 surveyed in 2017, 33% of high school students (estimated 6,040) used marijuana in the past 30 days, 21% (est. 3,752 students) used alcohol, 15% (est. 2,745) used prescription medication without having a prescription, and 4% (est. 640) used synthetic marijuana (CDC, 2018). Further, according to the 2015 and 2016 State Estimates of SAMHSA's National Survey of Drug Use and Health (NSDUH), past month illicit drug, alcohol, and marijuana use among the District's 12 to 17-year olds were higher than the U.S. rate. Past month illicit drug use for 12 to 17-year olds and past month binge alcohol use among 12 to 20-year olds are among the highest in the U.S (18% DC vs. 13% U.S.). While prevalence data are not readily available on the mental health conditions for the District's 12–17-year olds, the latest estimates show that 21% of the 18-25-year olds have experienced mental illness in the past year.

DBH, DHCF, and a network of certified substance abuse treatment providers have worked to expand access to adolescent substance abuse and mental health treatment. Currently, Adolescents/TAY (ages 12-21) can access services directly from the substance abuse treatment provider near their home, school, or job, and every adolescent/TAY accessing substance abuse treatment through the Adolescent Substance Abuse Treatment Expansion Program (ASTEP) is screened for indicators of a mental health disorder using the Global Appraisal of Individual Needs (GAIN). However, to meet the need of the District's youth and young adults, DBH would like to widen its portfolio of evidence-based treatment and recovery models specifically for this population.

The only substance use disorder evidence-based treatment currently provided for youth is the Adolescent Community Reinforcement Approach (ACRA). ACRA is a behavioral approach for youth and young adults with substance use/co-occurring disorders. ACRA promotes increasing the family, social, and educational/vocational protective factors that support recovery. The goal of ACRA is to improve life satisfaction, increase harm-reduction knowledge, and promote abstinence from drugs and alcohol. Through the DC City Grant, school-based counselors will be trained on Motivational Enhancement Therapy (MET)/Cognitive-Behavioral Therapy (CBT) and continue the ACRA work. Some counselors were trained in December 2018 and January 2019 on MET/CBT.

To widen its portfolio, DBH would like to include practices such as The Seven Challenges program, which starts where youth "are at" (usually resistant and reluctant to change), not where adults wish they might be or where young people often pretend to be (ready, willing, and prepared to succeed with immediate abstinence). Research and studies demonstrate the effectiveness of The Seven Challenges as a "co-occurring" program that significantly decreases the substance use of adolescents and dramatically improves their overall mental health status. Data also show that the program has been especially effective with a large number of substance-

abusing youth who have trauma issues. Additionally, DBH would like to add The Integrated Co-Occurring Treatment Model (ICT), which is an integrated treatment approach embedded in an intensive home-based method of service delivery that provides a core set of services to youth with co-occurring disorders of substance use and serious emotional disability and provides services to the families caring for them.
Models of treatment, such as those described would allow DBH to address the specific needs of youth and young adults and assist providers with reaching and treating both substance use and mental health disorders for this population in an effective way. While DBH is taking essential steps to reach youth and young adults, providers need the evidence-based resources to be able to offer effective treatment that will aid in the long-term recovery of both substance use and mental health.

Continuous Quality Improvement
DBH is a data-driven agency and has adopted a focus of continuous quality improvement. The Department recognizes that it must create a structured process for identifying gaps, analyzing, and improving service delivery. Quality improvement and data collection are located within two administration: Systems Transformation Administration and Accountability Administration.

Systems Transformation Administration
The Systems Transformation Administration (STA) coordinates DBH's strategy development and performance improvement processes to help advance our mission: to develop, manage and oversee a public behavioral health system for adults, children and youth, and their families that is consumer-driven, community based, culturally competent and supports prevention, resiliency, and recovery and the overall well-being of the District of Columbia. This work involves building consensus among diverse stakeholders, implementing strategic priorities, and mobilizing the behavioral health system to take action.

The Administration includes a Data and Performance Management Division that meets the agency's data reporting and analysis needs by working with staff throughout the Department to identify what information is needed, creates reports and dashboards that presents and makes the information accessible, and helps staff understand what the information means and how it can be used to improve performance. The Division also coordinates DBH's annual Performance Accountability Report (PAR), which includes DBH accomplishments, reports, and measures.

Led by the Data and Performance Management Division, DBH is partnering with a nationally-recognized vendor (NRI) to develop a performance management framework to help establish benchmarks for high-quality performance, including one set of priority metrics covering system-level outcomes and processes. In addition to recommending priority metrics, NRI will make recommendations for a continuous quality improvement (CQI) process by which performance will be monitored, and technical assistance will be provided to providers. DBH is seeking to enhance and consolidate its historical and emerging provider measurement systems into one comprehensive and efficient CQI framework.
The District Automated Treatment and Accounting (DATA) system is the current electronic health record for SUD reporting. The Department has the current capability to generate extensive custom data reports using SSRS (a SQL Server statistics program fully incorporated into DATA), which allows information to be extracted at the client, program, and provider level. This

capability has already been used in past years to inform strategic planning, monitoring activities, and quality improvement planning. SSRS is sufficient for the majority of our SUD data needs. There are more sophisticated reports that are beyond the capacity of SSRS to complete, and these reports are purchased from FEI (the developer of the DATA System).

Additionally, the newly implemented SQL data warehouse, which is the repository for a SUD and Mental Health data, as well as Medicaid and other claims-based data, allows for DBH to track client-level data between both systems. DBH is currently able to collect and report on client-level data. DBH uses the SUD TEDS and NOMS format for federal reporting.

STA shares data with providers monthly and provides technical assistance to improve data quality. In FY20, the focus will shift to monitoring outcomes on priority population metrics, such as transitions between levels of care and client retention.

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

Primary Prevention Data Collection

The District will continue to collect provider level primary prevention data. This data will be collected through the Data Infrastructure Reporting System (DIRS) every month. DIRS is an electronic reporting system that is used to collect, analyze, and evaluate prevention efforts taking place throughout the District. Providers (sub-grantees) submit data on the number of new activities; individuals reached through planned prevention activities, the number of new Community Prevention Networks (CPNs) developed, and the number of community action plans developed and implemented.

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

The Mental Health Block Grant statutory reporting requirement **Criterion 1** addresses **Comprehensive Community-Based Mental Health Service Systems** defined as: *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 health/substance use disorders (M/SUD). States must have 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 individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities.*

The District's behavioral health system is based on services, functions, initiatives, projects, and activities that cross several DBH Administrations. *Criterion 1- Comprehensive Community-Based Mental Health Service Systems* will address the adult system of care, and *Criterion 3-*

Children's Services addresses the system of care for children, youth, transition age, young adults and their families.

Definition Adults with Serious Mental Illness (SMI): SAMHSA defines adults with SMI as persons age 18 and over who: 1*) currently meet or at any time during the past year has met criteria for a mental disorder – including within developmental and cultural contexts – as specified within a recognized diagnostic classification system (e.g., most recent editions of DSM, ICD, etc.), and 2) display functional impairment, as determined by a standardized measure that impedes progress towards recovery and substantially interferes with or limits the person's role or functioning in family, school, employment, relationships, or community activities.*
Goal of Adult Services: The primary goal for the adult service system is to develop and provide an integrated system of care for adults with serious mental illness and/or co-occurring substance use disorders (SUD). This includes DBH providing mental health and SUD services. It also includes DBH contracting with community providers for mental health and SUD services and supports.

Overview of Adult Services System

Mental Health Rehabilitation Services Providers
The District of Columbia Department of Behavioral Health (DBH) serves the State Mental Health Authority (SMHA) providing services and contracting with community providers for mental health services and supports. The adult mental health rehabilitation services (MHRS) include: 1) diagnostic-assessment; 2) medication/somatic treatment; 3) counseling; 4) community support; 5) crisis/emergency; 6) rehabilitation/day; 7) intensive day treatment; 8) assertive community treatment; 9) supported employment; and 10) health homes. As of July 2019, there are 59 MHRS providers; 21 of which are child/youth-serving providers.

Adults served include the following:

Fiscal Year	Adults Ages 18 and over
2015	19,117
2016	
2017	21,133
2018	19,855
2019 April	13,369

Substance Use Disorder Services Providers: DBH also serves as the District of Columbia Single State Agency (SSA) for substance use disorders providing services and contracting with community providers for substance use disorder services and supports. The level of care for the substance use disorder services include: Level 1: Opioid Treatment Program (OTP); Level 1: Outpatient; Level 2.1: Intensive Outpatient Program; Level 2.5: Day Treatment; Level 3.1: Clinically Managed Low – Intensity Residential; Level 3.3: Clinically Managed Population-Specific High-Intensity Residential; Level 3.5: Clinically Managed High – Intensity Residential Services (Adult Criteria) or Clinically Managed Medium – Intensity Residential Services (Adolescent Criteria); Level3.7-WM: Short-term Medically Monitored Intensive Withdrawal

Management ("SMMIWM"); and Level-R: Recovery Support Services. As of July 2019, 31 certified SUD providers includes three child and youth outpatient providers, one child and youth residential provider, and one parent with children provider

Clinical Services Administration

The Clinical Services Administration supervises the operation of all clinical programs and sets standards for the provision of clinical care throughout the public behavioral health system. The programs and services associated with this Administration include DBH outpatient direct care services.

Behavioral Health Services Division: Directs and manages mental health services at two (2) DBH-operated locations, currently 35 K Street Northeast and 821 Howard Road Southeast.

Adult Services Branch- Provides clinical assessment and treatment for persons age 18 and older who present with urgent same-day mental health concerns and evaluations for persons in crisis that do not arise to the level of needing an emergency room visit.

Adults served include the following:

Fiscal Year	Number Served
FY 2017	5410
FY 2018	4370
FY 2019 April	2685

Pharmacy Branch- Provides psychiatric medications for residents enrolled in the public behavioral health system who are uninsured and unable to pay for medications. Although this Division also serves children, the description of the Children's Services Branch is included under Criterion 3- Children's Services.

Comprehensive Psychiatric Emergency Program (CPEP) Division **-** Provides emergency mental health services to adults age 18 and older, including immediate and extended observation care to individuals who present in crisis, as well as services in the community; and participates in the District's cold weather alert response.

*Psychiatric Emergency Services Branch***-** Provides immediate access to multi-disciplinary emergency psychiatric services 24/7; assesses and stabilizes psychiatric crises of patients who present voluntarily or involuntarily who live or visit the District, and formulates appropriate next level of care in the community or at other treatment facilities.

*Mobile Crisis/Homeless Services Outreach Branch***-** The Mobile Crisis services include: 1) respond to individuals in the community in psychiatric crisis; 2) provide phone and in-person assessments; 3) receive referrals from concerned citizens, Metropolitan Police Department (MPD), neighbors, family members, and government agencies; 4) provide services 9:00 a.m.-1:00 a.m. daily; 5) crisis assessment and stabilization; 6) psychoeducation; 7) community linkage and transport to first appointments; 8) grief and loss counseling; 9) coordinate visits with other District agencies; 10) FD12 completion in likelihood of injury; and 11) consultations.

The mobile crisis service visits are in the table that follows.

Fiscal Year	Mobile Crisis Service Visits
FY 2017	1124
FY 2018	1707
FY 2019 April	1154

The Homeless Outreach services include: 1) provide services to homeless individuals in the District with behavioral health concerns; 2) receive referrals from concerned citizens, MPD, neighbors, and family members; 3) provide services 9:00 a.m.-9:00 p.m. Monday through Friday; 4) case management; 5) housing assistance; 6) mental and physical health linkage; 7) entitlement linkage; 8) substance use linkage; 9) Travel's Aid assistance; and 10) support the Mayor's encampment protocol.

The number of homeless outreach service visits include the following:

Fiscal Year	Homeless Outreach Service Visits
FY 2017	4901
FY 2018	7890
FY 2019 April	4412

*Access HelpLine Division***-** Enrolls consumers into services, authorizes appropriate units and duration of services based on the clinical review of medical necessity criteria; and ensures District residents receive crisis services, as well as provides telephonic suicide prevention and other counseling as appropriate.

The number of Access HelpLine calls include the following:

Fiscal Year	Access HelpLine Incoming Calls	Access HelpLine Suicide Calls	Access HelpLine/Washington Metropolitan Area Transit Authority Suicide Line Calls
FY 2017	69,857	2,497	83
FY 2018	75,653	3,887	73
FY 2019 April	47,298	2,611	39

Forensics Division Provides and oversees continuum of behavioral health and other services for justice-involved individuals from pre-arrest to post-incarceration to ensure their successful return to the community.

Forensic Outpatient Services **-** This service provides: 1) court-ordered outpatient competency restoration and evaluations for pre-trial defendants at the adult clinic; 2) court-ordered evaluations at the D.C. Superior Court for both pre-trial and post-trial defendants; 3) medication monitoring and management for Not Guilty By Reason of Insanity (NGRI) individuals who have been discharged from Saint Elizabeths Hospital and reside in the community with an order of

conditions; and 4) mental health liaisons to the D.C. Superior Court, jails and prisons to link justice-involved individuals to services and coordinate care on their behalf.

Pre-Trial and Re-Entry Forensic Services **-** Links pre-trial individuals and returning citizens to mental health services. A Department of Behavioral Health (DBH) Mental Health Liaison is co-located at the Court to 1) provide screenings and mental health assessments for the Pre-trial Services Agency (PSA) and makes referrals for mental health services; and 2) authorize assertive community treatment (ACT) for D.C. services residents in the criminal justice system in need of a higher level of care.

Also, works to maintain the connection if an individual is incarcerated. These services include the: 1) Mental Health Specialists located at the D.C. Jail who screen and links individuals requiring mental health services or co-occurring substance use disorder services, and coordinates release planning activities for those already linked to DBH; and 2) Liaison Coordinator, co-located with the Court Services and Offender Supervision Agency (CSOSA), screens and links individuals to services.

Court Urgent Care Clinic Services (D.C. Superior Court) **-** Serves individuals in the criminal justice system who need of immediate mental health and/or substance use disorder services. Individuals can be referred by a judge, pre-trial officer, probation officer, or an attorney. This partnership between D.C. Superior Court, DBH, and Pathways to Housing DC (contractor) allows immediate access to support services and establishes linkages to long-term providers to ensure effective treatment alternatives and prevent repeat offenders.

Department of Corrections **-** Three (3) DBH employees all co-located at the Department of Corrections (DOC) provide linkage support for all detained individuals. These employees contact core services agencies (CSAs) to ensure continuity of care for detainees. They also conduct a weekly group to ensure detained individuals are aware of community resources and emphasize the importance of compliance with treatment in the community. These employees document all efforts made to provide behavioral health support in the community and keep track of whether the individual attends their intake appointment at the CSA after release from the DOC.

Court Services and Offenders Supervision Agency (CSOSA)/Pre-Trial Services Agency (PSA) - DBH partners with CSOSA and PSA, both federal entities responsible for supervising individuals who are awaiting trial on criminal charges in the District of Columbia, and those who have been convicted and sentenced to a period of community supervision in the District. As stated above, two (2) DBH staff are co-located in the agencies to provide linkage support and ensure continuity of care for justice-involved individuals.

Juvenile Remediation Program **-** DBH received funds from the Justice Grants Administration to introduce and conduct remediation services for juveniles involved in the criminal justice system. Those funds allowed the hiring of a remediation counselor who educates juveniles in the community about legal procedures.

Saint Elizabeths Hospital **-** Within the hospital, the forensic consult-service provides pre-trial and post-trial forensic evaluations for inpatients who are involved in the criminal justice system. The forensic division also oversees the management of Not Guilty by Reason of Insanity (NGRI) individuals to ensure that court-ordered updates and directives are executed in a timely manner.
Assessment and Referral Center Division **-** Assess and refer adults seeking treatment for substance use disorders to appropriate services including detoxification, inpatient, Medication-Assisted Treatment (MAT), outpatient substance use disorder treatment programs, or recovery support services. The Mobile Assessment and Referral Center (MARC), a mobile outreach vehicle travels to identified locations four days a week between 11 am and 3 pm and collaborates with sister human service agencies to increase outreach efforts. The team conducts screenings for mental health and substance use disorders as well as offers free anonymous HIV counseling and testing services. Anyone that screens for a possible mental health or substance use disorder is provided with information on how to access services. Additionally, the team offers real-time assistance to the access services via a call to Access Help Line or transportation to the Assessment & Referral Center (ARC) for substance use disorder treatment referrals.

The MARC visits include the following:

Fiscal Year	Mobile Assessment and Referral Center Visits
FY 2015	265
FY 2016	1,263
FY 2017	763

Consumer and Family Affairs Administration (CFAA)

Overview: The CFAA is responsible for providing leadership and direction in planning, developing, and coordinating ways to promote the involvement of consumers, including family members and young adults, across the behavioral health system. The expertise from a consumer perspective strengthens the DBH peer support certification program, protects the legal and civil rights of consumers, builds awareness among community members and providers, and monitors consumer satisfaction and perceived quality of care.

This centralized mandate increases the engagement of consumers, family members, and young adults as partners in wellness, resiliency, and recovery in a manner that is inclusive, trauma-informed, and consistent with best practices. The members of the CFAA Network include recipients of behavioral health services, behavioral health advocates (individuals, providers, and organizations), consumers, guardians of consumers, certified peer specialists, recovery coaches, and other District government agencies.

During FY 2018:

- 23 individuals were newly certified as Peer Specialists Training
- 23 Certified Peer Specialist completed Forensic Peer Specialist Training
- 28 individuals completed the Recovery Coach training

Also, in FY 19, DBH plans to certify 20 new certified Peer Specialists.

Recovery Coaching Training A 36-hour Recovery Coaching Training curriculum prepares persons in recovery, recovery program staff, leaders of recovery provider organizations, peer specialists, and recovery coach candidates to implement recovery coaching skills and strategies within an array of recovery support services.

In Fiscal Year 2018 and 2019, two (2) instructors conducted the Recovery Coaching Training with 95 individuals. Participants completed the 30-hour course and received a training certificate. The course content included topics related topics to: 1) Advocacy, 2) Mentoring/Education, 3) Recovery/Wellness Support, and 4) Ethical Responsibility.

In March 2019, DBH Consumer and Family Affairs Administration in collaboration with the Woodley House established a scholarship dedicated to the memory of Ms. Valenti, funded by Woodley House and her many friends and family. The scholarship supports persons with lived experience in their pursuit of Peer Specialist or Recovery Coach Certification and employment in the field of behavioral health. During the inaugural year, five (5) Peers were granted scholarships to support items such as business start-up cost, online education courses, used car, business attire, and laptops. Additionally, 12 Peers received monetary gift cards as an appreciation, and one (1) Peer was offered full-time employment.

Some current projects are described below.

Peer-Operated Drop-In Center **-** The purpose of the community Drop-in Center is to provide mutual support, self-help, advocacy, education, information, and referral services. The primary goal is to assist people with psychiatric illnesses who may also have co-occurring substance use disorders, and other medical conditions to regain control over their own lives and their recovery process. The Drop-in Center promotes an environment that is conducive to self-directed recovery, based on consumer experience, knowledge, and input. During FY'2018, DBH established two (2) community Drop-in Centers.

D.C. Certified Peer Academy (DCCPA) - The DCCPA launched in late FY 2017. It offered access to subject matter experts and support and helped to expand certified peer-run organization's knowledge, expertise, sustainability, and capacity to carry out their mission. It also provided opportunities to connect with and learn from other Certified Peer Run Organizations, (CPRO), Recovery Community Organizations (RCO), Youth Run Organizations (YRO), and Family Run Organizations (FRO) that faced similar challenges. The project ended in FY'18. This intensive Technical Assistance (TA) supported the implementation and sustainment of activities that engaged peer leaders from mental health and substance use communities and assisted DBH to achieve the development of implementation plans to expand Peer-Operated Centers (POCs) and recovery support efforts.

Rock The Mic – DBH launched this annual celebratory event in 2018 during children's mental health awareness week. The event is designed to entertain, empower, and educate the community on the importance of mental health. The event provides a platform for children and families, youth/young adults, and adults to share through spoken word poetry, short stories, art, and dance.

Various government agencies, community-based organizations, and schools will be in attendance to increase the awareness of available services.

Evidence-Based Practices

- *Assertive Community Treatment (ACT)* - DBH implements ACT, an evidence-based, intensive, integrated, rehabilitative, treatment, and community-based service. Ann interdisciplinary team provides this service to adults with serious and persistent mental illnesses. DBH ACT teams include a team leader; psychiatrist or psychiatric care provider; registered nurse; social worker; certified addictions counselor; peer support specialist; supported employment specialist; clinically trained, licensed general practitioner; and, recovery specialist. DBH uses the DACTS (Dartmouth Assertive Community Treatment Fidelity Scale to measure Fidelity
- The services include: 1) mental health-related medication administration, and monitoring; 2) crisis assessment and intervention; 3) symptom assessment, management and individual supportive therapy; 4) substance use treatment for consumers with co-occurring addictive disorders; 5) psychosocial rehabilitation and skill development; 6) interpersonal, social, and interpersonal skill training; and 7) education, support and consultation to consumers' families and their support system, which is directed exclusively to the well-being and benefit of the consumer.
- As of July 1, 2019, there are 8 ACT providers: 1) Anchor Mental Health, 2) Community Connections, Inc., 3) Family Preservation, 4) Hillcrest Children and Family Center, 5) MBI, 6) Pathways To Housing, 7) Amazing Love, and 8) Life Care. These providers collectively have 23 teams. The Dartmouth Assertive Community Treatment Fidelity Scale is used annually to review each team. DBH also developed an ACT Review Tool to assess the quality of services provided. DBH has two (2) combined Transition to Independence Process (TIP) Model and ACT teams, known as TACT, that targets transition-age youth ages 18-29.

The data for consumers served through the ACT program is as follows:

Fiscal Year	Number Served
FY 2017	2,230
FY 2018	2,292
FY 2019 April	1,937

Supported Employment Program - DBH provides an evidence-based Supported Employment Program designed for adult consumers (age 18 and older) with serious mental illnesses for whom competitive employment has been interrupted or intermittent as a result of a significant mental health problem. Supported Employment involves obtaining a part-time or full-time job where the consumer receives supports in a competitive employment setting and earns at least minimum wage. The services provided to the consumers participating in a DBH Supported Employment Program are: intake, assessment, benefits counseling, treatment team coordination, job development, job coaching, and follow-along supports.

DBH currently has nine (9) certified Supported Employment providers: 1) Anchor Mental Health, 2) Community Connections, 3) Psychiatric Center Chartered, 4) Pathways to Housing,

5) MBI, 6) PSI, 7) PRS, 8) Volunteers of America, and 9) Hillcrest. Each provider has a total of 2-7 Employment Specialists (depending on the size of the program) carrying a maximum caseload of 20 clients per Employment Specialist. The current maximum DBH capacity is 700; however, capacity can grow with demand. DBH uses a 14-point fidelity scale to review and rate the quality of supported employment services annually.

The number of consumers served in Supported Employment by providers includes:

Fiscal Year	Number Served
FY 2017	716
FY 2018	545

There were approximately 873 consumers employed over these two years. The average hourly salary was approximately $10.26 - $12.90. The types of jobs the consumers performed included but were not limited to**:** Sales Associate, Program Assistant, Driver, Peer Specialist, Child Care, Custodial, Food Services, Geriatrics, Home Health Aide, Banking, Stocking, Medical/Nursing Assistant, Security Guard, Management, Customer Service, Hospitality, various government roles, and other positions.

The Supported Employment partners are listed below:

- *Department of Human Services* - DBH and the Department of Human Services Economic Security Administration have a memorandum of understanding (MOU) that allows DBH to provide supported employment services to individuals with serious mental illnesses who receive Temporary Assistance for Needy Families (TANF). DBH continues to provide behavioral health screening and referral to appropriate clinical services for the TANF by the MOU that began in FY 2014.

  In FY 2017, there were 200 individuals screened and referred to providers for ongoing behavioral health services. In FY 2018, 213 individuals were screened and referred to providers for ongoing behavioral health services.

- *Department on Disability Services (DDS*) - DBH is an active partner in the "Employment First Initiative" that is centered on the belief that all individuals, including individuals with significant disabilities, are capable of full participation in integrated paid competitive employment. DBH evidence-based Supported Employment fits perfectly with Employment First-principles and practices.

- *The Rehabilitation Services Administration (RSA)* is a component of DDS. DBH and RSA have a memorandum of agreement (MOA) where RSA jointly supports DBH certified Supported Employment providers. RSA directs funds for job development, job placement, and job retention services. In FY 2017, DBH Supported Employment providers received purchase orders totaling $1,093,050.90 for the provision of these three (3) services. In FY 2018, providers received $981,375.00 for these services.

Prevention Activities

National Capital Region Compact to Combat Opioid Addiction - The Mayor of the District of Columbia and the Governors of Maryland and Virginia have pledged to work collaboratively to help stop the damaging effects of opioid addiction on the lives of those addicted, their families, law enforcement, health care providers, and the broader community. Their efforts to fight this public health and public safety emergency include: 1) a regional strategy to raise awareness of opioid and substance abuse, 2) curb stigmatization of addiction through regional communication strategies, 3) develop targeted messaging on the risks of synthetic opioid overdose and Fentanyl, and 4) convene the second Regional Summit in FY 2018. To monitor the success of the District, Maryland, and Virginia will share periodic updates about the efforts to fulfill these commitments. DBH on behalf of the District of Columbia supported the Annual Summit and participated on the Planning Committee.

Through the work of this body, a strategic plan, "Live Long DC." (Plan included in this application) was developed to guide the work of the District in addressing opioid use disorders.[3]

Prevention Centers - DBH funds four (4) D.C. Prevention Centers (DCPCs) that are designed to strengthen the community's capacity to reduce substance use and prevent risk factors. The DCPCs are dynamic, community-based hubs that serve two (2) wards each and include: 1) Latin American Youth Center (Wards 1 & 2); 2) National Capital Coalition to Prevent Underage Drinking (Wards 3 & 4); 3) Sasha Bruce Youth Work, Inc. (Wards 5 & 6); and 4) Bridging Resources In Communities (Wards 7 & 8).

The services include community education, community leadership, and community change. Community education focuses on current, relevant drug use/access information. Community leadership builds the prevention capacity of current and emerging leaders and identifies potential Community Prevention Networks (CPNs) for data-driven planning. It also facilitates the CPNs in the 5-step Strategic Prevention Framework action planning (assessment, capacity building, strategic planning, implementation, and evaluation). Community change involves working with the networks in action plan development and implementation. The Centers address measures for three (3) outcomes: 1) changes in priority risk and protective factors; 2) community changes (e.g., new policies, programs, and practices that address the prevention needs assessment and action planning); and 3) distal or behavioral outcomes.

Combating Opioid Misuse within the HEP-C/HIV Population - DBH substance use disorder staff attended this training event in September 2016. The presentations addressed the challenges in screening, treating, and managing patient populations co-infected with Hepatitis-C, HIV, mental illness, and opioid misuse.

Prevention Symposium - Originally implemented in October 2016, this symposium has taken place three (3) years in a row (FY'16 – 18). The participants included DBH substance use disorder staff, prevention center staff, and other participants. The session discussions included:

[3] https://livelong.dc.gov/page/strategic-plan-0

1) Under Age Drinking, 2) Use of Social Media for Prevention Messaging, and 3) Marijuana Use. This event, which is aimed at building up the substance use prevention workforce within the District, focuses on different areas of substance use prevention each year. With a desire to build upon the previous year's success, the planning committee researches national trends and successes in locations comparable to the District from which lessons learned can be adopted.

D.C. Epidemiological Outcomes Workgroup (DC EOW) - The DC EOW goals will be sustained through local and Strategic Prevention Framework Partnership for Success funds. Workgroup goals include: 1) continue updating District and Ward alcohol, tobacco and other drug data that includes consumption, consequences, risk and protective factors, demographics and health disparities; 2) develop a collaborative effort to build a common, systematic methodology for conducting prevention needs assessment based upon a risk assessment system to guide prevention policy, program planning, and resource allocation; 3) utilize risk and protective factor data, incidence and prevalence data to estimate service needs, target prevention resources, select appropriate preventive interventions, and evaluate the effects of the prevention system; and 4) develop District, and Ward reports, and resources for policy and program planners and community stakeholders. The emphasis on risk and protective factors increases an understanding that substance use and other aspects of behavioral health share many of the same risk, and protective factors. Common risk factors predict diverse behavior problems including, substance use, anxiety and depression, delinquency, violence, school dropout, and teen pregnancy. Because common risk factors predict diverse behavior problems, it is important to ensure that prevention efforts reach those young people exposed to many risk factors during their development.

Membership is made up of representatives from the following agencies: 1) Department of Health; 2) Department of Behavioral Health; 3) Child and Family Services Agency; 4) D.C. Metropolitan Police Department; 5) Criminal Justice Coordinating Council; 6) Alcohol Beverage Regulatory Agency; 7) Department of Consumer and Regulatory Affairs; 8) Children's National Health System; 9) D.C. Pretrial Services Agency; 10) Department of Transportation; 11) D.C. Hospital Association; 12) The Children's Trust; 13) Legacy Foundation: 14) DBH D.C. Prevention Center representative; and 15) Research Triangle Institute.

DBH supports the SAMHSA premise that the backbone of an effective prevention system is an infrastructure with the ability to collect and analyze epidemiological data and to use this data to identify areas of greatest need. DC EOW data sources will continue to include the D.C. Youth Risk Behavior Survey, National Survey on Drug Use and Health (NSDUH), Behavioral Risk Factor Surveillance System, and archival indicators. A D.C. Ward level telephone survey was piloted in the fall of 2015 and was re-administered for the next three years to address Ward gaps in youth and adult data, especially risk and protective factors.

Recovery Coaching Training - 36-hour Recovery Coaching Training curriculum prepares persons in recovery, recovery program staff, leaders of recovery provider organizations, peer specialists, and recovery coach candidates to implement recovery coaching skills and strategies within an array of recovery support services.

In FY' 2018 and 2019, two (2) instructors conducted the Recovery Coaching Training with 95 individuals. Participants completed the 30-hour course and received a training certificate. The

course content included topics related topics to 1) Advocacy, 2) Mentoring/Education, 3) Recovery/Wellness Support, and 4) Ethical Responsibility.

Adults, Young Adults and Youth Substance Use Campaigns

"The Blunt Truth" **2015** (addresses marijuana use) - The *Blunt Truth* campaign focuses on educating the public about the laws governing marijuana consumption in the District of Columbia. Materials point out the "cans" and "can nots," so that individuals can make informed decisions and stay within the realm of the law.

***"Adult Synthetics*" 2016** (addresses synthetic drug use among adults) - Building upon the K2 Zombie campaign, the Adult Synthetics campaign clarifies that the purchase, sale, and use of synthetic drugs are illegal in the District of Columbia. The campaign addressed designer drugs such as "Molly" and other drugs found to be popular among adults. The associated laws were made available through brochures, palm cards, and a website to inform as many adults as possible.

***"Opioid Awareness Campaign"* 2017** (addresses opioid use among adults, young adults and youth) - DBH Substance Use Disorder Services Prevention Division developed this campaign to raise awareness about the risks associated with opioid use and to direct individuals to help. Phase 1 targets adults, specifically older African American male heroin users age 40-69. It highlights increased health risks of using heroin, especially batches laced with other synthetic opioids such as fentanyl and carfentanil. It also promotes the use of Naloxone that can reverse an overdose resulting from heroin use. The emphasis will be on seeking medical attention following administration of the Naloxone.

***"More Harmful Than You Think"* 2017** - The More Harmful Than You Think campaign is an expansion of DBH's opioid awareness campaign which primarily targets youth. In focusing on youth, the campaign highlights the misuse of prescribed opioids such as pills and cough syrup. The campaign seeks to draw a contrast between how people "think" they look while misusing opioids (e.g., fun-loving, the life of the party, etc.) and how they may actually look while misusing opioids (e.g., disoriented, lethargic, drugged, etc.).

Beyond its initial launch, the campaign will continue targeting youth and young adults to shed light on how the misuse of prescribed opioids can lead to addiction, be a gateway to more potent variations of opioids, or result in death. Also, a focus will remain on addressing the notion that many individuals who are misusing prescription opioids are not knowledgeable of the risks and/or the class of drugs they are using (e.g., the same family as heroin).

District of Columbia Olmstead Plan 2017-2020

Since 2007, the District's Office of Disability Rights (ODR) has had the responsibility of

developing and submitting the city's Olmstead Compliance Plan to the Mayor for approval. In August 2015, Mayor Muriel Bowser created an Olmstead Working Group charged with making recommendations for revisions to future iterations of the District's Olmstead Plan to support this effort, and to include a broad array of voices in the process. In 2016, during its first full year of existence, the Olmstead Working Group focused its efforts on determining what data the District should track to allow for a comprehensive picture of what transition looks like for individuals leaving institutionalized care and attempting to access long-term services and supports in the District. The Group concentrated its efforts and discussion around data collection that would aid the District in its effort to create a seamless system across agencies that tracks a person's progress toward independence in a meaningful, understandable way.

Improving Long-Term Care in the District - The District is engaged in a multi-year effort to design and implement a seamless process for accessing Long Term Services and Supports (LTSS). The system embraces the principles of No Wrong Door and will ensure that individuals receive accurate information regardless of where they enter the system. Efforts are underway to streamline and simplify the eligibility process. These system improvements will reduce fragmentation, and the time it takes to connect to needed services.

The Olmstead Plan details remaining system challenges and lays-out specific action steps in nine (9) strategic areas. That work will take place within the context of several on-going District-level initiatives aimed at systems improvement. These include Age-Friendly DC; DHCF's system reform efforts; *Employment First* State Leadership Mentoring; National Core Indicators work; and DC's No Wrong Door Initiative. Also, a strong advocacy community lends its support and oversight, led by groups such as the DC Developmental Disabilities Council (DDC), Project ACTION!, the DC State Rehabilitation Council (DC SRC), and the DC Statewide Independent Living Council (SILC).

*The 2017 Olmstead Plan***-** The Olmstead Working Group created a multi-year Plan based on the same nine priority areas that were the focus of the 2016 Plan: 1) A Person-Centered Culture; 2) Community Engagement, Outreach and Training; 3) Employment;
4) Housing; 5) Intake, Enrollment and Discharge Processes; 6) Medicaid Waiver Management and Systems issues; 7) Quality of Institutional and Community-Based Services, Providers and Workforce; 8) Supporting Children and Youth, and 9) Wellness and Quality of Life.

Each action step in each priority area has a measurable, trackable, and meaningful goal that will lead the District into 2020 with a cross-agency system that is more relatable, comprehensive, and based more on an individual's preferences and concrete goals while in transition.

Government Agencies- The primary District agencies that collaborate to implement the Olmstead Plan are described below.

Department of Behavioral Health (DBH) - The DBH provides prevention, screening and assessment, intervention, and treatment and recovery services and supports for children, youth, and adults with mental health and/or substance use disorders. Services include emergency psychiatric care, residential services and community-based outpatient care. DBH also operates Saint Elizabeths Hospital, which is the District's inpatient psychiatric facility.

DC Health (DC Health) - DC Health's Health and Intermediate Care Facility Divisions administer all District and federal laws and regulations governing the licensure, certification and regulation of all health care facilities in the District. In this role, Health Regulation and Licensing Administration (HRLA) staff inspect health care facilities and providers who participate in the Medicare and Medicaid programs, certified per District and federal laws, respond to consumer and self-reported facility incidents and complaints, and conduct investigations, if indicated. When necessary, HRLA takes enforcement actions to compel facilities, providers and suppliers to come into compliance with District and Federal law.

Department of Health Care Finance (DHCF) - The DHCF is the District's Medicaid agency and the primary payer for all long term services and supports (LTSS) the city provides. Medicaid funds pay for care in institutional settings including nursing facilities and Intermediate Care Facilities for Individuals with Intellectual and Developmental Disabilities (ICF/IDDs), as well as a variety of home and community-based services (HCBS).

Department of Human Services (DHS) - The DHS routinely serves people with disabilities. For example, in FY 2017 approximately 46% of applicants were assessed as likely to have a chronic substance use disorder or severe mental illness of some magnitude, and 8% to have a learning disability in income-based programs such as TANF, SNAP, and Medicaid. In the homeless services program, 55% of singles and 26% of adult-head of families entering shelters were assessed to have a disability in at least one of eight (8) categories. In the Adult Protective Services program (that investigates reports of abuse, neglect, exploitation and self-neglect and provides temporary services and supports), an estimated 47% of those served were assessed to have a disability.

D.C. Office on Aging (DCOA)- The DCOA manages the Aging and Disability Resource Center (ADRC) and funds the Senior Service Network, which together consist of more than 20 community-based organizations, operating 37 programs for District residents age 60 and older, people with disabilities (age 18-59), and their caregivers. Also ADRC provides information, coordinates service access, and provides direct social work services to help people move to the community and remain in the community for as long as possible. In FY' 2015 (the most recent data available), the ADRC served 11,290 people, 9.38% of whom were 18-59 living with a disability. The remaining individuals served by ADRC are people age 60 and older who may also have a disability.

Department on Disability Services (DDS) - The DDS oversees and coordinates services for District residents with disabilities through a network of community-based, service providers. Within DDS, the Developmental Disabilities Administration (DDA) coordinates person-centered home and community services so each person can live and work in the neighborhood of his or her choice. DDA promotes health, wellness, and high quality of life through service coordination and monitoring, clinical supports, and a robust quality management program. During the period October 1, 2017, through September 30, 2018, DDA served 2,447 people.

DDS's Rehabilitation Services Administration (RSA) provides comprehensive, person-centered

employment services and supports for people with disabilities, pre-employment and transition services for youth with disabilities, independent living services and services for people with visual impairments. During the period October 1, 2017, through September 30, 2018, RSA served 5,268 people.

Office of Disability Rights (ODR) - The ODR assesses and evaluates all District agencies' compliance with the ADA and other disability rights laws, providing informal pre-complaint investigation and dispute resolution. ODR also provides expertise, training, and technical assistance regarding ADA compliance and disability sensitivity and rights training to all D.C. agencies. ODR's current initiatives include efforts to increase access to District-owned and leased facilities, worksites and community spaces; leading monthly disability-wellness seminars and managing the District's Mentoring Program for students with disabilities.

Office of the State Superintendent for Education (OSSE) - The OSSE is the District's state education agency. OSSE is responsible for ensuring that all education-related public agencies identify and evaluate children who may have a disability and provide an education that meets the children's individualized needs alongside peers without disabilities to the maximum extent appropriate. OSSE also has oversight of non-public special education schools -- the most restrictive educational placements for children with disabilities. In FY 2015 (the most recent data available), 12,173 children with qualifying disabilities ages 3- 21 were served. In addition, OSSE oversaw IDEA Part C early intervention services for approximately 700 infants and toddlers. Finally, OSSE operated hundreds of buses that traveled 34,000 miles per day to transport more than 3,000 students with disabilities to their schools across the region.
Department of Youth Rehabilitation Services - The Department of Youth Rehabilitation Services (DYRS) is responsible for the supervision, custody, and care of young people charged with a delinquent act in the District in one of the following circumstances:

- Detained in a DYRS facility while awaiting adjudication.
- Committed to DYRS by a DC Family Court judge following adjudication.

Youth can be initially committed to the agency until the age of 18 and may remain in DYRS' care until the age of 21. The agency provides comprehensive support services to committed youth, both in its secure facilities and within the community, and is designed to help young people get on the right track and successfully transition into adulthood.

Department of Child and Family Services Agency - The DC Child and Family Services Agency (CFSA) is the public child welfare agency in the District of Columbia responsible for protecting child victims and those at risk of abuse and neglect and assisting their families.

CFSA has four primary functions:

1. Take and Investigate Reports: CFSA Child Protective Services (CPS) takes reports of known or suspected child abuse and neglect of youngsters up to age 18 in the District 24 hours a day at 202-671-SAFE. When a report indicates a child may have suffered abuse or neglect as defined in law, CPS must investigate to determine whether the report is true or false. Investigative social workers look into reports of child abuse and

neglect by parents, guardians, or others acting in a parental capacity wherever they occur in the District.

2. Assist Families: In child welfare, serving primary clients—children—means helping their parents or caretakers. When CFSA identifies child victims of abuse or neglected, trained social workers from CFSA and private organizations under contract to CFSA step in to keep children safe while working with their families. Social workers connect families to services that can help them overcome long-standing difficulties that endanger their children.
3. Provide Safe Out-of-Home Care: When a home presents too much danger, CFSA temporarily removes children to safe settings—and promptly seeks agreement with the removal from Family Court. Relatives take some children. CFSA also recruits, trains, and licenses foster parents and also licenses, monitors, and maintains contracts with group homes and other safe places for children and youth.
4. Re-establish Permanent Homes: Young people grow up best in a family. CFSA works to ensure every child and youth leaves the system to return safely to parents, to go to a permanent home with relatives or others through guardianship, or to join a new forever family through adoption.

Other Agencies- Many other District agencies serve and support people with disabilities. In doing so, they regularly interface with the agencies listed above. The other government agencies include 1) D.C. Housing Authority (independent agency), 2) D.C. Public Libraries, 3) D.C. Public Schools, 4) Department of Corrections, 5) Department of Housing and Community Development, 6) Department of Employment Services, 7) Department of Parks and Recreation, and 8) D.C. Department of Transportation.

Health Homes Initiatives

Health Home 1- The District of Columbia Health Homes (HH) initiative launched in January 2016 is a joint effort by DBH and the Department of Health Care Finance (DHCF). 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 HH are for people with Medicaid who have: 1) 2 or more chronic conditions; 2) one chronic condition and are at risk for a second; 3) one serious and persistent mental health condition; 4) chronic conditions listed in the statute that includes mental health, substance abuse, asthma, diabetes, heart disease and being overweight; and 5) other chronic conditions such as HIV/AIDS may be considered by the Centers for Medicare and Medicaid (CMS) for approval. Also, states can target health home services geographically but cannot exclude people with both Medicaid and Medicare from health home services.

The 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.

Fiscal Year	Consumers Served
2017	2,177
2018	2,001
2019 April	1,271

Health Homes 2/ MyHealth GPS- HH2 launched in July 2017. The model includes 1) providers integrate and coordinate all primary, acute, behavioral health, and long-term services and supports; 2) must include fee-for-service (FFS) and managed care organization (MCO) beneficiaries, and 3) Centers for Medicare and Medicaid Services (CMS) provides 90/10 match for the first 8 quarters. The eligibility requirements include: 1) have 2 or more chronic conditions; 2) have one chronic condition and are at risk for a second; and 3) have one serious mental illness (SMI). Required services are the same as the six services described under Health Home 1. 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.

Mental Health Community Residence Facilities (MHCRF) Licensure

This service is in the DBH Accountability Administration within the Licensure Division. The tasks include 1) review and process applications for MHCRF approval, 2) monitor MHCRF compliance with agency regulations and policies, and 3) generate and enforce deficiency statements and corrective action plans when necessary. These facilities are privately owned residences that house individuals age 18 or older, with a principal diagnosis of mental illness and who require 24-hour on-site supervision, personal assistance, lodging and meals, and who are not in the custody of the District of Columbia Department of Corrections.

Supportive Residence (SR): Provides 24-hour on-site supervision when residents are in the facility; medication monitoring; maintenance of a medication log to ensure that medication is taken as prescribed; assistance with activities of daily living; arrangement of transportation; monitoring behaviors to ensure consumer safety; and participation in treatment planning and follow-up. DBH licenses these facilities.

Supportive Rehabilitation Residence (SRR): Provides 24- hour, structured housing support for consumers with severe and persistent mental illnesses who need an intense level of support to live within the community. The specific services offered include: 24-hour awake supervision; assisting the consumer to obtain medical care; providing training and support to assist consumers in mastering activities of daily living; maintaining a medication intake log to document medications dispensed as prescribed; provision of 1:1 support to manage behaviors or perform functional living skills; transportation to doctor's appointments; assistance with money management; and participation in treatment planning, implementation, and follow-up. DBH licenses these facilities.

Intensive Rehabilitative Residence (IRR): Provides 24- hour intensive level of care for individuals enrolled in the DBH behavioral health system that have medical issues that put them at risk for needing nursing home care if they do not receive physical health care nursing

supports along with the appropriate mental health rehabilitation services. DBH licenses these facilities.

Transitional Supportive Residence (TSR): Provides 24- hour beds specifically for persons with a principal diagnosis of mental illness and who are enrolled in the DBH behavioral health system and are expected to be ready for the transition to more independent living in 6-12 months. Consumers in the TSR CRF receive focused training to strengthen their ADLs and address behavioral issues. DBH licenses these facilities.

In FY 2019 (as of May 1, 2019), there were 95 MHCRF licensed by DBH. They include: 1) 64 SRs, 2) 29 SRRs, 3) 1 IRRs, and 4) 1 TSR.

Crisis Stabilization Beds
Provides a short-term, safe, supportive living environment for consumers who do not require inpatient treatment for stabilization. DBH contracts with two (2) community providers for 16 crisis beds, eight at Jordan House and eight at Crossing Place.

Housing Programs
Home First Housing Subsidy Program (HFHSP) - The HFHSP provides housing vouchers for individuals and families who live in an apartment or home of their choice and sign their leases. Consumers pay 30% of their household income to the landlord toward their rent, and the HFHSP subsidizes the balance of the rental amount. DBH administers the HFHSP, supported with locally-appropriated funds

Supported Independent Living Program (SIL) - The SILP provides an independent home setting with services and supports to assist consumers in transitioning to a less-restrictive level of care. The SLP offers training in life skill activities, home management, and community services, along with supports through a comprehensive continuum of care based upon individual, recovery-driven needs. Weekly home visits and monitoring is conducted by Community Support Workers to ensure that the individual receiving service is able to maintain community tenure and move to independent living.

D.C. Local Rent Supplement Program (LRSP) - The LRSP is comprised of vouchers for DBH consumers, tied to affordable housing units, for many of which DBH has provided capital funding for new construction or preservation (renovation). DBH identifies individuals in the public behavioral health system for LRSP vouchers. D.C. Housing Authority (DCHA) administers the LRSP, by the rules and regulations of the DCHA Housing Choice Voucher Program, supported with local funds.

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

Mental Health Statistics Improvement Program Survey (MHSIP) for Adults

The MHSIP survey, designed for the adult mental health population, revealed that DBH served 21,133 adult consumers in FY 2017 and 19,855 adult consumers in FY 2018. From this general population, a random sample of 2,600 adult consumers who received at least two (2) mental health services within the past 6-months was selected to participate in the survey. Four hundred and twenty-nine consumers, extracted from the DBH claims database, consumers completed the MHSIP survey.
The MHSIP survey presents statements about services within 8 domains and asks respondents to state to what degree they agree or disagree with them. The domains include: 1) Access, 2) Participation in Treatment Planning, 3) Quality and Appropriateness, 4) Social Connectedness, 5) Functioning, 6) Outcomes, 7) General Satisfaction, and 8) Person-Centered Care Planning.

Criterion 2: Mental Health System Data Epidemiology

The Department of Behavioral Health (DBH) does not generate data on prevalence. 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.

The most recent data that the Department of Behavioral Health (DBH) has is 2017 data provided by the National Association of State Mental Health Directors/National Research Institute (NASMHPD/NRI) for adults with SMI and children/youth with SED.

- ***(2017) District of Columbia Adults with Serious Mental Illness (SMI)***

Civilian Population Adults Age 18+	Civilian Population Age 18+ with SMI (5.4%)	Lower Limit of Estimate (3.7%)	Upper Limit of Estimate (7.1%)
565,698	30,548	20,931	40,165

- ***(2017) District of Columbia Children/Youth with Serious Emotional Disturbances (SED)***

Civilian Population Youth Age 18+		Age 5-17% in Poverty	DC Tier % in Poverty	LOF Score ≤ 50		LOF Score ≥ 60	
				Lower Limit	Upper Limit	Lower Limit	Upper Limit
49,674		19.20%	High	3,477	4,471	5,464	6,458

Data Source: https://www.nri-inc.org/our-work/projects/uniform-reporting-system-and-mental-health-client-level-data/

Behavioral Health Data Summary

The following represents a set of substance use and mental health indicators as measured by data collection efforts sponsored by SAMHSA's 2016-2017 National Survey on Drug Use and Health (NSDUH) (the most recent data available). The presentation for each indicator reflects the percentage of respondents who answered positively and the estimated number in thousands. *(* = Indicators where the District percentage is higher than the U.S.)*

Substance Use Indicators

Past Month Marijuana Use Among Adolescents Aged 12-17 and Adults Aged 18 or Older in the District of Columbia and the United States (2016-2017) - The percentage of persons indicating marijuana use in the past month was higher for District youth (8.26% or about 3,000) and almost twice as high for adults (17.67% or about 98,000) compared to the percentage of youth (6.46%) and adults (9.51%) nationally.

Substance Use	Youth (12-17)			Adult (18 or older)	
Past Month Marijuana Use	US	DC		US	DC
Percentage	6.46%	8.26%*		9.51%	17.67%*
Estimate (In Thousands)	1,611	3		23,377	98

Past Month Illicit Drug Use Other than Marijuana Among Adolescents Aged 12-17 and Adults Aged 18 or Older in the District of Columbia and the United States (2016-2017) – The percentage of persons indicating use of illicit drugs other than marijuana in the past month was slightly higher for District youth (3.23% or about 1,000) and adults (5.48% or about 30,000) compared to the percentage of youth (2.43%) and adults (3.47%) nationally.

Substance Use	Youth (12-17)			Adult (18 or older)	
Past Month Illicit Drug Use Other Than Marijuana	US	DC		US	DC
Percentage	2.43%	3.23%*		3.47%	5.48%*
Estimate (In Thousands)	605	1		8,533	30

Past Year Pain Reliever Misuse Among Adolescents Aged 12-17 and Adults Aged 18 or Older in the District of Columbia and the United States (2016-2017) – The percentage of persons indicating misuse of pain relievers in the past year was slightly higher for District youth (3.91% or about 1,000) and adults (4.42% or about 24,000) compared to the percentage of youth (3.31%) and adults (4.26%) nationally.

Substance Use	**Youth (12-17)**			**Adult (18 or older)**	
Past Year Pain Reliever Misuse	US	DC		US	DC
Percentage	3.31%	3.91%*		4.26%	4.42%*
Estimate (In Thousands)	824	1		10,473	24

Past Month Alcohol Use Among Adolescents Aged 12-17 and Adults Aged 18 or Older in the District of Columbia and the United States (2016-2017) – The percentage of District youth indicating alcohol use in the past month was slightly lower (8.42% or about 3,000) compared to youth nationally (9.54%). For adults in the District, the percentage was about 15% higher (70.08% or about 389,000) compared to adults nationally (55.43%).

Substance Use	**Youth (12-17)**			**Adult (18 or older)**	
Past Month Alcohol Use	US	DC		US	DC
Percentage	9.54%	8.42%		55.43%	70.08%*
Estimate (In Thousands)	2,377	3		136,287	389

Past Month Binge Alcohol Use Among Adolescents Aged 12-17 and Adults Aged 18 or Older in the District of Columbia and the United States (2016-2017) – The percentage of District youth indicating binge alcohol use in the past month was slightly lower (4.84% or about 2,000) compared to youth nationally (5.06%). For adults in the District, the percentage was 12% higher (38.83% or about 215,000) compared to adults nationally (26.33%).

Substance Use	**Youth (12-17)**			**Adult (18 or older)**	
Past Month Binge Alcohol Use	US	DC		US	DC
Percentage	5.06%	4.84%		26.33%	38.83%*
Estimate (In Thousands)	1,262	2		64,720	215

Past Month Cigarette Use Among Adolescents Aged 12-17 and Adults Aged 18 or Older in the District of Columbia and the United States (2016-2017) – The percentage of persons indicating cigarette use in the past month was lower for both District youth (1.78% or about 1,000) and adults (19.65% or about 109,000) compared to youth (3.29%) and adults (20.01%) nationally.

Substance Use	**Youth (12-17)**			**Adult (18 or older)**	
Past Month Cigarette Use	US	DC		US	DC
Percentage	3.29%	1.78%		20.01%	19.65%
Estimate (In Thousands)	821	1		49,192	109

Mental Health Indicators

Past Year Major Depressive Episode Among Adolescents Aged 12-17 and Adults Aged 18 or Older in the District of Columbia and the United States (2016-2017) – The percentage of District youth indicating a major depressive episode in the past year was lower (10.49% or about 3,000) compared to youth nationally (13.01%). For adults in the District, the percentage was slightly higher (7.89% or about 44,000) compared to adults nationally (6.89%).

Mental Health	**Youth (12-17)**			**Adult (18 or older)**	
Past Year Major Depressive Episode	US	DC		US	DC
Percentage	13.01%	10.49%		6.89%	7.89%*
Estimate (In Thousands)	3,243	3		16,949	44

Past Year Serious Mental Illness Among Adults Aged 18-25 and Adults Aged 26 or Older in the District of Columbia and the United States (2016-2017) – The percentage of younger adults aged 18-25 in the District indicating serious mental illness in the past year was slightly lower (6.25% or about 6,000) compared to younger adults nationally (6.68%). For adults aged 26 or older in the District the percentage was slightly higher (4.08% or about 19,000) compared to older adults nationally (4.01%).

Mental Health	**Adults (18-25)**			**Adult (26 or older)**	
Past Year Serious Mental Illness (Adults Only)	US	DC		US	DC
Percentage	6.68%	6.25%		4.01%	4.08%*
Estimate (In Thousands)	2,300	6		8,475	19

Past Year Serious Thoughts of Suicide Among Adults Aged 18-25 and Adults Aged 26 or Older in the District of Columbia and the United States (2016-2017) – The percentage of persons indicating serious thoughts of suicide in the past year was slightly lower for younger adults aged 18-25 (8.55% or about 8,000) and adults aged 26 or older (3.24% or about 15,000) in the District compared to younger adults (9.64%) and older adults (3.31%) nationally.

Mental Health	**Adults (18-25)**			**Adult (26 or older)**	
Past Year Serious Thoughts of Suicide (Adults Only)	US	DC		US	DC
Percentage	9.64%	8.55%		3.31%	3.24%
Estimate (In Thousands)	3,321	8		6,987	15

Past Year Received Mental Health Services Among Adults Aged 18-25 and Adults Aged 26 or Older in the District of Columbia and the United States (2016-2017) – The percentage of adults who indicated receiving of mental health services in the past year was higher for younger adults aged 18-25 (15.34% or about 14,000) and adults aged 26 or older (17.12% or about 79,000) compared to younger adults (13.9%) or older adults (14.72%) nationally.

Mental Health	**Adults (18-25)**			**Adult (26 or older)**	
Past Year Received Mental Health Services (Adults Only)	US	DC		US	DC
Percentage	13.90%	15.34%*		14.72%	17.12%*
Estimate (In Thousands)	4,785	14		31,112	79

Consumers Reporting Improved Functioning Among the Families of Youth Under 17 and Adults Aged 18 and Older in the District of Columbia and the United States (2017) – The percentage of mental health consumers reporting improved functioning was 20% lower among District youth

(51%) compared to youth nationally (71%). For adults aged 18 or older, the percentage reporting improved functioning was lower for the District (64%) compared to adults nationally (71%).

Mental Health	Youth (Family of)			Adult (18 or older)	
Consumers Reporting Improved Functioning	US	DC		US	DC
Percentage	71%	51%		71%	64%

Data Sources:
Substance Use and Mental Health Tables: https://www.samhsa.gov/data/report/2016-2017-nsduh-state-estimates-substance-use-and-mental-disorders
Mental Health Functioning: https://www.samhsa.gov/data/report/2017-uniform-reporting-system-urs-table-district-columbia

Physical Health Profile Overview
The information about the District of Columbia Health Profile is developed by DC Health and the Centers for Disease Control and Prevention. It includes: 1) life expectancy at birth, 2) mortality, 3) maternal and child health outcomes, 4) chronic health indicators, and 5) health disparities.

Life Expectancy at Birth *(District of Columbia, 2011-2015)*: The life expectancy at birth in years for the U.S. in 2015 was 78.8 years. The average for D.C. is 79.0.

D.C. Ward	Life Expectancy in Years
Ward 3	87.6
Ward 2	85.3
Ward 4	81.0
Ward 1	80.9
Ward 6	79.1
Ward 5	76.4
Ward 7	74.7
Ward 8	72.0

Data Source: D.C. Department of Health 2018 Health Equity Report

Mortality: *The ten leading causes of death in the District compared to the U.S. (* = Indicators where the District rate is higher than the U.S.)*

Health Indicator	U.S. (2016)	D.C. (2016)
Leading Causes of Death (age-adjusted death rate per 100,000 population)		
Heart Disease	165.5	211.7 *
Cancer	155.8	160.1 *
Accidents	47.4	58.3 *
Cerebrovascular Disease (Stroke)	37.3	38.4 *
Chronic Lower Respiratory Disease	40.6	24
Diabetes	21	19.8
Alzheimer's Disease	30.3	18.3
Influenza and Pneumonia	13.5	11.5
Kidney Disease	13.1	9
Suicide	13.5	5.2

Data Source: https://www.cdc.gov/nchs/data-visualization/mortality-leading-causes/index.htm

Maternal and Child Health Outcomes: *(* = Indicators where the District percentage is higher than the U.S.)*

Health Indicator	United States (2017)	District of Columbia (2016)
Infant Mortality (rate per 1,000 births)	5.9%	7.1 *
Low Birth Weight (percent of births)	8.30%	10.2% *
Pre-term Births (percent of births)	9.90%	10.8% *
Teen Birth Rate (per 1,000 women ages 15-19)	18.8	24.0 *
Birth Rate (per 1,000 women)		
Ages 20-24	71.0	48.9
Ages 25-29	98.0	49.5
Ages 30-34	100.3	77.8
Ages 35-39	52.3	72.9 *
Ages 40-44	11.6	21.7 *

Data Sources: D.C. Department of Health, Perinatal Health and Infant Mortality Report, 2018 and https://www.cdc.gov/nchs/data/nvsr/nvsr67/nvsr67_08-508.pdf

Chronic Health Indicators: *(* = Indicators where the District percentage is higher than the U.S.)*

Health Indicator: Adults 18 and older	United States (2017)	District of Columbia (2017)
Overweight and Obesity (BMI):		
Overweight (BMI 25.0-29.9)	35.3%	31.2%
Obese (BMI 30.0-99.8)	31.3%	22.9%
Cardiovascular Diseases:		
Angina or Coronary Heart Disease (CHD)	3.9%	1.9%
Heart Attack/Myocardial Infarction (MI)	4.2%	2.7%
Stroke	3.0%	3.2% *
Diabetes:		
Diagnosed with Diabetes	10.5%	7.5%
Asthma:		
Current Asthma	9.4%	9.4%

Data Source: https://www.cdc.gov/brfss/brfssprevalence/index.html

Health Disparities

The District of Columbia has the highest maternal mortality rate in the country, and Black/African American women accounted for 75% of the maternal deaths that occurred between 2014 and 2016 (D.C. Office of the Chief Medical Examiner, 2019).

- Non-Hispanic Black infants account for a disproportionate percentage of all infant deaths, and the disparity between Non-Hispanic Black infant deaths and Non-Hispanic White is growing (D.C. Vital Records, 2015).
- Blacks/African Americans in the District of Columbia have the highest obesity rates. (Behavioral Risk Factor Surveillance System, 2017).
- Hispanics in the District of Columbia make up the highest percentage of overweight residents and are least likely to exercise (Behavioral Risk Factor Surveillance System, 2017).
- Ward 8 had the highest age-adjusted death rate from heart disease at 369.4 per 100,000 population (D.C. Vital Records, 2014).
- Life expectancy in the District has mirrored the U.S. trend and decreased from 2014-2015. The geographic disparity within the District is more than 17 years, with life expectancies topping 89 years in parts of northwest D.C. and, in neighborhoods east of the Anacostia River, dropping as low as 72 years (D.C. Department of Health, Health Equity Report, 2018)

Criterion 3*:* Children's Services

The Mental Health Block Grant statutory reporting requirement **Criterion 3** addresses **Children's Services** defined as: *provides for a system of integrated services in order for children to receive care for their multiple needs. Services that should be integrated into a comprehensive system of care include: social services; educational services, including services provided under Individuals with Disabilities Education Act (IDEA); juvenile justice services; Substance Use Disorder Services; and health and mental health services.*

DBH's Community Services Administration develops, implements, and monitors a comprehensive array of prevention, early intervention and community-based behavioral health services and supports for adults, children, and youth and their families that are culturally and linguistically competent and supports resiliency, recovery and overall well-being for district residents who have mental health and substance use disorders. The Community Services Administration also provides specialty programs such as direct school-based services, court-ordered and community assessments, and oversight of Health Homes, youth placed in Psychiatric Residential Treatment Facilities (PRTF) and specialty courts for youth involved in the juvenile justice system.

Definition Children/Youth with Serious Emotional Disturbances (SED): SAMHSA defines children with SED as persons birth to 18 who: *1) currently meet or at any time during the past year has met criteria for a mental disorder, including within developmental and cultural contexts, as specified within a recognized diagnostic classification system (e.g., most recent editions of DSM, ICD, etc.), and 2) display functional impairment, as determined by a standardized measure that impedes progress towards recovery and substantially interferes with*

or limits the person's role or functioning in family, school, employment, relationships, or community activities.

The Goal of Child and Youth Services: The goal is to ensure that children/youth and their families have access to a coordinated system of care (SOC) that is easy to navigate, community-based, family-driven youth-guided, and able to meet their multiple and changing needs. DBH is committed to developing a comprehensive SOC for children, adolescents, transition-aged youth, and their families that promote prevention, early intervention, and treatment. DBH also develops with the youth and family an individualized plan that focuses on the provision of services within the community.

Overview of Child and Youth Services

Mental Health Rehabilitation Services

The Department contracts with community providers for mental health services and supports. The child/youth mental health rehabilitation services (MHRS) include: 1) diagnostic-assessment; 2) medication/somatic treatment; 3) counseling; 4) community support; 5) crisis/emergency; and 6) community-based intervention. As of July 2019, there are 21 MHRS certified child/youth providers; 3 are child only providers, and 18 are child/youth providers.

The number of children/youth served includes the following:

Fiscal Year	Children/Youth Ages 0-20
2017	4807
2018	3857
2019 April	2617

Childhood Interventions

- *Early Childhood Mental Health Consultation (ECMHC)-Healthy Futures:* This evidence-informed mental health consultation project provides early childhood consultation to parents, children and their families, teachers, and providers about mental health and early identification of young children at risk of or displaying signs and symptoms of mental health disorders. ECMHC-Healthy Futures promotes social and emotional development in children and transforms their challenging behaviors. The children range in age from birth to age 5. Healthy Futures served 42 child development centers and 19 home providers for a total of 61 sites in the fiscal year 2019.

  In FY 2019, the ECMHC- Healthy Futures program operated in several sites that included child development centers and the new expansion-sites. The expansion-sites are showing a demonstrable positive level of change in child behaviors and classroom environments.

The number of project sites by type includes the following:

(3 centers are both QIN and Pre-K)

Project Site Type	Number of Sites
	61 Sites
Child Development Centers (HF Sites)	11
Home-Based Providers	19
Pre-Kindergarten Incentive	19
Quality Improvement Network	15

Early

D.C. Social Emotional and Early Development Project (D.C. SEED): DC SEED is a 4-year SAMHSA System of Care (SOC) Expansion and Sustainability Cooperative Agreement that addresses specific largely unmet needs of young children (birth-6) who are at high imminent risk for or diagnosed with SED. The project started on October 1, 2016, and will end September 30, 2020. These evidence-based and promising practices being implemented or expanded to meet the needs of young children and families include Child-Parent Psychotherapy for Family Violence (CPP-FV); Parent-Child Interaction Therapy (PCIT), Strengthening Family Coping Resources (SFCR), Intensive Home and Community-Based Services, and High Fidelity Wraparound. Providers are scheduled to be retrained in August 2019 to administer the D.C. 0-3 Network's Assessment Instrument to promote sustainability/adequate reimbursement through Medicaid. The goals include 1) train and support all current and future SOC Family Peer Specialists in Early Childhood, 2) establish, in collaboration with Help Me Grow, single point of entry for referral and linkage for all young children and families with SED, and 3) ensure that 100% of Child Development Centers in the District have access to individualized early childhood mental health phone consultations by 2020.

Parent-Infant Early Childhood Enhancement Program (PIECE): The PIECE Program provides early intervention and treatment to children ages birth to seven years of age, and their families who present with challenging social, emotional and disruptive behaviors, that causes impaired functioning at home, school and in the community. Also,-the PIECE Program provides services to mothers who are pregnant and post-pregnancy to mothers experiencing mental health challenges that impact early attachment and parenting of their infant child.

The PIECE Program seeks to provide comprehensive services to children and families that enhances early cognition, language development, emerging motor and adaptive skills, social, emotional and behavioral functioning, which supports school readiness. The program utilizes several treatment modalities to strengthen the parent child dyad, as well as two evidence-based practices. The program services include individual, family, art therapy, play therapy, and the parents' psychoeducational group. The two evidence based practices are Child-Parent Psychotherapy (CPP) focusing on families with young children exposed to violence and other forms of trauma, and Parent-Child Interaction Therapy (PCIT) which focuses on teaching parents and caregivers skills and techniques to improve disruptive behaviors.

The PIECE Program works to address the mental health needs of young children and their families throughout the District of Columbia. However, the highest prevalence of our consumers is from wards six, seven, and eight.

Fiscal Year	Capacity	Total Served	CFSA Involved
FY18	140	135	51
FY19	140	116	43 (2nd Quarter)

The PIECE Program provides developmental screenings, diagnostic assessments, treatment plans, case management, individual, family, art, and play therapy, two evidence-based treatments (PCIT and CPP), psychoeducational parenting groups, school observations and home visitation for young children and maternal services.

Physicians' Practice Group (PPG): The PPG transitioned to a primary focus on Child and Adolescent Urgent Same Day Services in January 2018. Services include a clinical assessment of safety, diagnostic evaluations, and recommendations for treatment for children and youth ages 6-21, and families who present with self-identified or referral-based urgent requests to include challenging social, emotional, and disruptive behaviors that contribute to impaired functioning at home, school/daycare, and the community. The same-day urgent care services are triaged to determine urgency and need.

- These Urgent Care services are available to eligible children and adolescents who are: 1) residents of the District of Columbia, 2) receive services within the DBH provider network, and 3) linked to child servicing agencies such as, Child and Family Services Agency, Department of Youth Rehabilitation Services, District of Columbia Public Schools, and court-involved children. The youth must present with a legal guardian, or a person with a Medical Power of Attorney, to obtain necessary consents for care and treatment.
- On occasion, court evaluations are scheduled by the PPG Triage Team.
- The PPG continues medical, psychiatric oversight of children in the PIECE Program who may benefit from medication assessments and medication management.

The PPG data includes the following:

Fiscal Year	Total Served
FY 2016	647
FY 2017	845
FY 2018	73
FY 2019 (July)	62

Co-Located Programs: The co-location of DBH clinicians at various District government agency and community-based sites who conduct behavioral health screenings, assessments, and consultations, and make referrals to the behavioral health provider network.

School Mental Health Program

The School Mental Health Program (SMHP) promotes social and emotional development that addresses psycho-social and mental health problems that become barriers to learning by providing prevention, early intervention, and treatment services to youth, families, teachers and school staff. Services are individualized to the needs of the school and may include screening, behavioral and emotional assessments, school-wide or classroom-based interventions, psycho-educational groups, consultation with parents and teachers, crisis intervention, as well as individual, family and group treatment.

The SMHP utilization data is presented in the table that follows:

School Mental Health Program (SMHP) Utilization			
Student Information	School Year 16-17 (FY17)	School Year 17-18 (FY18)	School Year 17-18 (FY19)
Students referred to SMHP clinician	2094	1767	1572
Students referred and seen by SMHP clinician	2094	1767	1549
Students on caseload	**924**	978	826
Students referred to outside services (housing, food, etc.)	294	246	131
Students referred to outside mental health services (core service agency, Managed Care Organization)	507	302	187

SMHP Primary Prevention and Secondary Prevention Programs: This includes evidence-based or evidence-informed programs implemented through DBH School Mental Health.

Violence Prevention: 1) *Connect With Kids- Adventures and Character Education Series* (What Works Clearinghouse endorsed, evidence-informed program), 2) *Too Good for Violence* (SAMHSA approved, evidence-based program), and 3) *Love Is Not Abuse* (an evidence-informed program for students that teaches youth about teen dating violence).

Sexual Abuse Prevention: 1) *Good Touch Bad Touch*- (National Mental Health Association Clearinghouse (NMHAC) endorsed, evidence-based program that teaches the skills needed to prevent or interrupt abuse), and 2) *Healthy Boundaries*- (NMHAC endorsed evidence-based program for 7th-9th graders).

Suicide Prevention: 1) *Signs of Suicide (SOS)* (SAMHSA approved, evidence-based depression and suicide prevention program), 2) *Ask 4 Help-K-5: Yellow Ribbon's Suicide Prevention Program (*an evidence-informed curriculum that specializes in the ongoing development and reinforcement of protective factors in children and youth) and 3) *QPR- Question, Persuade, Refer- Elementary, Middle and High Schools Staff* (an evidence-based prevention program developed for individuals (e.g., teachers, staff members, etc.) to learn how to recognize the

warning signs of suicide, and to teach how to question, persuade, and refer an individual in crisis).

Anger Management: Coping Cats Program-"Keeping your Cool" The Anger Management Workbook- a SAMHSA approved, evidence-based anger management program that teaches strategies that can be employed by both boys and girls, ages 10-17, to help them cope with a variety of anger-arousing situations.

Parenting Program: Parent Cafés (elementary, middle, and high schools). An evidence-informed parenting program that includes small group discussions among parents to promote individual self-reflection, and peer-to-peer learning based on five (5) research-based protective factors: parental resilience, social connections, knowledge of parenting and child development, concrete support in times of need, and social and emotional competence of children. Cafés are facilitated by a host in small groups where parents explore topics led by questions from the tool "*Parent Café in a Box*."

Substance Abuse Prevention: 1) *Teen Intervene*- Helps youth identify the reasons they have chosen to use alcohol or other drugs, examine the effects of substance abuse in their lives, and learn to make healthier choices. *Teen Intervene* includes updated information on the stages of change theory, motivational interviewing techniques, and cognitive-behavioral therapy, all incorporated into a practical, ready-to-use model. 2) *Botvins Life Skills Training Program-* (elementary, middle, and high schools). A SAMHSA approved evidence-based substance abuse prevention program that addresses the most important factors leading children and adolescents to use drugs. The program teaches a combination of drug resistance skills, self-management skills, and general social skills to children in 3rd -12th grades.

Too Good for Drugs substance use prevention began in FY18-19 with 5th, 7th and 9th grades. These grades were matched to YRBS data for onset of use and critical grades to receive curriculum. In SY19/20, will look at expanding to other grades. It can be offered for all elementary, middle and high school students

Youth Suicide Prevention and School Climate Survey Amendment Act of 2016 (Law 21-120)
This law requires the Office of the State Superintendent for Education (OSSE) to adopt a rule requiring all District teachers and principals in public and charter schools to undergo training on suicide prevention, intervention, and postvention every two years. It also requires OSSE to develop and publish online written guidance to assist local education agencies (LEAs) in developing policies and procedures for handling various aspects of student mental and behavioral health. OSSE must examine and evaluate its guidance every five years, at a minimum, and notify LEAs within 30 days of updating the guidance. The law also requires OSSE to establish and implement a pilot program to collect school climate data (data regarding engagement, safety, and environment) through school climate surveys, and report school climate data to the Mayor and Council annually.

Children and Adolescent Mobile Psychiatric Service (ChAMPS)
FY 2019 is the 11th year of operation for ChAMPS via DBH contract with Catholic Charities of Washington Behavioral Health Services. The purpose is to provide immediate access to mobile emergency services for children, youth, and families experiencing a behavioral or mental health crisis. The service is available 24 hours, seven days a week for children and youth ages 6 to 18,

except for youth who are committed to the Child and Family Services Agency, and served until age 21. The mobile team: 1) provides on-site crisis assessments to determine the mental health stability of a youth and their ability to remain safe in the community; 2) assists in the coordination of acute care assessments and hospitalizations when appropriate; and 3) post-crisis follow-up interventions are conducted up to 30 days after the initial crisis intervention to ensure linkage to DBH mental health providers for ongoing treatment.

The ChAMPS data includes the following:

Fiscal Year	Total Children Served-Unduplicated	Total Calls Received	Total Deployments	Child & Family Service Agency Youth (calls)	Total FD-12s	Total Cases Resulting in Acute Care Admissions
FY 2017	707	1435	855	43	134	114
FY 2018	857	1682	837	19	112	48
FY 2019 April	580	1235	615	35	92	57
TOTAL	2144	4352	2307	97	338	219

Psychiatric Residential Treatment Facilities (PRTFs)

The Department of Behavioral Health has the authority and responsibility to determine medical necessity for PRTF placements for Medicaid and Medicaid eligible children and youth in the District of Columbia. DBH has established an interagency PRFT review committee that meets weekly to review complete referral packets for admission and continued stay in PRTF. DBH also provide centralized coordination and monitoring of treatment while in a PRTF and collaborate with District agencies for post-discharge planning.

Fiscal Year	**Total Reviewed**	**Initial Review**	**Continued Stay**
FY 15	74	39	35
FY 16	60	45	15
FY 17	54	38	16
FY18	26	18	8
FY19 Q2	17	8	9

The PTRF data includes the following:

Fiscal Year	Children/Youth in PRTFs	Average Length of Stay
2015	113	9.4 months
2016	131	8.5 months
2017	116	8.1 months
2018	81	7 months
2019 (May	62	8.5 months

Functional Assessment Scales

The Child and Adolescent Functional Assessment Scale (CAFAS) is used to measure children and adolescents functioning across life domains. It was designed to assess youth with emotional, behavioral, psychological, or substance use problems. The Preschool and Early Childhood Functional Assessment Scale (PECFAS) is the preschool version of the CAFAS. Both instruments assess a child's day-to-day functioning across critical life domains and indicate whether a child's functioning improves over time.

Child/youth-serving agencies utilizing the CAFAS and/or PECFAS includes the following:

Child and Family Services Agency (CFSA) - Implements the CAFAS/PECFAS for all children/youth. Included are children in out-of-home care (foster care, group settings, psychiatric residential treatment facilities, and supervised return to the biological home), and children/youth who remain in their biological home but are receiving services and monitoring through CFSA.
Department of Youth Rehabilitation Services (DYRS) - Administers the CAFAS when a Notice of Intent to Commit is filed and then administers it every 90 days for all committed youth. It is used in the quarterly Team Decision Making (TDM) meeting to identify needs for the plan of care and illustrate change and improvement over time.

Department of Human Services (DHS) - Utilizes the CAFAS for all youth actively enrolled in the Parent and Adolescent Support Services (PASS) in the Alternatives to Court Experience (ACE) diversion program, and in the Teen Parent Assessment Program (TPAP). DHS utilizes the CAFAS data to measure outcomes in these short-term programs.

Department of Behavioral Health (DBH) - Continues to utilize the CAFAS/PECFAS across the child-serving providers. The CAFAS/PECFAS total score informs about the types and quantity of services that receive automatic approval for inclusion in the child/youth's plan of care.

Evidence-Based Practices (EBPs)

DBH is committed to improving the lives of children, youth, transition-age youth, and families through the use of evidence-based practices. DBH contracts with Evidence Based Associates (EBA) to provide training, quality and fidelity reviews, and monitors most of the EBPs. EBA also provides technical support to District agencies implementing an EBP that they monitor.

There are currently seven (7) **EBPs** that include the following:

Child-Parent Psychotherapy for Family Violence- For ages 0-6 with a history of trauma exposure or maltreatment and their caregivers.

*Trauma Systems Therapy***-** For ages 0-19 who have experienced traumatic events and/or who live in environments with ongoing traumatic stress.

Parent-Child Interaction Therapy- For ages 2-6 who experience extreme behavioral difficulties with an emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns.

*Trauma-Focused Cognitive Behavioral Therapy***-** For ages 4-18, this service helps children, youth, and their parents overcome the negative effects of traumatic life events and address feelings.

*Multi-Systemic Therapy***-** For ages 10-17, with an emphasis on empowering parents/caregivers effectiveness as they assist the child/youth in successfully making and sustaining changes in individual, family, peer, and school systems.

Transition to Independence Process- An evidence-supported model for ages 14-29 that also engages families and other informal key players in a process to facilitate movement towards greater self-sufficiency and achievement of individual goals.

Functional Family Therapy - An evidence-based practice for youth and families ages 11-18 to improve within family attributions, family communication, and supportiveness while decreasing intense negativity and dysfunctional patterns of family behavior.

*The following **EBP's** are not monitored by EBA:*

Adolescent Community Reinforcement Approach- For ages 12-22, this approach seeks to replace environmental influences that have supported alcohol or drug use with prosocial activities and behaviors that support recovery.

Assertive Community Treatment- DBH implements ACT, an evidence-based, intensive, integrated, rehabilitative, treatment, and community-based service. This service is provided by an interdisciplinary team to adults with serious and persistent mental illnesses. DBH ACT teams include: a team leader, psychiatrist, registered nurse, social worker, certified addictions counselor, peer support specialist, supported employment specialist, and recovery specialist.

*Supported Employment- D*BH provides an evidence-based Supported Employment Program designed for adult consumers (age 18 and older) with serious mental illnesses for whom competitive employment has been interrupted or intermittent as a result of a significant mental health problem. Supported Employment involves obtaining a part-time or full-time job where the consumer receives supports in a competitive employment setting and earns at least

minimum wage. The services provided to the consumers participating in a DBH Supported Employment Program are: intake, assessment, benefits counseling, treatment team coordination, job development, job coaching, and follow-along supports.

Transition-Age Youth Initiatives

Now Is The Time (NITT)-Healthy Transitions: This grant, also known as *Our Time: Positive Transitions for Youth and Young Adults*, is designed to develop a transition-age youth (TAY) and young adults (YA) system of care that improves the life trajectories for youth and YA ages 16-25 with or at risk of serious behavioral health conditions. The purpose of this program is to improve access to mental health and substance use disorder treatment and provide support services through care coordination and planning. The populations for this effort are youth and YA residing in Wards 7 and 8 and young people identified as LGBTQ throughout the District.

*Community Agency Service Providers***-** Two (2) DBH core services agencies (CSAs), Community Connections and MBI Health Services, provide TAY and YA focused behavioral health services and supports. Total Family Care Coalition, a family run organization (FRO), in conjunction with DBH has facilitated several social outings and enrichment activities designed promote exposure and education in venues outside of their regular routine. The goal is to provide exposure to alternate social and entertainment activities, strengthen social and coping skills and encourage exploration of new opportunities.

Evidence Based Practices/Evidence Supported Services- The evidenced based or evidence supported services offered by the two (2) community-based organizations include: 1) Transition to Independence Process (TIP) Model; 2) Assertive Community Treatment (ACT); 3) First Episode Psychosis-Cognitive Behavioral Therapy (FEP-CBT), 4) Supported Employment (SE); and 5) Transitional Housing-Wayne Place (TH-WP).

*TAY Services and Supports***-** The services and supports include: 1) Mental Health Rehabilitation Services (MHRS); 2) TIP/ACT; 3) TAY SE; 4) substance use disorder (SUD) treatment; 5) housing supports; 6) social services linkage and support; 7) educational/vocational training; 8) life skills enhancement training and support; and 9) enrichment activities.

*FY 2017 First Episode Psychosis Transition Age Youth (FEP/TAY) Pilot Project***-** The goal of the District of Columbia FEP early intervention program is to change the long-term prognosis for young people coping with schizophrenia. The FEP program is being implemented by Community Connections one of the Department of Behavioral Health (DBH) transition age youth (TAY) provider agencies. Known as the Youth Blossom program, young adults who are experiencing their first episode of psychosis receive coordinated specialty care from a team of skilled specialist. FEP Youth Blossom Program uses the NAVIGATE Model. The NAVIGATE inspired team model includes a psychiatrist, program consultant, program director program evaluator, resiliency trainer, and supported employment and education specialist. The NAVIGATE-inspired services include recovery focus, employment, family education, psychiatric screening, and psychotherapy.

Referrals- The number of referrals FY' 19 referrals as of July 2019 include **74** consumers.

5% of referrals were walk-in referrals.

5% of referrals originated from the District DBH and the Department of Corrections.

60% of referrals were from MedStar Washington Hospital Center Behavioral Health and Psychiatry, 1 individual was referred from Children's National Behavioral Health and Psychiatry.

20% of referrals were intra-agency program referrals from within Community Connections.

8% of referrals were referred from the Half-Way Back program.

2% of referrals were from two (2) public charter schools, Maya Angelou Public Charter School and Idea Public Charter school both located in Washington, D.C.

Demographic Profile of TAY Serve- The demographic characteristics of the TAY served to date are described below.

Age of TAY Served: All of the **74** referred individuals fall within the 16-26 age range. The breakdown of each age group includes the following:

Age	Individuals
16	3%
17	3%
18	3%
19	3%
20	16%
21	22%
22	6%
24	25%
25	6%
26	13%

Race and Ethnicity of TAY Served: Of the **74** TAY in FEP, **86%** of identified as Black or African American, **3%** of TAY served identify as Hispanic or Latino, **2%** of TAY served identify at Caucasian, and **9%** of TAY served identify as "Other".

The race and ethnic data is in the table that follows:

Race/Ethnicity	Percentage of
Black/African-American	86%
Hispanic or Latino	3%
Caucasian	2%
Other	9%

Living Arrangement and Residential Setting of TAY Served: The data for living arrangements and residential settings includes the following:

Living Arrangement	Residential	Percentage of
Correctional facility	Jail	9%
Family	House	26%
Family	Apartment	17%
Family	Unknown	10%
Friend/Other	Apartment	2%
Homeless	Shelter	4%
Homeless	House	8%
Homeless	No fixed address	8%
Transitional housing	Shelter	2%
Transitional housing	No fixed address	6%
Section 8 Housing	N/A	8%

Employment and Education Status of TAY Served: The data for employment and education status includes the following:

Employment	Percentage of Individuals
Unemployed-Seeking	54%
Full-Time Student	16%
Unemployed-Not	11%
Employed-Part Time	8%
Unknown	11%

The data for education level is in the table that follows.

Education Level	Percentage of Individuals
High School	38%
11th Grade	6%
10th Grade	4%
Some College	15%
12th Grade	13%
8th Grade	2%
9th Grade	4%
Unknown	15%

Service Outcomes: The referrals to date include **74** consumers. Of the **74** consumers referred, **54%** continue to receive services from the FEP pilot program while the other **56%** were referred to outside resources within Community Connections or to neighboring agencies within the D.C. Metropolitan area.

Psychiatric Services and Medication Management: All FEP enrolled consumers (100%) are receiving medication management services and continued psychiatric care from the FEP pilot program psychiatrist. 100% of FEP consumers are linked to psychotherapeutic services delivered by the FEP Resiliency Trainer. In addition, all FEP consumers (100%) continue to receive continued support in addressing clinical and socio environmental consumer needs from a NAVIGATE inspired model provided by the FEP Resiliency Trainer.

Education and Employment Services: Of the current (100%) of enrolled FEP consumers are connected and receiving services from the FEP Supported

Employment and Education Specialist. Services provided include addressing vocational and educational consumer needs within the NAVIGATE inspired model.

Pending Status/Referred to Other Programs: Per program protocol, each consumer enrolled in FEP has to meet program criteria prior to their full enrollment in FEP and this is completed by the FEP team psychiatrist. Furthermore, an initial assessment is administered to ensure that FEP is the best program fit for the individual's needs in addition to identifying whether each individual referred to FEP meets program criteria. Due to this reason, three individuals are currently pending approval to date. Seventeen percent of referred individuals were referred to Community Connections sister program, TAY-SOC, while no individual is pending a complete referral to the TAY-SOC program.

*Transition Age Youth Housing Initiative***-** Wayne Place, a transition age youth (TAY) transitional housing facility, opened in March 2015. It is the result of a partnership between DBH and the Child and Family Services Agency (CFSA) to help young men and women between the ages of 18-24, who might otherwise be homeless, build the skills they need to be self-sufficient. This initiative also includes life skill training for youth and young adults who need support to live independently and succeed.

During the TAY stay at Wayne Place, residents are assigned to a Transition Specialist that supports them as they work to achieve their individual goals. They are encouraged to attend all workshops that are offered on-site. The topics include: financial literacy, housing, employment readiness, conflict resolution, life skills, civic engagement, health, education, domestic violence, and peer to peer.

Services for Lesbian, Gay, Bi-sexual, Transgender, Questioning (LGBTQ) Youth and Young Adults

Wanda Alston Foundation (WAF) - Advocates for increased resources for youth while providing programs including housing, life skills training, linkages to other social services, and capacity-building assistance for other community allies.

Supporting and Mentoring Youth Advocates and Leaders (SMYAL) - Some of the services include: 1) case management (development of personal action plan, weekly check-in meetings, and crisis navigation); 2) supportive services (medical care, mental health services, and self-care support); 3) skill development (education, job readiness, and life skills such as cooking, budgeting, etc.); 4) social support (community outings and access to LGBTQ youth networking); and 4) after-care (open line of post-program communication between the youth and their case manager for up to 12 months).

Transgender Health Empowerment, Inc. (T.H.E.) - Works to enhance the quality of life of the diverse transgender population by advocating for and supporting a continuum of health and social services. In fulfilling their mission, T.H.E. is the home of the Tyra Hunter Drop-In Center for transgender, gay, lesbian and bisexual youth, providing showers, laundry, clothing, and food to the homeless. T.H.E. also operates transitional housing for gay, lesbian, bisexual and transgender youth.

Different Avenues - Provides services to youth and young adults who are homeless, or living in unstable housing. Many of the clients are transgender, gay, lesbian or bisexual. It also assists youth who are parents and their families. The services include a drop-in center, HIV/AIDS prevention education, sexual health education, access to drug prevention and mental health services, peer-based leadership training, and legal referrals.

Capital Center for Psychotherapy and Wellness - Named Washington Blade's 2016 Best LGBT Owned Business, The Capital Center for Psychotherapy and Wellness takes a holistic approach to health and wellness. They focus on using multiple modalities to treat all aspects of a person's health. They offer LGBT Therapy.

The DC Center for the LGBT Community **-** offers individual and group mental health support services for LGBTQ survivors of violence and crime in the District of Columbia. This includes any individual or couple that has experienced any of the following types of victimization: intimate partner violence/domestic violence, sexual and/or physical assault, hate crime (racial,

religious, gender, sexual orientation, and/or other type of hate crime), bullying, physical abuse/neglect, teen dating victimization, and family violence.

Youth Pride Clinic at Children's National-The Youth Pride Clinic provides primary and specialty care services to LGBTQ (lesbian, gay, bisexual, transgender and questioning/queer) patients throughout the greater Washington, D.C., region. LGBTQ patients face unique health challenges, including higher rates of depression, suicide, sexually transmitted diseases, and HIV infection, and this clinic provides comprehensive primary and mental health care to LGBTQ youth and young adults between the ages of 12 to 21.

Office of the Ombudsman

The initial Office of the Ombudsman was called the DBH Child and Youth Services Ombudsman Program. It began in FY 2015 with full implementation beginning in FY 2016. The office is responsible for supporting consumer access to services to include assisting consumers in resolving problems with behavioral health providers, behavioral health facilities, and in addressing barriers to services.

***FY 2017 Accomplishments*-** The achievements include 1) increase in the program staffing that includes the DBH Ombudsman and the Ombudsman Specialist, 2) development of a draft policy with support from the DBH Policy Division to address how complaints are handled within the agency, 3) outreach and education to internal staff and stakeholders about the Ombudsman's Office, and 4) enhancement of the database by utilizing the Consumer and Family Affairs Administration grievance categories and creating sub-categories to describe service gaps. Currently, DBH categories are defined as complaints or inquiries related to Access, Clinical Care or Administration. Currently, DBH categories are defined as complaints or inquiries related to Access, Clinical Care or Administration.

The available data during FY 2017 to date includes the following:

Contacts	Complaints	Inquiries & Notification
	95	14

FY 2018 Office of the Ombudsman - In FY 2018, the Office of the Ombudsman continued to support the needs of children/youth and families, transition age youth, and adults. It also provided support to individuals who received services through the DBH network and/or individuals who have questions about the public behavioral health system.

The core processes and functions include: 1) educating District residents about behavioral health coverage within the health benefits plan, managed care plan and other behavioral health services options; 2) assist consumers to access and navigate behavioral health care services, and 3) support the resolution of problems associated with accessing behavioral health services.

In responding to consumer/stakeholder inquiries and complaints the Ombudsman's office: 1) conducted intake; 2) tracked inquires and complaints to determine trends and patterns within the current system of care, 3) tracked and trend information that is collected to report on system gaps

related to service delivery; and 4) reviewed current policies to determine potential gaps and made system recommendations for changes.

Contacts	Complaints	Inquiries & Notifications
	135	10

FY 2019 Office of the Ombudsman - In FY 2019, the Office continues to work internally to address systemic issues at the agency. The work for 2019 is addressing the identification of general challenges within the agency and the District of Columbia behavioral health system. The office continues to focus on core processes that include, education, assistance in navigating services within the system, and when needed tangible support to address problems with an individual case. The Office of the Ombudsman continues to prioritize outreach and education to ensure that District residents, community based organizations, and other government agencies are aware of the office.

Contacts	Complaints	Inquiries & Notifications
	124 through July 11, 2019	23

Social Services

These services are provided by several District agencies. Some examples include:

1) *Department of Behavioral Health***-** provides a system of care for children/youth and their families that includes prevention, intervention, treatment services for mental health and/or substance use disorders in community-based, outpatient and residential, and emergency psychiatric care settings;

2) *Child and Family Services Agency*- protects child victims and those at risk of abuse and neglect and assists their families;

3) *Department on Disability Services*- provides innovative, high-quality services that enable people with disabilities to lead meaningful and productive lives as vital members of their families, schools, workplaces, and communities; and

4) *Department of Human Services*-1) Parent and Adolescent Support Services (PASS)- serves youth who commit status offenses and works cooperatively with families and service providers to reduce these challenging behaviors before child welfare and/or juvenile justice intervention is needed; 2) Teen Parent Assessment Program(TPAP)- a volunteer program that provides case management services for teen parents ages 14-17 with teen parents under the age of 18 participating in a living arrangement assessment; and 3) Violence in Dating Relationships- addresses issues related to non-healthy relationships (abusive-physically violent, controlling, verbally abusive) emphasizes physical and psychological abuse are not normal or acceptable even among teenage lovers.

Educational Services (including services provided under the Individuals with Disabilities Education Act)

Individuals with Disabilities Education Act (IDEA): Under the District of Columbia Public School Reform Amendment Act of 2007, the Office of the State Superintend of Education (OSSE) serves as the District's State Educational Agency (SEA) and is responsible for ensuring compliance with all programmatic and fiscal elements of IDEA. The SEA must annually assure that it will fulfill these responsibilities through its submission of a state-level plan to the U.S. Department of Education Office of Special Education Programs (OSEP). The allocation and monitoring of IDEA grant funds to applicable sub-grantees is a major component of the SEA's responsibility.

Part B of IDEA (PL 108-446) is a federal grant program that provides funds to SEA and local educational agencies (LEAs) to help ensure that students with disabilities, ages 3-21, have access to a free appropriate public education (FAPE) to meet each student's unique needs and prepare him or her for further education, employment, and independent living. These funds are provided to the SEA and LEAs using formulas outlined in the IDEA regulations. IDEA Part B funds are non-discretionary and must be spent for specific purposes.

The IDEA State Allocation Policy: 1) clarifies OSSE's administrative procedures regarding how it allocates and uses the IDEA Part B funding the District receives, and 2) clarifies LEA and public agency obligations related to IDEA.

Child Welfare

The DC Child and Family Services Agency (CFSA) is the District of Columbia's public child welfare agency that is responsible for protecting child victims and those at risk of abuse and neglect and assisting their families. CFSA's primary focus is 1)to receive and investigate reports of suspected child abuse and neglect of children (ages 0-18), 2) to assist families by connecting them to community resources that can help to overcome and ameliorate risks that endanger children, 3) to provide safe, out-of-home care when the family home presents danger for the children, and 4) to re-establish permanent homes so that every child can either safely return home or go to a permanent home with relatives, or others through guardianship or adoption.

In order to address it mission and goals, in 2012, CFSA embodied a strategic framework which continues to guide their practice and promotes the improvement of outcomes for children and families. The strategic framework is known as the Four Pillars. Each pillar features a values-based foundation, a set of evidence-based strategies, and a series of specific outcome targets.

Pillar One: Front Door – Families stay together safely. Children deserve to grow up with their families and should be removed from their birth homes only as the last resort when families cannot or will not take care of children themselves.
Pillar Two: Temporary Safe Haven – Children and youth are placed with families whenever possible. Planning for permanence begins the day a child enters care.

Pillar Three: Well Being – Every child has a right to a nurturing environment that supports healthy growth and development, good physical and mental health, and academic achievement. Youth in foster care pursue activities that support their transition to adulthood.
Pillar Four: Exit to Positive Permanency – Children and youth leave the child welfare system quickly and safely for a well-supported family environment or life-long connection. Youth actively prepare for adulthood.

Juvenile Justice Services

These services include the: 1) Assessment Center, 2) HOPE Court, 3) Juvenile Adjudicatory Competency Program, 4) Juvenile Behavioral Diversion Program, and 5) Alternatives to Court Experience.

Assessment Center: Provides the Superior Court of the District of Columbia with court-ordered, high-quality, comprehensive, culturally competent mental health consultation, and psychological and psychiatric evaluations for children and related adults with involvement in child welfare, juvenile justice, and family court.
Here Opportunities Prepare you for Excellence (HOPE Court): HOPE Court has been inception has been in inception since January 11, 2018. It is operated within DC Superior Court in partnership with Court Social Services, OAG and Core Service Agencies. HOPE Court is a voluntary, specialized court for youth who have Person In Need of Supervision (PINS), Delinquency and/or Neglect cases, and who have specific factors, at-risk or engaged in commercial sexual exploitation, that make them eligible for referral, review, and if appropriate, participation. Youths found eligible for HOPE Court are invited to partner with community supports in their treatment planning.

Fiscal Year	Youth
2019 Q2	11

Juvenile Adjudicatory Competency Program (JACP): This program is a partnership with Court Social Services to provide the District of Columbia Family Court with comprehensive, culturally sensitive and clinically appropriate competency evaluations to assist in the determination of a juvenile's capability to stand trial. The competency evaluation will comply with the requirements as outlined in the District of Columbia statute §16-2315 (b-1).

Fiscal Year	Referrals	Competent	Not Competent	Refused	Incomplete
2017	17	8	3	N/A	4
2018	13	4	8		0

Juvenile Behavioral Diversion Programs (JBDP)

Alternative to Court Experience (ACE)- ACE, established in 2014, is a diversion program developed in collaboration between the Office of Attorney General, Court Social Services Division, the Department of Behavioral Health, the Department of Human Services' Parent and Adolescent Support Services program (PASS), and community-based service providers. ACE

assesses the needs of youth diverted from the juvenile justice system, links them and their families with appropriate services, and monitors successful program participation. The ultimate goal of the program is to help youth and their families address the underlying issues causing the negative behaviors while minimizing the likelihood of reoffending, thus offering youth the opportunity to avoid acquiring a juvenile record.

The JBDP enrollment data includes the following:

Fiscal Year	Enrollment
2017	84
2018	50
2019 April	15

The District Department of Human Services operates the ACE program. Juvenile prosecutors at the Office of the Attorney General (OAG) divert appropriate youth from the justice system to ACE, where program specialists comprehensively assess each child's needs for services and supports. The assessment measures each child's stress, trauma and behavioral needs. ACE coordinators use this evaluation and provide an individually tailored program of wraparound services that will help each child achieve success and avoid re-offending. These services include things like family and individual therapy, mentoring, tutoring, mental-health treatment, recreation and school supports.

Law Enforcement Services: The District of Columbia Metropolitan Police Department, Youth and Family Services Division (YFSD), is responsible for investigating: 1) child abuse and neglect; 2) child sexual abuse and exploitation (including child pornography and child prostitution); 3) juvenile missing persons under the age of 18 and parental kidnapping; 4) persons in need of supervision (PINS); 5) process juvenile arrestees; 6) locate youth absconding; and 7) internet crimes against children.

Substance Use Disorder Services: Substance use disorder treatment services include a variety of strategies: 1) assessment (comprehensive, ongoing, brief), 2) drug screening; 3) clinical care coordination; 4) case management; 5) case management HIV; 6) crisis intervention; 7) counseling (individual, family, group, psycho-educational, and psycho-educational HIV); 8) medication management; 9) recovery support; 10) residential room and board; 11) recovery support evaluation; 12) recovery support management; 13) recovery mentoring and coaching; 14) life skills support; 15) spiritual support; 16) education services; 17) transportation services; 18) recovery social activities; and 19) environmental stability.

SAMHSA Center for Substance Abuse Treatment State Youth Treatment (SYT) Grant: The purpose of the SYT Grant is to increase and enhance treatment for adolescents and transitional aged youth (TAY) through collaboration with local treatment provider sites. The goals include: 1) enhance and strengthen the collaboration and coordination of substance use treatment and mental health services (including services for HIV/AIDS), 2) build a system of care to integrate and improve treatment for adolescent and TAY with substance use disorders (SUD) and co-occurring substance use and mental disorders, and 3) enhance services that adolescent and TAY and their families/primary caregivers receive.

The SYT grant was awarded from September 2013 through August 2017. The DBH received a No Cost Extension which extended the award from September 2017 through August 31, 2018. The DBH received an additional NCE for four months which extended the project till January 31, 2019. Riverside is no longer an ASTEP provider and was removed from the grant effective March 31, 2018.

Medication-Assisted Treatment (MAT) - The use of methadone as pharmacotherapy for long-term treatment for opiate or other forms of dependence, for youth and adults. A client who receives MAT must also receive SUD counseling.

D.C. Prevention Centers
There are four (4) Centers that focus on two (2) District wards each. They were developed to strengthen community capacity, address needed community and system changes, reduce substance use risk factors, and achieve target outcomes for District children and youth. The Centers promote healthy children, youth, and families as well as a drug-free city through preventing and delaying the onset of Alcohol, Tobacco, and Other Drug (ATOD) use.
Substance Use Disorder Social Marketing Strategies- These strategies are presented from the perspective of youth and related adults.

"The Blunt Truth" (addresses marijuana use)
Stresses the health and legal effects associated with marijuana use. In engaging individuals, the campaign takes the approach of providing the facts to challenge the myths commonly adopted by individuals considering consuming marijuana.

"There's a Reason" **(**addresses underage drinking**)**
Adult- While the target "impact" audience for this campaign is youth, the target audience for engagement is primarily adults. The "There's a Reason" campaign stresses the importance of setting safeguards in place and establishing parameters to prevent and/or reduce opportunities for underage drinking.

Opioid Awareness Campaign" (addresses opioid use among adults, young adults and youth) - DBH developed this campaign to raise awareness about the risks associated with opioid use and to direct individuals to help. Phase 1 targets adults, specifically older African American male heroin users age 40-69. It highlights increased health risks of using heroin, especially batches laced with other synthetic opioids such as fentanyl and carfentanil. It also promotes the use of Naloxone that can reverse an overdose resulting from heroin use. The emphasis will be on seeking medical attention following administration of the Naloxone.

"*More Harmful Than You Think"* In supporting DBH's efforts to address opioid misuse, this campaign targets youth whose consumption of opioid misuse might be in the form of misusing prescribed opioids such as pills and cough syrup. It draws a contrast between how people "think" they look when consuming opioids (e.g., fun-loving, the life of the party, etc.) and how they may actually look while misusing opioids (e.g., drugged, disoriented, lethargic, etc.).

"K2 Zombie" (addresses fake weed and other synthetic drug use among youth) - The K2 Zombie campaign was developed in response to the District becoming aware of a substance referred to as "incense" that youth were smoking and having adverse reactions. The campaign highlights, for youth, in particular, the physical and psychological risks associated with consuming K2. It clarifies that what was being sold as "fake weed" or a safe alternative to marijuana use is synthetic chemical compounds that, in some cases, have an even more disastrous effect on the user.

"Adult Synthetics" (addresses synthetic drug use among adults)- Building upon the K2 Zombie campaign, the Adult Synthetics campaign clarifies that the purchase, sale, and use of synthetic drugs are illegal in the District of Columbia. The campaign addressed designer drugs such as "Molly" and other drugs found to be popular among adults. The associated laws were made available through brochures, palm cards, and a website to inform as many adults as possible.

*Community Engagement***-** Substance use disorder prevention-service teams participate in community and health events, gives presentations to organizations and agencies, and respond to requests for training and technical assistance.

Health and Mental Health Services

Health Homes 2/ MyHealth GPS: The model includes: 1) providers integrate and coordinate all primary, acute, behavioral health, and long-term services and supports; 2) the model must include fee-for-service (FFS) and managed care organization (MCO) beneficiaries; and 3) Centers for Medicare and Medicaid Services (CMS) provides 90/10 match for the first 8 quarters. The eligibility requirements include 1) have 2 or more chronic conditions, 2) have one chronic condition and are at risk for a second; and 3) have one serious mental illness (SMI). Required 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. 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.

DC Mental Health Access Project (DC MAP):
DC MAP supports the integration of health and mental health by providing pediatricians with immediate access to mental health and/or psychiatric consultation as children/youth are identified as potentially needing behavioral health services. DC MAP is a team of psychiatrists, psychologists, social workers, and care coordinators who provide free mental health phone consultation for primary care clinicians in the District. In addition to phone consultations, referrals, face to face consultations as clinically indicated, education and training are offered to support primary care clinicians to address behavioral health concerns.

The number of behavioral health screenings includes the following:

Fiscal Year	Behavioral Health Screenings
2015	22,762
2016	26,608
2017	51,291
2018	52,534

On January 1, 2017, DCMAP began to screen for health risks in the caregiver for the benefit of the patient.

The number of screenings for caregivers is listed below:

Fiscal Year	Behavioral Health Screenings
2018	780
2019 Q1 and Q2	695

Youth Services Survey for Families (YSS-F)

The YSS-F survey gives parents and/or guardians an opportunity to share their perception of services provided to their children and/or adolescents. The information reported is summarized from the DBH FY 2018 YSS-F survey. There were 3404 child and adolescent consumers served in FY 2016. From this general population, a random sample of 2,600 consumers who received at least two (2) mental health services within the past 6-months in the District was selected to participate in the survey. Four hundred and twenty-six caregivers completed the YSS-F survey.

The YSS-F survey includes a total of 26 items that are divided into seven domains. They include: 1) Access, 2) Participation in Treatment Planning, 3) Cultural Sensitivity, 4) Social Connectedness, 5) Functioning, 6) Outcomes, and 7) General Satisfaction.

The FY 2016 findings show that the caregivers were most satisfied with Cultural Sensitivity 93%) and Participation in Treatment Planning (89%). Caregivers, however, were least satisfied with their child's Functioning (53%) and Outcomes (63%). The latter findings are areas for improvement.

Transition age youth ages 16-25 were a subset of the population. They have unique needs and require different types of programs due to their transitional period into adulthood. Caregivers expressed greater satisfaction with cultural sensitivity, functioning, outcomes, and general satisfaction. There were no notable changes for access or social connectedness.

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

The Mental Health Block Grant statutory reporting requirement **Criterion 4** addresses **Targeted Services to Rural and Homeless Populations and to Older Adults** defined as: *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.*

Targeted Services to Rural Populations
The District of Columbia is an urban area.

Targeted Services to Homeless Populations

Like all major cities in America, the District of Columbia faces a severe shortage of affordable housing, particularly for individuals at 0-30% of Area Median Income (AMI). To address this challenge, the District is investing millions of dollars each year in the creation of new affordable and supportive housing, and is also in the midst of a total transformation of its housing crisis response system.

DC Interagency Council on Homelessness & the Homeward DC Plan
The District of Columbia Interagency Council on Homelessness (ICH) is a group of cabinet-level leaders, providers of homeless services, business, private sector representatives, advocates, and persons with lived experience that come together to inform and guide the District's strategies and policies for meeting the needs of individuals and families who are homeless or at imminent risk of becoming homeless. The ICH serves as the District's Continuum of Care Governance Board (CoC) under the federal Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act.

In 2015, the ICH developed and released a comprehensive strategic plan, *Homeward DC*, to guide the District's efforts at transforming its homeless services system into an effective crisis response system with the ultimate goal of ensuring homelessness in the District is a rare, brief, and nonrecurring experience. The data-driven plan identifies over 40 strategies across five broad objectives: 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.

The District is currently in the middle of its 4th year of plan implementation. Since FY16, which marked the first official investments in the plan, family homelessness has decreased a remarkable 45.3 percent. However, during this same period, homelessness among unaccompanied adults increased by 5.2 percent – a reflection of the tremendous inflow of individuals, newly experiencing homelessness each year. Behavioral health issues remain a significant challenge among this population. The sections that follow provide more detail on the services available to and the characteristics *of persons experiencing homelessness in the District.*

Description of Targeted Services Available to Persons Experiencing Homelessness
The District makes the following services available for residents facing housing crises: year-

round emergency shelter, meal services, daytime services, street outreach, emergency rental assistance, targeted prevention assistance, transitional housing, rapid rehousing, targeted affordable housing,[4] and permanent supportive housing. These services are available for unaccompanied adults, persons in families, unaccompanied youth, and pregnant and parenting youth. The CoC also targets many of its services to specific subpopulations such as veterans, the LGBTQ population, and survivors of domestic violence to meet their unique service needs better.

Families in the District seeking homeless services may visit the Department of Human Services' (DHS) Virginia Williams Family Resource Center for referral to preventative and emergency resources based on need. If families have a safe place to stay for even one night, they will be referred to a homelessness prevention provider to preserve the housing and prevent a shelter stay. When prevention is not an option, families will be placed immediately into shelter. All families placed in shelter have access to rapid rehousing assistance, while a smaller subset is matched to longer-term interventions via the District's Coordinated Assessment and Housing Placement (CAHP) system.[5]

Unaccompanied adults experiencing homelessness may access any of the District's low barrier emergency shelters for overnight accommodations, meals, and connection to longer-term support. Permanent housing resources, such as rapid rehousing assistance and permanent supportive housing, are allocated according to the community's prioritization protocols via the District's Coordinated Assessment and Housing Placement (CAHP) system. In 2018, the District expanded staffing at its low barrier shelters, bringing on more than 20 additional case managers to help reduce case management ratios and speed up system exits among those who have been in shelter the longest.

To further enhance service connectivity, particularly for unsheltered adults, the District opened a Downtown Day Services Center in partnership with the Downtown DC Business Improvement District and Pathways to Housing DC. The Center offers a variety of supportive services, including work supports from the District Department of Employment Services, assistance obtaining identification via the District Department of Health and the District Department of Motor Vehicles, benefits assistance from the Department of Human Services, and medical services from Unity Health Care. The Center also provides meals and access to laundry and shower facilities, building on the services offered at the Adams Place Day Center, which opened in 2016.

2019 Shelter and Housing Inventory

The following table shows the number of units for unaccompanied individuals and families in the District's CoC. This inventory includes all programs dedicated to serving households who currently are experiencing or who have experienced homelessness. The majority of the District's

[4] Targeted affordable housing is a permanent subsidy earmarked for use by the homeless services system that provides with light-touch services, targeted to those living with a disabling condition, who do not require the level of services associated with permanent supportive housing.

[5] CAHP provides standardized access and coordinated referrals to the housing placement process that ensures that persons experiencing homelessness receive appropriate assistance with both immediate and long-term housing and service needs.

programs and services are funded with local dollars, with additional funding coming from the U.S. Departments of Housing and Urban Development (HUD), Health and Human Services (HHS), and Veterans Affairs (VA), as well as from other private funding sources.

DISTRICT OF COLUMBIA 2019 SHELTER & HOUSING INVENTORY		
	Units for Individuals	**Units for Families**
Winter Shelter	839	-
Emergency Shelter	2,384	667
Transitional Housing	900	225
Rapid Rehousing	365	1,893
Permanent Supportive Housing	3,729	1,274
Other Permanent Housing	1,779	976

The District of Columbia is one of just a few jurisdictions nationally and the only jurisdiction in the Washington region that provides a legal right to shelter to any resident who needs it. Accordingly, the District typically adds over 800 beds for unaccompanied individuals to its shelter capacity during the hypothermia season, which runs from November through March, when demand for shelter increases.[6]
While the District does not have a set number of winter shelter units for families, the emergency shelter capacity for families expands throughout the year to meet the needs of households with children as well as women who are pregnant.

Dedicated housing resources – especially Rapid Re-Housing and Permanent Supportive Housing – continue to be added each year under the Homeward DC plan with the goal of scaling those programs to fully meet the need of the community. While hundreds of units have been added in recent years, hundreds more will be needed in the years ahead.

2019 Point in Time (PIT) Count Results
The number of persons who are experiencing homelessness in the District of Columbia on the night of PIT – those who were sleeping on the streets, in emergency shelters, or in transitional housing facilities – decreased by 5.5 percent from the 2018 count and is down by 11.9 percent from the PIT count conducted five years ago.

However, the results of the 2019 count vary by population. Although the number of persons in families experiencing homelessness decreased by 15.6 percent from last year, the number of unaccompanied individuals increased by 2.8 percent. This mirrors the 2018 PIT results when the CoC saw a decrease among families but a slight increase in unaccompanied adults.

[6] Defined in the *Homeless Services Reform Act* (HSRA).

	POINT IN TIME COUNT BY CATEGORY, 2015 - 2019						
	2015	**2016**	**2017**	**2018**	**2019**	**% Change 2018-2019**	**% Change 2015-2019**
Unaccompanied Individuals	3,821	3,683	3,583	3,770	3,875	2.8%	1.4%
Persons in Families	3,477	4,667	3,890	3,134	2,646	-15.6%	-23.9%
Total Persons Experiencing Homelessness	**7,298**	**8,350**	**7,473**	**6,904**	**6,521**	**-5.5%**	**-11.9%**

Families

Nearly 700 families exited the emergency shelter system for permanent destinations between PIT 2018 and PIT 2019. Further, the District's Homelessness Prevention Program (HPP) has been a key resource in the District's work to end homelessness among families. Since the program launched, DHS staff and a network of providers have helped an average of nearly 1,100 families per year maintain their housing and avoid a shelter stay. DHS is also piloting a flexible rent subsidy program to support low-income households that are earning income but have trouble making ends meet. Increased prevention resources, along with a reformed shelter system and scaled housing resources to help families exit shelter, have each been instrumental in the success the CoC has seen within the family subsystem. This multifaceted approach highlights the importance of comprehensive system reform with various interventions working together simultaneously.

Unaccompanied Individuals

The CoC sees an average of 150 unaccompanied individuals experiencing homelessness exit homelessness for housing resources each month, yet the District's count of single men and women experiencing homelessness increased by 2.8 percent from 2018 and is up 1.4 percent from the count conducted five years ago. The CAHP system matches individuals to rapid rehousing, targeted affordable housing, and permanent supportive housing based on their service needs, and the CoC's HMIS data shows strong housing retention rates among individuals – 85 percent for time-limited subsidy recipients and 94 percent for permanent subsidy recipients. While the CoC expected that this level of housing performance would result in the same kind of success seen among families, a persistent inflow of individuals, newly experiencing homelessness, continues to challenge the system. The District has seen the number of individuals who are newly experiencing homelessness in a given year increase from 5,588 in fiscal year 2015 to 6,933 in fiscal year 2018 – a nearly 25% increase. To address this inflow challenge, the District recently launched a shelter diversion program for single adults and continues to look at ways to improve coordination with feeder systems, including the justice system, the child welfare system, and the behavioral health system.

Characteristics and Service Needs

Surveys are conducted during the PIT count to gather additional information on demographic characteristics, service needs, barriers to housing, and economic indicators of persons

experiencing homelessness.

The following tables detail the rates at which persons reported living with various disabling conditions or their affiliation with various subpopulation categories. The CoC uses this information to develop programming that addresses the disability- or subpopulation specific-related service needs seen among the persons counted at PIT.

REPORTED DISABLING CONDITIONS AMONG PERSONS EXPERIENCING HOMELESSNESS						
	Single Adults: 2019	**Single Adults: 2018**	**Adults in Families: 2019**	**Adults in Families:2018**	**TOTAL (All Adults)2019**	**TOTAL (All Adults) 2018**
Substance Abuse (SA) History	21.9%	30.4%	3.3%	1.7%	17.9%	23.4%
History of Mental Illness (MI)	30.8%	32.4%	19.0%	7.4%	28.2%	26.3%
Dual Diagnosis (SA & MI)[7]	12.5%	14.5%	1.9%	1.2%	10.2%	11.3%
Chronic Health Problem	21.1%	24.6%	6.5%	1.5%	17.9%	19.0%
Developmental Disability	4.0%	4.9%	2.3%	1.5%	3.6%	4.0%
Living with HIV/AIDS	3.0%	4.0%	1.1%	0.2%	2.6%	3.1%
Physical Disability	16.3%	18.0%	5.8%	3.1%	14.1%	14.4%

The characteristics and service needs reported during PIT are typically consistent from year to year, with disabling conditions and subpopulation affiliation being more prevalent (in most categories) among unaccompanied adults as opposed to adults in families. While this was still true in 2019, the rates at which adults in families reported disabling conditions was higher than what the CoC saw from the family subsystem in 2018, and rates reported among individuals in 2019 were lower than were seen among individuals counted in 2018.

Likewise, the rates at which unaccompanied individuals and adults in families report affiliation with various subpopulations have historically differed between the two subsystem groups. Though this was true again in most of the 2019 results (e.g., veteran status, formerly resided in institutional settings), some categories show the affiliation rates becoming more similar between the two groups (formerly in foster care, speaks a language other than English).

[7] Dual Diagnosis is a subset of both Chronic Substance Abuse (CSA) and Severe Mental Illness (SMI) categories. Persons counted in the Dual Diagnosis category are counted in both the CSA and SMI categories in these tables.

REPORTED SUBPOPULATION AFFILIATION AMONG PERSONS EXPERIENCING HOMELESSNESS						
	Single Adults: 2019	**Single Adults: 2018**	**Adults in Families: 2019**	**Adults in Families:2018**	**TOTAL (All Adults)2019**	**TOTAL (All Adults) 2018**
Domestic Violence History	20.7%	19.0%	32.3%	33.6%	23.2%	22.6%
Speaks a Language Other than English	4.0%	4.0%	5.7%	1.7%	4.4%	3.4%
U.S. Military Veteran	7.6%	8.0%	0.5%	0.3%	6.0%	6.2%
Formerly in Foster Care	9.4%	8.4%	9.7%	11.4%	9.5%	9.1%
Formerly Resided in an Institutional Setting	41.0%	49.6%	10.6%	22.2%	34.5%	43.0%

Cooperative Agreements to Benefit Homeless Individuals (CABHI): The D.C. Department of Behavioral Health (DBH) received a SAMHSA CABHI grant that began on October 2, 2015. The focus is to help people with behavioral health conditions to find housing and supportive services. CABHI's primary goal is to ensure that the most vulnerable people experiencing homelessness and chronic homelessness receive access to housing, treatment, and recovery support services. The population includes veterans, singles, and youth. The other goals include: 1) enhance the infrastructure for coordinating, developing, planning, supporting and providing effective treatment and recovery support services; 2) expand and enhance treatment and recovery support services; and 3) prepare for program sustainability through evaluation, planning and ensuring the most effective use of resources.

The D.C. CABHI began enrolling clients in June 2016, and most evaluation activity has been related to process measures. Evidence shows that D.C. CABHI is proceeding and working to make its monthly targets. During Year 1, the evaluation team developed a monthly tracker that allows providers to report on a variety of measures such as the number of new clients enrolled in CABHI, the cumulative number of clients in CABHI, the number of service referrals, the number of clients housed, the number of provider outreach engagements, Medicaid enrollees, staffing, and client demographics. Data from the monthly tracker is being used to ensure that the CABHI grant: 1) is being implemented as intended; 2) services are being provided; 3) identifies who provides the services; 4) the service costs and related context; 5) changes in the project plans as deemed appropriate by the data; and 6) determine the degree to which the program achieved its objectives to include increasing service capacity and positively impacting health disparities. The tracker also serves as a performance monitoring and management tool.

The CABHI grant closed out in April 2019. DBH is planning on implementing a new Outreach/Engagement team to help sustain and expand the CABHI initiatives.

- *Projects for Assistance in Transition from Homelessness (PATH) Grant:* The SAMHSA PATH program funds services for people with serious mental illness experiencing homelessness. DBH administers the District's PATH Grant.

  Service Area**:** The PATH Grant funds are used to support two (2) DBH programs: 1) Homeless Outreach Program (now under newly implemented under the Community Response Team (CRT), and 2) Housing Subsidy Program (HSP). These programs serve homeless individuals throughout the District.
  PATH Funds Supported Services: The HOP conducts outreach and case finding for consumers who reside in locations unfit for human habitation (e.g., streets, abandoned vehicles, buildings); low barrier shelters; transitional programs; and other temporary residences. The HOP services include: crisis services, case management, transportation, and linkage services for persons with long-term mental health and substance use disorders. The HSP provides assistance for housing homeless consumers. This has historically included providing individuals who are homeless with first month rent and/or security deposits.

Persons Served: The HOP links veterans to the Veterans Administration (VA) Medical Center, Veterans Administration Supportive Housing (VASH) program, and the VA Community Resource and Referral Center (CRRC). The CRRC works with homeless and at-risk veterans. Those veterans who cannot or will not be linked to the CRRC receive the full complement of HOP services.

Recovery Supports: DBH continues its commitment to the "No Wrong Door" approach to services, whereby consumers with co-occurring disorders can receive treatment for all of their needs, regardless of where they enter the DBH system of care. Also, HOP staff makes referrals and transports homeless individuals to the DBH Assessment and Recovery Center (ARC) for substance use treatment services.

SSI/SSDI Outreach, Access, and Recovery (SOAR): This is a national program designed to increase access to the disability income benefit programs administered by the Social Security Administration (SSA) for eligible adults who are experiencing or at risk of homelessness and have a mental illness, medical impairment, and/or a co-occurring substance use disorder. As part of the new employee orientation and training, staff are enrolled in the SOAR training. All members of the HOP have been trained in SOAR. HOP staff attempt to assess each consumer's benefits needs; however consumer engagement and openness about their benefit is difficult. Consumers who are eligible and amenable to seeking benefits are targeted for quick assessment and enrolled in eligible programs.

Vulnerability Index- Service Prioritization Decision and Assessment Tool (VI-SPDAT): In 2015, HOP, along with several providers in the Continuum of Care, participated in the development of the VI-SPDAT. This tool works as a coordinated entry system used by stakeholders to identify and register homeless people in the District. In 2016 and 2017, there was continued sharing of available resources for housing, collaboration on locating individuals, and referral to appropriate levels of mental health care, health care, and substance use treatment. There was also an effort to identify subpopulations for specialized housing such as homeless veterans, LGBT adults, emancipated minors, and persons living with AIDS.

The use of the common assessment tool (VI-SPDAT) for homeless individuals will be promulgated across the entire DBH provider network including mental health and substance use providers to ensure homeless individuals are participating in the District's Coordinated Entry System and to assist in prioritizing DBH resources. The use of the VI-SPDAT assessment tool has provided an expedient process to transition individuals from homelessness into housing.

Targeted Services to Older Adults

- *District of Columbia Office on Aging (DCOA):* The DCOA mission is to advocate, plan, implement, and monitor programs in health, education, employment, and social services that promote longevity, independence, dignity, and choice for older District residents (age 60 and older), people with disabilities (ages 18-59), and their caregivers.

- *District of Columbia State Plan on Aging FY 2017-2018:* The State Plan is the blueprint for coordinating and delivering services and supports provided through DCOA. It describes the roles< and responsibilities, challenges and focus areas. It also describes ways to improve and expand quality health and social support services to older District residents.

  Issues and Challenges: These include: 1) abuse, neglect and financial exploitation; 2) aging in place; 3) Alzheimer's disease and related dementia; 4) caregiver support; 5) falls prevention; 6) housing; 7) hunger; 8) social isolation and underserved populations; and 9) transportation.

  Services and Supports: DCOA administers the Older Americans Act (OAA) core services (supportive services, nutrition, health promotion, caregiver support, and elder rights) through the Senior Service Network (SSN), comprised of 20 community-based non-profit and private organizations that operate 37 programs. The services and supports are organized into three (3) categories: 1) Customer Information, Assistance and Outreach, 2) Home and Community-Based Supports, and 3) Nutrition Services.

  Needs Assessment and Feasibility Study: In FY 2016, DCOA commissioned a study to help identify older adult needs in the District and how they can be addressed. The final report will analyze the District's demographic trends, program services and supports, facility capabilities and opportunities, and national best practices. The needs assessment will help identify service gaps and community demands that will inform the agency's future service provision.

  *Age-Friendly DC Initiative**:*** This initiative is part of an international effort launched by the World Health Organization (WHO) in 2007 and addresses two (2) significant demographic trends: 1) urbanization and 2) population aging. WHO identified 8 aspects of urban communities that influence the health and quality-of-life of the older people living there: 1) outdoor spaces and buildings, 2) transportation, 3) housing, 4) social participation, 5) respect and social inclusion, 6) civic participation and employment, 7) communication and information, and 8) community support and health services. The District added 9) emergency preparedness and resilience and 10) elder abuse, neglect, and fraud. The District also developed an *Age-Friendly DC Strategic Plan 2014-2017*. An

Age-Friendly DC 2016 Progress Report was also developed. Age-Friendly DC relies on a Mayoral-appointed Task Force for advice and guidance. The Task Force is composed of community leaders, deputy mayors, and agency directors, appointed by the Mayor, and each assigned to pay particular attention to one (1) of the 10 Age-Friendly DC domains. As a member of this group, DBH participants focus on issues related to:
1) introducing or expanding primary mental health screening programs for older adults, 2) providing training on behavioral health for counselors and aides working in hospitals and home-based care units, and 3) expanding the number of peer counseling and support programs and increase the number of older adult peer counselors.

- *Interagency Partnerships:* DBH has developed a Memorandum of Agreement (MOA) with District agencies including the D.C. Office on Aging (DCOA) and the Department of Health Care Finance (DHCF) to move individuals, most of whom are elderly, out of nursing homes and community hospitals into the community. DBH's role is to ensure that individuals enrolled in the mental health system receive appropriate transitional and ongoing services and supports that assist them to function effectively in the community. DBH mental health providers are responsible for coordinating all available community services and managing the delivery of care to individuals assigned to their agency.

- *Pre-Admission Screening/Resident Review (PASSR):* As the public mental health authority, DBH is responsible for the PASRR Level II, which is required for any individual with mental illness entering or being discharged from a nursing facility or who is in a nursing facility and has a change in condition in either their mental health or functional abilities.

Criterion 5: Management Systems

Financial Resources

The District of Columbia FY 2018 proposed budget is $271,104,891. The Congressional approval of the District's budget is pending. Once the DBH budget receives Congressional approval, the actual figure and breakdown will be provided.

Staffing/Human Resources*:* In May 2018 the total number of staff for DBH was 1286, which includes Behavioral Health Authority (506) and Saint Elizabeths Hospital (780)

Vacancies Filled in FY 2018: Critical vacancies/positions filled during FY 2018 include the following:

- Behavioral Health Technician
- Billing Services Specialist
- Clinical Care Coordinator
- Clinical Psychologist
- Deputy Director of Administrative Operation
- Director, Disaster & Support Behavioral
- Director, Specialty Care Division
- Director, System Transformation Admin
- Facilities Systems Specialist

- Family Engagement Coordinator
- Food Service Worker
- Health Systems Specialist
- Housekeeping Aide
- Housekeeping Aide Foreman
- Human Resources Assistant
- IT Specialist (Data Management)
- Lead Pharmacist
- Mental Health Counselor
- Mental Health Specialist
- Occupational Therapist
- Pharmacy Technician
- Policy Officer
- Program and Policy Coordinator
- Program Coordinator
- Psychiatric Nurse
- Recovery Peer Specialist
- Social Worker
- Specialist Police Officer
- Staff Assistant
- Supervisory Consumer Affairs Specialist
- Supervisory Pharmacist
- Training Support Assistant
- Treatment & Recovery Support Specialist
- Treatment Program Specialist
- Reimbursement Specialist
- Pharmacist
- Social Workers
- Supervisory Psychiatric Nurses
- Behavioral Health Technicians
- Early Childhood Clinical Specialist
- Dental Assistant
- Housekeeping Aides
- Mental Health Specialist
- Supervisory Security and Safety Specialist
- Psychiatric Nurses
- Public Health Analyst
- Community Services Review Logistics Specialist
- Mental Health Counselor
- Food Service Worker
- Special Police Officers
- Claims Management Analyst
- Mental Health Counselor
- Applied Research and Evaluation Manager

- Forensic Mental Health Counselor
- Billing Services Specialist
- Budget Analyst

Human Resources Activities During FY 2018: A number of significant human resource development activities were undertaken during FY 2017.
They include:

- Actively engaged in implementation of the DBH Realignment.
- Scheduled and conducted more comprehensive Benefits Entitlement and Information Sessions for employees.
- In conjunction with the D.C. Office of Labor Relations, engaged in negotiation and implementation of compensation agreements for DBH collective bargaining agreements
- Negotiated non-compensation collective bargaining agreement for DBH Social Workers.
- Provided mandatory training (Sexual Harassment and Cyber Security Training) to all employees
- Conducted FMLA training to MSS Managers
- Finalized classification audits
- Implemented Union and Non-Union pay adjustments
- Managed the Mandatory Drug and Alcohol Testing Program for employees serving children and youth.

DBH Training Institute Division:

The Training Institute, which is part of the DBH Systems Transformation Administration, works to enhance the knowledge and competencies of the DBH provider network and internal and external customers through performance-based and data-driven learning environments.

The data in the table that follows provides information about the DBH Training Institute courses provided in FY 2018 to April 2019. It is organized by 1) the number of persons taking the course, 2) the course delivery method, and 3) the name of the course.

Students Passed	Delivery Method	Course Name
6	Classroom	Adolescent Community Reinforcement Approach (A-CRA) Training
13	Classroom	Adult Community Services Review (CSR) Overview
25	Classroom	ASAM Criteria Skill-Building
366	Classroom	Behavioral Health Disorders, Engagement & Referral
13	Classroom	Bounce Back

39	Classroom	Brief Effective Treatment (MET + CBT) for Substance Use in Youth & Young Adults
75	Classroom	CAFAS Rater Training
16	Classroom	CBI Provider Training Series: CBI II & III Clinical Model Overview
26	Classroom	CBI Provider Training Series: CBI II and III Overview
32	Classroom	CBI Provider Training Series: Child and Family Teaming
40	Classroom	CBI Provider Training Series: Early Childhood Development and Milestones Overview
83	Classroom	CBI Provider Training Series: Risk Assessment, Safety Planning, and Crisis Stabilization
14	Classroom	CBI Provider Training Series: Supervisory and Ethical Challenges
9	Classroom	Child-Parent Psychotherapy Learning Collaborative (Session #3)
101	Classroom	Claims Review Committee: Process and Responsibility
16	Classroom	Cognitive Behavioral Intervention for Trauma in Schools (CBITS)
12	Classroom	Community Service Review (CSR): Adult New Reviewer Training
4	Classroom	Community Services Review (CSR): Adult Returning Reviewer Training
19	Classroom	Creating Safe and Connected Classrooms with Conscious Discipline.
31	Classroom	CSEC 101: Lived Experience, Assessment and Vicarious Trauma
36	Classroom	CSEC SERIES: The SERVE Model; A Brain-Based Approach for Complex Traumatic Stress
57	Classroom	CSEC Series: Treatment Modalities and Application in Work with At-Risk/Confirmed CSEC Youth
13	Classroom	Disaster Behavioral Health Responder Certification Training (Two-Day Course)
40	Classroom	Five Key Elements of Behavioral Health Practice
457	Classroom	Gender, Sexuality, and the LGBT's of Queer Cultural Competency
37	Classroom	Level of Care Utilization System (LOCUS) Training-of-Trainers
21	Classroom	Motivational Interviewing: Introduction and Beyond
19	Classroom	Motivational interviewing: Introduction and Beyond (2-day Training-of-Trainers)
145	Classroom	Officer Agent Certification
39	Classroom	Owning and Operating a Mental Health Community Residence Facility
16	Classroom	Parent-Child Interaction Therapy Refresher Workshop – Back to Basics and Toddler Adaptations
19	Classroom	Parent-Child Interaction Therapy Refresher Workshop – Introduction of Child-Adult Relationship Enhancement (CARE)
9	Classroom	PECFAS Rater Training

76	Classroom	Recognizing and Responding to Suicide Risk: Essential Skills for Clinicians
44	Classroom	Revised Chapter 38 & Quick Base Review for MHCRF Owners
59	Classroom	safeTALK: Suicide Alertness for Everyone
28	Classroom	Stages of Change (1-day)
58	Classroom	Stages of Change: Training-of-Trainers (2-days)
27	Classroom	Supervising Encounter Notes
8	Classroom	Supporting Those That are Grieving
18	Classroom	The Trans-Theoretical Model of Change: Stages of Change
26	Classroom	The Trans-theoretical Model of Change: Stages of Change Training-of-Trainers
32	Classroom	TIP Model Advanced and Integrated Practices: Trauma-Informed Care
9	Classroom	TIP Model Advanced and Integrated Practices: Values and Moral Development
27	Classroom	TIP Model Complete Part TWO Core Practice Training, Documentation and Application Methods
30	Classroom	TIP Model Orientation, Complete Part One Core Practice Training and Application Methods
25	Classroom	Training/Presentation Design, Delivery & Evaluation
25	Classroom	Trauma-Focused Cognitive Behavior Therapy Booster Training
13	Classroom	Trauma-Focused Cognitive Behavior Therapy Initial Training
237	Classroom	Trauma Screening and Assessment
16	Classroom	Trauma Systems Therapy
242	Classroom	Trauma-Informed Care
90	Classroom	Treatment Planning for Person-Centered Care: Training-of-Trainers
98	Classroom	Working in a Mental Health Community Residential Facility
1591	Online	Clinical Documentation: Writing Encounter Notes

- **Training Providers of Emergency Health Services**

The Crisis Intervention Officer (CIO) program in the District of Columbia began in 2009 as a collaborative effort between the Washington Metropolitan Police Department (MPD), the Department of Behavioral Health (DBH) and Washington DC community mental health providers. Nationally, the program is called Crisis Intervention Teams (CIT), but the District elected to certify individual officers as CIOs rather than teams of officers with the intent of decreasing response time and providing the specialized training to more officers. In addition to MPD, officers from multiple law enforcement agencies within the District have attended the 40-hour training including but not limited to U.S. Secret Service, U.S. Capitol Police, U.S. Marshal Service, Amtrak Police, American University Police, D.C. Housing Authority, U.S. Park Police, and Washington Metropolitan Area Transit Authority (WMATA) Police.
The data for the District Metropolitan Police Department and other agencies includes the following:

Fiscal Year	DC Metropolitan Police Department	Other Agencies	Total Trained	Active in the Field
FY 2017	957	193	1150	1005
FY 2018	1073	231	1304	1159
FY 2019 April	1119	250	1369	1224

- **Disaster Behavioral Health Training**

  The DBH Disaster Behavioral Health Training began in 2012.

  The purpose of the training is to help trainees: 1) understand the role of disaster behavioral health; 2) understand the structures in place for small scale and large scale events in the District of Columbia; 3) approaches to empower resilience and 4) learn psychological first aid. Trainees then create a volunteer team of trained mental health professionals and laypeople available to provide services to the District in the event of a disaster that exceeds current staff capacity. During FY 2018 (October 2017 to September 2018), DBH Disaster Services conducted one training for new disaster responder cadre members (13).

During FY 2018, disaster services also participated in 2018 Healthcare Emergency Preparedness Summit providing Disaster Behavioral Health training to medical leaders from the Washington DC community (35 approx.).

The persons trained include the following:

Fiscal Year	Persons Trained by DBH Disaster Services
2017	124
2018	48

District of Columbia

Opioid STR Needs Assessment

Grant # 1 H79 TI080229-01

July 31, 2017

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Brief Overview: The District & The National Opioid Epidemic

The District of Columbia is an urban environment located on 61 square miles of land with an estimated 681,170 residents (2016). The city is divided into four heterogeneous quadrants and 8 Wards, of unequal size and population. As of 2016, the District was 47.7% African American Alone, 45.6% White Alone, 10.9% Hispanic or Latino (of any race), and 4.1% Asian Alone—with a significant geographic disparity. The median household income for 2011-2015 was $70,848 but 17.3% of the population was living in poverty.[i] Moreover, because of the District's proximity to Maryland and Virginia, individuals flow freely between the three jurisdictions, particularly persons who inject drugs. This overview informs the nature of the opioid problem as well as the DC Department of Behavioral Health's (DBH) planned response.

On a national scale, the opioid epidemic is unprecedented. For 2015, SAMHSA's National Survey on Drug Use and Health reports 871,000 past-year users of heroin[ii] and 3.8 million misusers of pain relievers.[iii] In the District, the same survey reports 3,000 heroin users (there are no state-level estimates of non-medical use of pain relievers).[iv] Among high school students, YRBS shows that 4.6% of students report past-year heroin use and 13.5% report past-year non-medical use of prescription pain medications. While the District has had a long-standing population of heroin users, which has remained largely constant over the decades, these youth statistics are troubling (and are the impetus for youth-focused prevention in the District). Moreover, the District's Office of the Chief Medical Examiner (OCME) reports that opioid overdose deaths nearly tripled between 2013 and 2016, from 83 to 216.

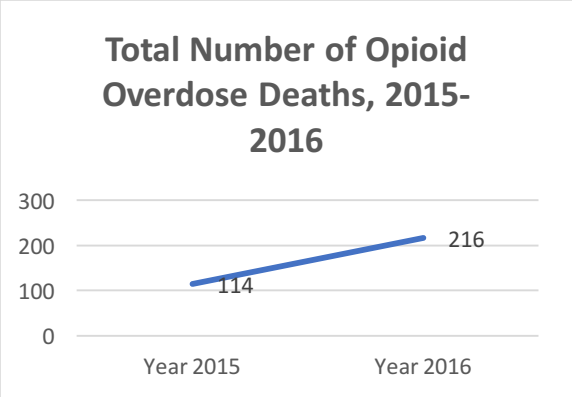
National data also show that the District's treatment system is feeling the consequences of increased opioid abuse. According to TEDS, the number of treatment admissions for heroin in the District increased from 1,187 in 2013 to 1,517 in 2015 (28%). TEDS also reports that admissions for non-heroin opiates more than doubled between 2013 and 2015, from 47 to 112. While much smaller in absolute terms, this is still a disconcerting trend. This report examines the District's opioid situation in more detail in an effort to assess needs using District-level data.

Opioid-Involved Overdoses: Fatal & Non-Fatal

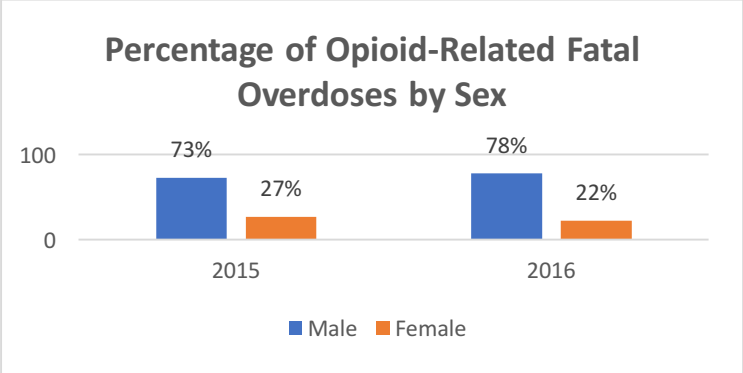
Fatal Overdoses

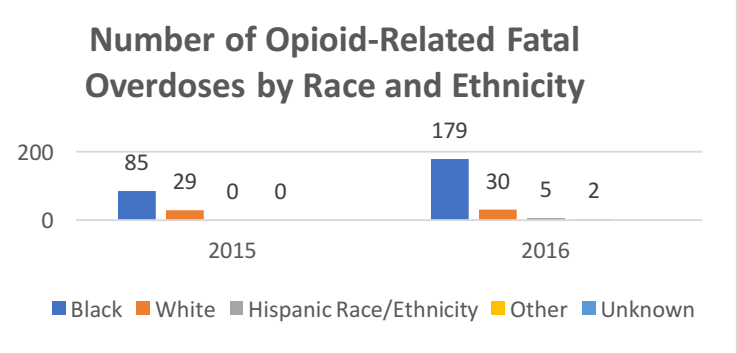
According to the DC Office of the Chief Medical Examiner (OCME) there were 114 opioid-related fatal overdoses in 2015 and 216 such deaths in 2016, an 89% increase.[v] In fact, there were only 83 fatal overdoses in 2013, indicating a 160% increase over three years. Based on U.S. Census estimates, these figures translate to 31.71 fatal overdoses per 100,000 for 2016.[vi]

As of this writing, DBH was able to obtain data only for January and February of 2017, in which OCME recorded 24 opioid related deaths. However, given the small sample size, we will not extrapolate those numbers into a declining rate for 2017.

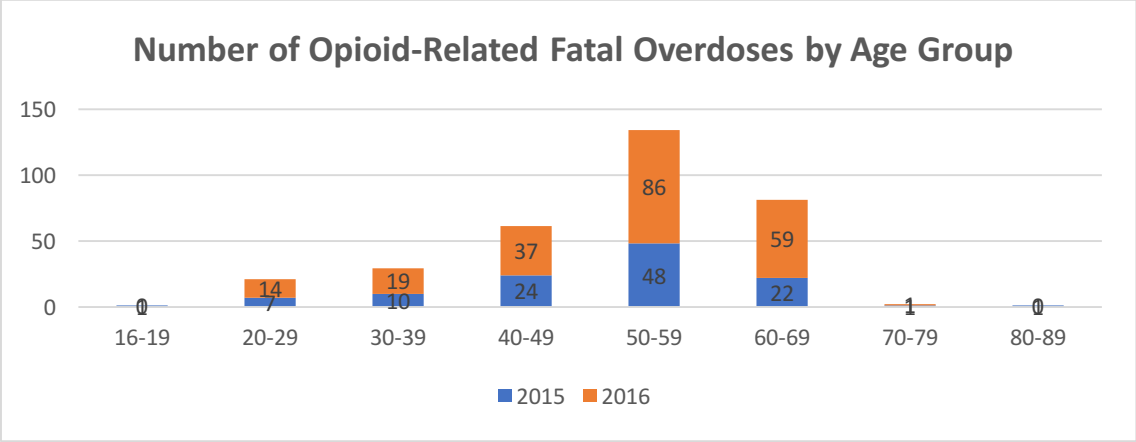


As indicated in DBH's STR proposal, fatal overdoses have been concentrated among older, African American males. Men constituted 73% of the 114 fatal opioid overdoses in 2015 and 78% of such overdoses in 2016. African Americans accounted for 75% of fatal opioid overdoses in 2015 and 83% of those fatalities in 2016.

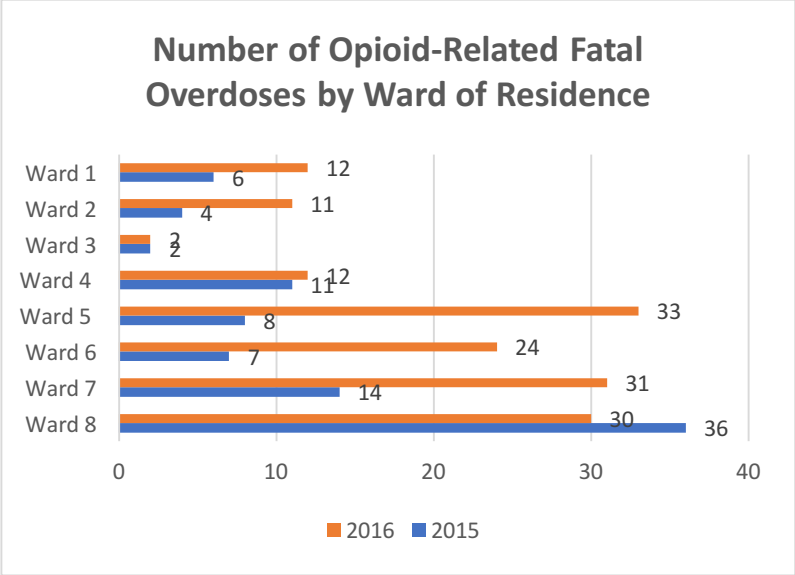




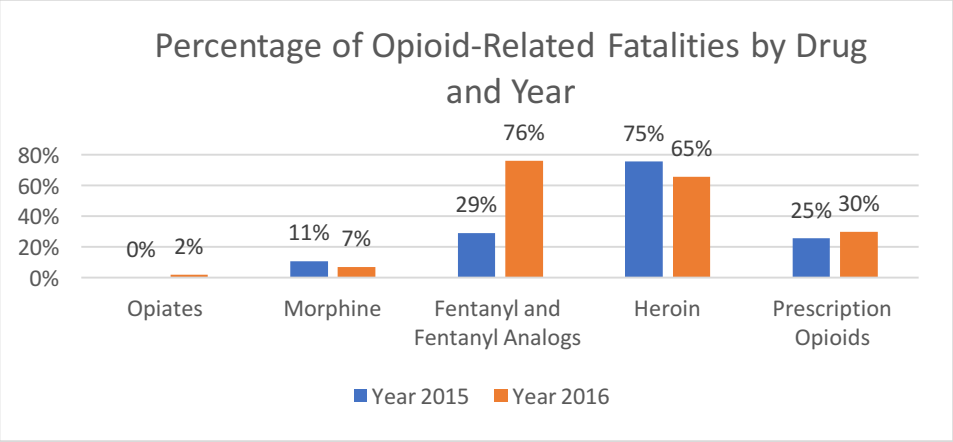
In 2016, individuals between the ages of 50 and 69 accounted for 67% of the fatal opioid overdoes (40% in the 50-59 age group; 27% in the 60-69 age group), demonstrating that the District's fatal overdoses are skewing towards older residents. In contrast, the 30-39 age group accounted for 8% and the 20-29 age group accounted for only 6%.



Data from OCME also reveal important geographical variation in fatal opioid overdoses, indicating that Wards 5, 7, and 8 collectively account accounted for 44% (n=95) of the fatal opioid overdoses in 2016. Notably Ward 6 saw a significant increase in fatalities from 2015 to 2016 (almost equaling the rate in Wards 5, 7 & 8), while Ward 8 experienced a small reduction over the same period. Fatality data indicate that Wards 5, 7, 8 and 6 are at the greatest risk.



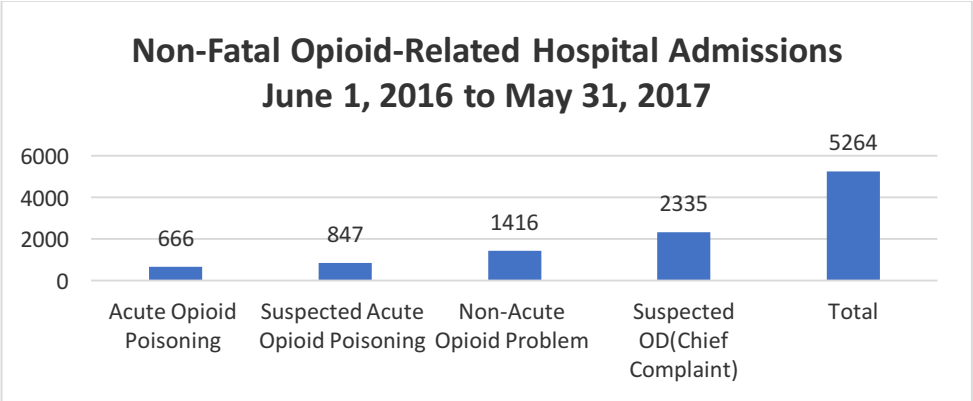
Importantly, the specific drugs detected among fatal overdose victims changed between 2015 and 2016. Heroin was present in 75% of the fatal overdoses in 2015 but only 65% of fatal overdoses in 2016. In contrast, the presence of fentanyl and its analogs increased dramatically over the same period, from 30% in 2015 to 76% in 2016. And prescription opiates were involved with a larger absolute number of overdoses in 2016 than 2015, but accounted for roughly similar (albeit growing) percentage in both years (25% in 2015; 30% in 2016). These data indicate that fentanyl constitutes the single largest fatal overdose threat, followed closely by heroin. However, these findings also indicate that most individuals who overdose are using many kinds of opiates, as more than one drug is usually present in each case.



OCME data also show that methadone was present in the largest share of fatalities involving a prescription opioid—in 2015 (n=9) and 2016 (n=20)—indicating that methadone may be utilized as a drug of abuse or, alternatively, that individuals enrolled in methadone MAT may be overdosing on other opioids while still taking their prescribed methadone. Buprenorphine was also present in four fatal overdoses in 2015 and seven fatal overdoses in 2016. The implications of these findings are discussed in more detail in under Opioid Service Gaps.

Non-Fatal Overdoses

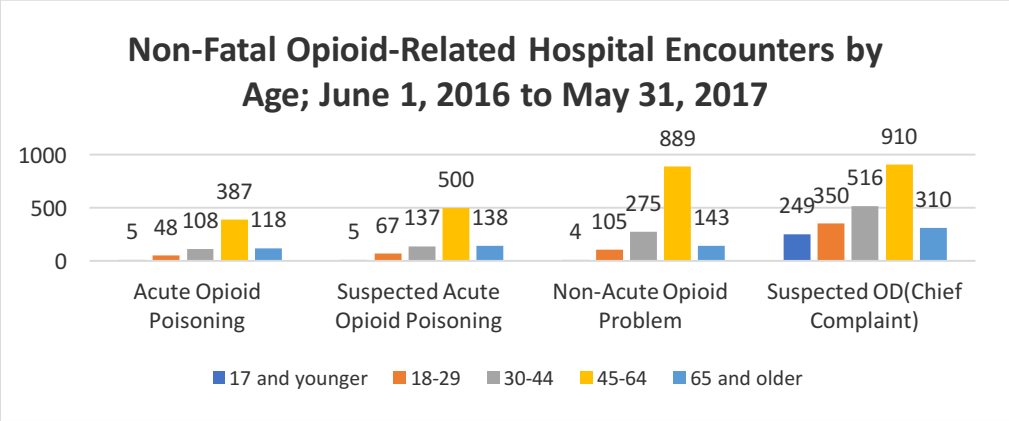
In addition to data on fatal overdoses, the District also collects data on non-lethal opioid-related admissions at eight primary hospitals in the city.[1] In the 12-month period between June 1, 2016 and May 31, 2017, there were 666 incidents of acute opioid poisoning, 847 incidents of suspected acute opioid poisoning, 1,416 incidents of a non-acute opioid problem, and 2,335 incidents of a suspected overdose-related complaint.[2]

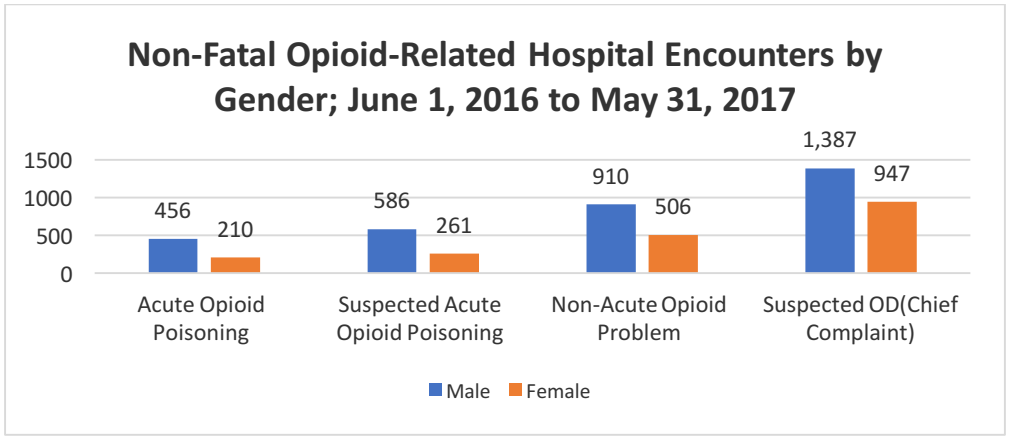


[1] Howard University Hospital does not record data at the same level of detail as others. All of Howard's 413 potential opioid-related incidents are therefore recorded only as "suspected overdose related complaint."

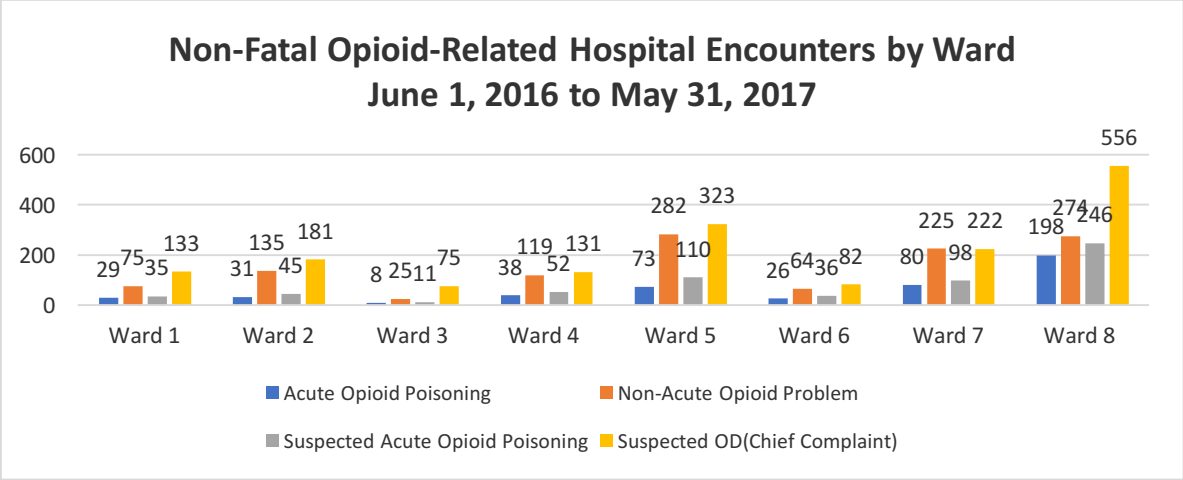
[2] "Acute opioid poisoning" indicates that opioid poisoning was the discharge diagnosis code; "suspected acute poisoning" is a non-poisoning opioid discharge diagnosis code and overdose/unresponsiveness/poisoning as the chief complaint; "Non-acute opioid problem" is a non-poisoning opioid discharge diagnosis code without overdose/unresponsiveness/poisoning in the chief complaint; and "suspected overdose-related complaint" is overdose/unresponsiveness/poisoning in the chief complaint but no explicit opioid diagnosis.

Non-fatal overdoses appear to adhere largely to the demographic trends observed for fatal overdoses. Non-fatal overdoses are significantly more common in the 45-64 age group, with individuals in that range accounting for 58% of the acute overdoses and 59% of the suspected acute poisonings. Similarly, males accounted for 68% of confirmed acute opioid poisoning incidents and 69% of suspected acute poisonings. Hospital data do not currently allow for accurate reporting on race/ethnicity.

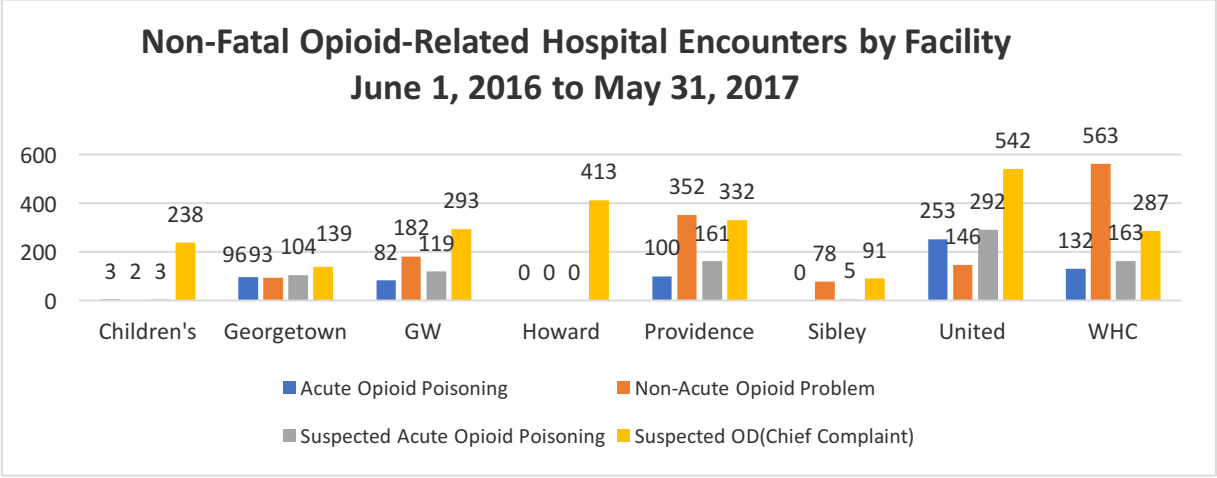




Geographically, non-fatal overdoses were broadly similar to fatal overdoses—concentrated in Wards 5, 7, and 8. Together, those 3 wards accounted for 53% of acute opioid poisonings and 54% of suspected acute opioid poisonings (only slightly larger than their collective share of fatal overdoses). Notably, however, Ward 8 had significantly more non-fatal overdoses than any other ward, despite having roughly similar numbers of fatal overdoses to Wards 5 and 7.



Finally, these data allow us to view non-fatal overdose data by specific hospital, and therefore by geography. Unfortunately, data from Howard University Hospital do not allow for comparisons of acute and suspected acute poisonings. Looking at data for the other seven hospitals, United Medical Center (Ward 8) accounts for 38% of acute opioid poisoning incidents, followed by Washington Hospital Center (Ward 5) with 20%, Providence (Ward 5) with 15%, Georgetown (Ward 2) with 14%, George Washington (Ward 2) with 12%. Children's Hospital (Ward 5) and Sibley Memorial (Ward 3) appear to see very few confirmed opioid overdoses, though this may be a function of different data reporting schemas.



These data reflect the geographic concertation of the fatal overdoses—in that hospitals in Ward 8 and Ward 5 see the largest share of opioid-related incidents. Examining the broadest definition of overdose to include Howard University Hospital, the trends continue largely similarly—but with Howard seeing the second-largest number of incidents (after United). These data are valuable to for targeting additional resources under STR. See Opioid Service Gaps.

Prescription Drug Monitoring Program (PDMP) Data

The District's PDMP sits within the DC Department of Health (DOH) under the Health Regulation and Licensing Administration, Pharmaceutical Control Division. After passing legislation to create the PDMP in 2014, program registration began July 1, 2016—with database information access beginning in October 2016.

The DC PDMP collects data on Schedule II-V drugs. Presently, the District's PDMP allows for individual-level PDMP reporting for prescribers, pharmacists, law enforcement, licensing boards, and others (e.g., the state Medicaid office). However, because the PDMP is still relatively new, as of this writing, the District does not have the ability to conduct aggregate analytics for research and planning purposes, including those that would reveal opioid and/or benzodiazepine prescriptions per 100 persons. As a result, the District cannot currently use PDMP data to locate areas that are at the highest risk for overprescribing, misuse, or diversion.

DOH is currently acquiring these analytic capabilities (with the help of a CDC grant discussed below) and will work with DBH, the Heroin Task Force, and other relevant stakeholders to effectively utilize these analytic capabilities to assess the scope of opioid and benzodiazepine prescriptions and craft targeted prevention and treatment approaches, as warranted. Notably, a small amount of data is available from the OCME on the presence of prescription drugs in fatal overdoses. For all fatal opioid overdoses in 2016, methadone was present in 9% of cases, oxycodone was present in 6%, codeine in 5%, and buprenorphine in 3%. All other drugs for which OCME tests were present in less than 3% of cases.

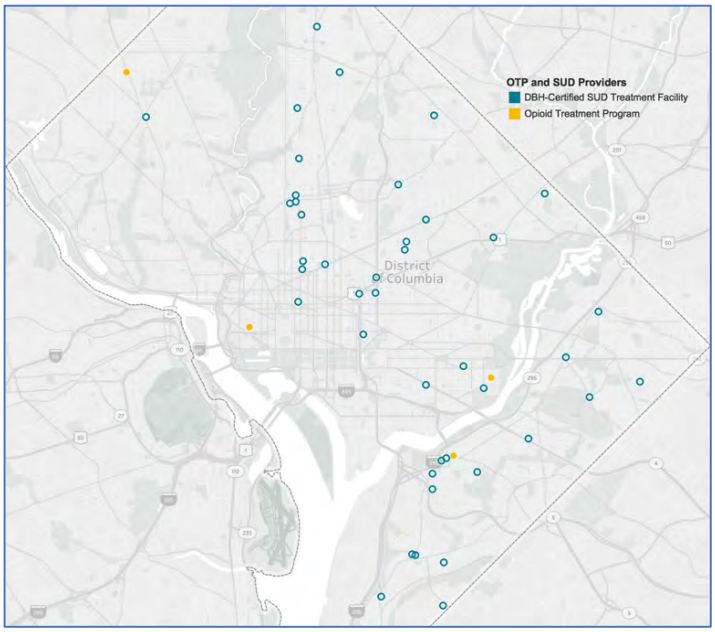
PDMP Policy/Legislation

Under District law, dispensers are required to report all reportable-dispensations; however, neither prescribers nor dispensers are required to query the system prior to writing a prescription for or issuing a controlled substance.

Medication Assisted Treatment, Program Capacity & Demographics

The District's SUD treatment system is partially bifurcated. DBH certifies "providers" but does not have jurisdiction over private physicians or physician groups. DBH's treatment system has 30 certified substance abuse treatment providers, of which 16 have contracts (Human Care Agreements, HCAs) to provide treatment services on DBH's behalf. The 30 certified providers operate 48 facilities throughout the city. The District has four (4) DBH-certified Opioid Treatment Programs (OTPs), three of which have HCAs. In addition, the District has 77 Office-Based Opioid Treatment (OBOT) providers; however, OBOTs are not under DBH jurisdiction and are not counted as "providers" above. OBOTs are discussed in more detail below.

Non-Office-Based SUD Treatment Providers: OTPs & Non-OTPs



In FY 2016, the DBH system conducted 6,008 unique client assessments[3], of which 2,460 (41%) identified heroin as the primary drug of abuse, while another 116 (2%) identified other opiates and synthetics as the primary drug of abuse.[4] Taken together, individuals whose primary SUD problem was either heroin or other opiates constituted 43% (n=2,576) of all assessments conducted in the DBH SUD treatment system. Demographically, these individuals are similar to those suffering fatal and non-fatal overdoses.

For FY2016, 52% of these individuals were between the ages of 50 and 69.[5] Individuals using opioids were 70% male (n=1,716) and 89% African American (n=2,293). In addition, 16% reported a housing status of “homeless”, another 27% reported “dependent living”, and 56% were living independently. These housing status data serve to further highlight the challenges faced by the District’s opioid users as well as by the public SUD system serving them.[6]

District Opioid Treatment Programs (OTPs)

The four DBH-certified methadone OTPs are located in Wards 2, 3, 6, and 8. They have a cumulative capacity of 2,015 (of which 1,825 slots are for public-pay clients). DBH has contracts with Good Hope Institute, United Planning Organization (UPO), and Partners in Drug Rehabilitation Counseling (PIDARC) to provide publicly funded methadone MAT. All OTPs provide psychosocial interventions either in-house or on a contract basis, per the terms of their certification and as required by District law.

[3] This report uses client assessments because DBH’s system renders this the most accessible dataset. Not all of the 6,008 unique clients who received assessments enrolled in treatment. So, this constitutes a slight over count of the treatment admissions but provides a rich dataset for analysis and offers a proxy measure for new enrollments.
[4] There were also five cases where the primary drug of choice was non-prescription methadone.
[5] Another 28% (n=734) were 80+ years old. This seems to be a data error and has been excluded from analyses.
[6] Ward of residence data was not immediately available at the time of this publication.

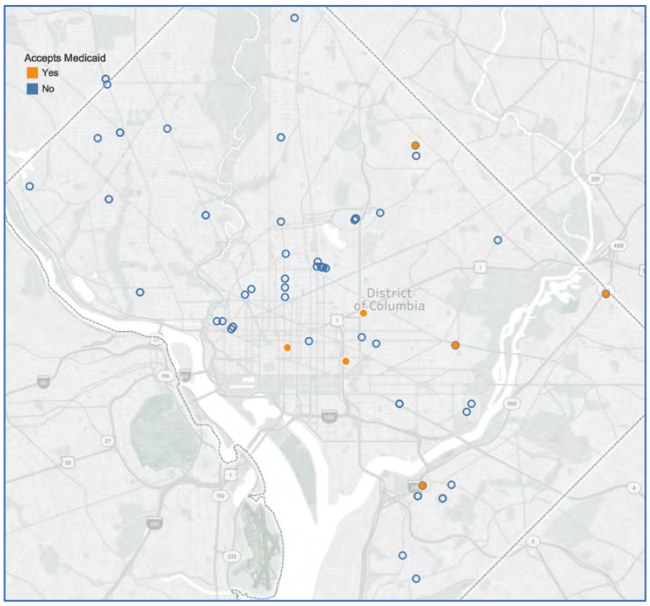
- **Good Hope Institute- Ward 8**; 1320 Good Hope Road SE, Washington, DC 20020 **(Capacity: 700)**
  - **FY2016 public enrollment[7]: 720**
- **UPO- Ward 6**: 1900 Massachusetts Ave, SE Washington, DC 20003 **(Capacity: 400)**
  - **FY2016 enrollment: 488**
- **PIDARC- Ward 2** 2112 F St. NW, #102 Washington, DC 20037 **(Capacity: 725)**
  - **FY2016 enrollment: 841**
- **Aquilla- Ward 3 & Ward 6** 5100 Wisconsin Ave NW, Suite 307, Washington, DC 20016; 721 D Street SE, Suite 2, Washington, DC 20003 **(Capacity: 190)**
  - **FY2016 enrollment: Unavailable to DBH (all clients are non-public payers)**

Enrollment at the three OTPs accepting public pay clients increased 62% from FY2015 to FY2016, from 1,264 clients to 2,049 clients. These increases were driven by a significant expansion at Good Hope (from 430 to 720) and PIDARC (from 306 to 841). Enrollment at UPO actually declined over the same period (from 528 to 488). Enrollment at the three contracted OTPs was 60% male in FY2016. Though data were not available at the time of this writing, they are consistent with the demographics found throughout this report

District Office-Based Opioid Treatment (OBOTs)

According to SAMHSA and DC DOH, there are 77 office-based opioid treatment (OBOT) locations in the District, spread across all 8 Wards (See map). Seven of the OBOT practitioners are also certified by DC Department of Health Care Finance (DHCF) to provide office-based MAT through Medicaid. As indicated on the map, the Medicaid-certified OBOTs are located in Wards 2, 5, 6, 7, and 8. There are currently no OBOTs accepting Medicaid clients in Wards 1, 3, or 4.

Office-Based Opioid Treatment Locations (Medicaid vs. Private Pay)



[7] DBH does not have access to information on private-pay clients.

According to the SAMHSA website (as of July 11, 2017), there are 14 DATA-certified physicians who may treat up to 30 patients each and no DATA-certified physicians who may see up to 100 patients each—down from the 16 and 3 that SAMHSA reported for 2016 and down still further from the 19 and 5 that SAMHSA records for 2015.[vii] However, these data are inconsistent with the SAMHSA data displayed graphically above, indicating that there are 77 authorized buprenorphine prescribers in the District, at least some of whom DBH believes are certified at the 100-patient level. Moreover, DBH is aware that at least one physician (Dr. Edwin Chapman) has been approved to treat up to the new limit of 275 patients. Because these practitioners are not subject to DBH regulation, DBH does not currently have data on whether they are prescribing up to their capacity. For updates to the needs assessment, DBH may be able to obtain data on clients served under Medicaid from DHCF but currently has no mechanism for tracking private-pay clients.

Moreover, as part of an FY2017 effort to enhance buprenorphine-based MAT, DOH has awarded funds to one provider to conduct capacity building and support a needs assessment and targeted delivery of training, capacity building activities, and technical support to clinicians (physicians, NPs, PAs, clinical pharmacists) to apply for or already waived to prescribe buprenorphine-based treatment. DBH will work to ensure that STR funds support but do not supplant these efforts. And future needs assessments will include updates on this DOH-funded expansion. DOH aims to increase the number of active prescribing physicians by 300%. DBH will work closely with DOH to improve the coordination of an OBOT expansion.

Federally Qualified Health Centers (FQHCs) and Look-A-Likes

There are seven Federally Qualified Health Centers (FQHCs) with 35 locations throughout the city. They are:

- Community of Hope (Ward 1, Ward 5, and Ward 8)
- Elaine Ellis Center of Health (Ward 7)
- Family and Medical Counseling Services (Ward 8)
- La Clinica Del Pueblo (Ward 1)
- Mary's Center for Maternal & Child Care Inc. (Wards 1, 4, & 5)- does opioid treatment but not DBH SUD certified
- Unity Health Care Inc. (Wards 1, 2, 3, 5, 6, 7 & 8)
- Whitman Walk Clinic (Wards 2 & 8)- does opioid treatment but not DBH SUD certified

There is also one FQHC Look-A-Like, Bread for the City, with two additional locations in Wards 6 and 8. Of these FQHCs, only two—Mary's Center and Whitman Walker Clinic—are currently providing opioid treatment services. Data on the number of opioid clients served at these FQHCs is not available to DBH at the time of this writing because FQHCs are only subject to DBH if they are also certified SUD treatment providers. DBH may be able to obtain data on Medicaid-funded treatment at FQHCs to enhance future planning efforts. In addition, as part of an

FY2017 effort to enhance buprenorphine-based MAT, DOH has awarded sole source awards to four FQHCs to support the development of their capacity to provide opioid RSS inclusive of but not limited to: behavioral counseling, vocational rehabilitation, assessment of other socio-economic needs, housing, mental health, addressing general health issues with special emphasis on sexually transmitted infections, case coordination, and case management services. This project is still in its infancy, so DOH does not have any data yet. DBH will work with DOH to support this effort. These sites may not be fully accounted for the RSS section below.

Detoxification & Hospitals

There are 10 hospitals in the District, in Wards 1, 2, 3, 5, & 8. The eight primary hospitals are:

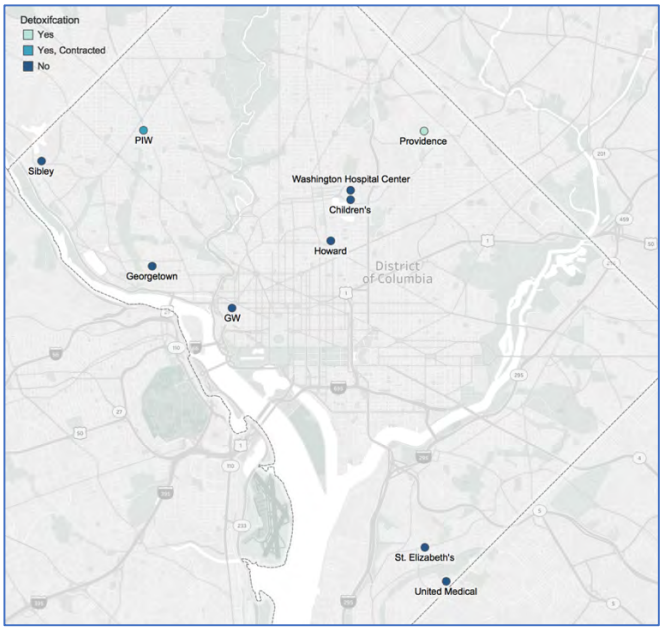
- Children's National Medical Center (Ward 5)
- Georgetown Univ. Hospital (Ward 2)
- George Washington Univ. Hospital (Ward 2)
- Howard University Hospital (Ward 1)
- Providence Hospital (Ward 5)
- Sibley Memorial Hospital (Ward 3)
- United Medical Center (Ward 8)
- Wash. Hospital Center (Ward 5)

In addition, there are two psychiatric hospitals:

- Psychiatric Institute of Washington (PIW) (Ward 3)
- St. Elizabeth's Hospital (Ward 8 and operated by DBH

Only Providence and PIW offer detoxification services, and DBH contracts only with PIW.

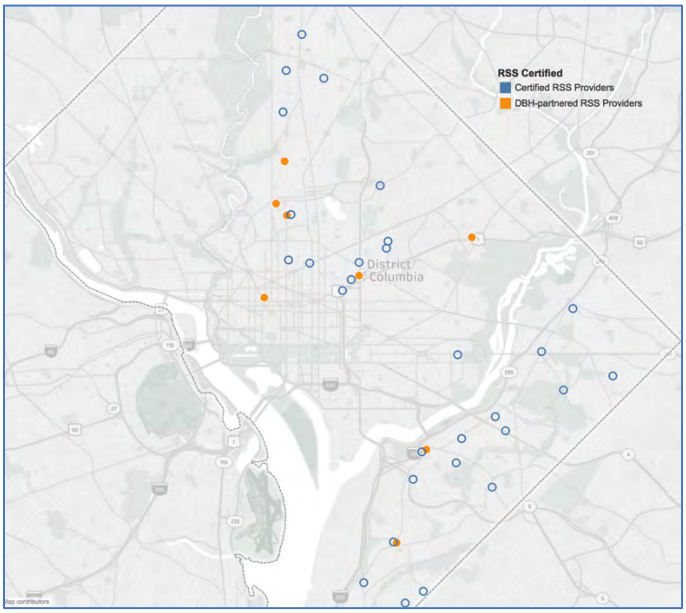
District Hospitals (Including Psychiatric Facilities)



Recovery Support Services System and Initiatives

Through DBH, the District certifies 14 recovery support service (RSS) providers with a total of 37 facilities. Of the certified RSS providers, eight currently provide District-funded RSS. In addition, all but one of the certified RSS providers are also DBH-certified SUD treatment providers. There are certified RSS providers in every ward except Ward 3. See the map below. DOH is also working to enhance the RSS capabilities of four selected FQHCs.

RSS Providers, Certified Only & DBH-Partnered



DBH-certified RSS providers may provide any of the following eight (8) services: Recovery Support Evaluation, Recovery Support Management, Recovery Coaching, Life Skills Support Services, Education Support Services, Recovery Social Activities, Transportation (Public), and (in certain cases) Environmental Stability. There is currently no opioid specific training or component to DBH's RSS certification system or to the specific recovery services described above. Furthermore, demographic and utilization data opioid RSS clients are not available at the time of this writing.

Recovery Coaches & Peer Specialists

DBH has two local recovery-related positions: Recovery Coaches and Peer Specialists.[8]

Within DBH, any individual can become a Recovery Coach (regardless of lived experience) by taking DBH's Recovery Coach training. The first Recovery Coach Training was held in April 2017 with 19 attendees, of which 11 were non-DBH staff. Each Recovery Coach must complete 40 hours of training to receive a Certificate of Completion. As of this writing, future Recovery

[8] Both designations are locally certified but not nationally certified.

Coach trainings will be announced by DBH's Office of Consumer and Family Administration. Currently, DBH does not have a national certification program for Recovery Coaching.

In addition, DBH has a Peer Specialist Certification Program housed in the Office of Consumer and Family Administration. To be eligible for the certification, an individual must be (a) a self-disclosed current or previous consumer of behavioral health services within the DBH network living in recovery with mental illness and/or substance use disorder (or a family member), (b) able to demonstrate personal recovery, and (c) show an ability to help others with their recovery. The six-week certification program requires the completion of classroom work, an 80-hour unpaid field practicum with a District community-based behavioral health provider, and a score of at least 85% on the certification exam. Once certified, peer specialists may: (1) Assist in the development of strengths-based personal goals, (2) Help a peer monitor individual progress and advocate for effective services (3) Model effective coping techniques and self-help strategies, (3) Act as a mentor or facilitator to help resolve issues, (4) Educate on how to navigate the behavioral health system, and (5) Build Community supports. The Peer Specialist program began in 2002.

Re-Integration for Persons Released from Incarceration

DBH recently signed an MOU with the DC Department of Corrections (DOC) through the Residential Substance Abuse Treatment (RSAT) program that will allow individuals to be assessed 10 days prior to release from incarceration. Based on their need, those clients can be referred directly from DOC to receive substance abuse and mental health services. This arrangement also allows DOC to use DBH's electronic health records system. Future iterations of the needs assessment will provide additional information on this new partnership and document a number of efforts under the Mayor's Office of Returning Citizen Affairs.

Naloxone-Related Efforts

Naloxone is administered in the community and through DC Fire and EMS Department (FEMS). Currently, the District's community naloxone distribution system is handled primarily by DOH. DOH has also worked with DHCF to ensure open prescription for naloxone (removing prior authorization) under both fee-for-service Medicaid and all three of the District's Medicaid Managed Care Organizations (MCOs). DBH's prevention branch is beginning to work much more closely with DOH, given the importance of naloxone in avoiding fatal opioid overdoses.

Community-Level Naloxone Efforts

DOH developed a Community Naloxone Pilot Program to train staff and community members to administer naloxone. Under the program, DOH provides naloxone training and kits to Helping Individual Persons Succeed (HIPs) and Family and Medical Counseling Services, which is also a DBH-certified SUD treatment provider and an FQHC. In addition, naloxone is disseminated through 12 needle exchange sites, located in every ward in the District except Ward 2.

DOH uses the peer educator model at HIPS and Family Medical to provide additional outreach in the community. 30 trained peers can administer naloxone, help disseminate important information (data-based messages on spikes in overdoses etc.), and link clients to support services.

Initially, DOH resupplied each site with naloxone kits on-demand; however, after encountering supply issues, DOH modified the system. First, DOH kept an "emergency" supply of to meet short term needs. Eventually DOH developed a standing monthly order to alleviate these concerns, now allocating 50-75 kits for each site per-month, based on observed trends. Over 1,000 kits were distributed since September 2016, and DOH has purchased an addition 2,500 for future distribution, focusing on Wards 5,7, and 8—which have been identified as the areas of greatest need (both in this report and previously by DOH).

DOH recently trained 140 community partners and volunteers between September 2016 and May 2017. Naloxone trainings are currently conducted monthly and the primary participants have been members of the pilot sites. However, trainings have also included staff from: The Metropolitan Police Department, the DC Public Court System, pharmacies, hospitals, and the DC Department of Corrections. DOH has also conducted targeted outreach to FQHCs and the DC Primary Care Association and is now seeking to directly target emergency room providers, the DC Department of Corrections, the DC Public Library, and the DC Department of Parks and Recreation for additional trainings. DOH has committed to financing the trainings locally for 3 years but is also seeking grant options.

FEMS Naloxone Efforts

DC Fire and EMS Department (FEMS) also administers naloxone and collects data on those administrations. Broadly, rates of administration have increased significantly since January of 2015. Peak monthly administration topped out at 314 in June of 2016. However, the mean annual administrations have also been steadily rising, with an average of 145 monthly administrations in 2015, 247 in 2016, and 236 in the first 4 months of 2017 (note that winter months historically have fewer administrations). In addition, demographically, individuals who receive naloxone from FEMS are broadly similar to individuals who suffer opioid-related overdoses (fatal or non-fatal) and to individuals assessed by DBH's public SUD treatment system. Individuals receiving naloxone were 90% African American, 74% male, and 52% ages 51-70 (with another 16% ages 41-50).

Non-Naloxone Prevention Systems & Initiatives

DBH's Substance Use Disorder Services (SUDS) Prevention branch shepherds much of SUD prevention efforts in the District (though, as noted, the naloxone-related prevention is under DOH). Taken together, DBH's efforts seek to prevent or delay the onset of alcohol, tobacco, and other drug use among District residents—with a particular focus on youth.

DBH has four DC Prevention Centers, which serve as prevention hubs throughout the District. As an extension of DBH, they are strategically placed to provide coverage for two wards each. Parent companies receive sub-grants from DBH with support from SABG funding. Each Center has a minimum of one director, one community mobilizer, and one PFS coordinator. The location and service area of each center is as follows:

- **Wards 1 & 2**: 1419 Columbia Road, NW, Washington, DC 20009 (Ward 1)
- **Wards 3 & 4**: 5335 Wisconsin Avenue, NW, Suite 440, Washington, DC 20015 (Ward 3)
- **Wards 5 & 6**: 1022 Maryland Avenue, NE, Washington, DC 20002 (Ward 6)
- **Wards 7 & 8**: 3939 Benning Road, NE, Washington, DC 20019 (Ward 7)

Over the past several years, the SUDS Prevention branch has been increasing its focus on opioid misuse. In 2017, DBH partnered with a pharmaceutical company and the Community Anti-Drug Coalitions of America (CADCA) to disseminate 100,000 medication deactivation pouches throughout the District. The pouches provide a safe and responsible method for disposing of unused prescription medication in the home, by combining tap water and 10-15 pills. This reduces unintended use by youth and also produced environmental benefits. Pouches were provided via pharmacies (Walgreens, CVS, and Harris Teeter) and community based partners.

In addition, using discretionary funding through SAMHSA's SPF Partnership for Success grant, the District is developing an opioid awareness campaign for youth to share messages around the risks associated with prescription medication misuse. This data-driven campaign will be launched in areas within DC where misuse of prescription medication has been more prevalent and is a direct result of data discussed earlier in this report. As an enhancement to the opioid awareness campaign, SAMHSA's STR funding will be used to create prevention messaging for adults who have historically been heroin users, focusing on: the risks associated with heroin use, additives to heroin, and the administration of naloxone. This campaign will be aimed at filling the information gap regarding the risks associated with heroin and other opioid misuse, especially given the recent data indicating the fatalities associated with fentanyl and its analogs. The campaign will improve public safety and reduce overdoses (fatal and non-fatal). Messaging around the District's Good Samaritan law (see below) will be included in the campaign.

DOH-Led Prevention Activities

DOH is pursuing many opioid-related prevention activities. This section details those for which DBH currently has information. However, DBH will update this section as new information on DOH's ongoing efforts becomes available through further improved collaboration under STR.

Needle Exchange

Since 2007, DOH has pursued a successful needle exchange program—removing 803,596 needles from the street in 2016 alone, and resulting in a 95% decline in the number of newly diagnosed HIV infections attributable to injection drug use from 2007 to 2016 (from 149 cases to 7 cases). A 2015 study indicates that the District has an estimated 12,000 active injection drug users.[viii] Data from District needle exchange programs also provide another source of data

on District heroin use, indicating that heroin remains the leading injection drug in the District. DOH leverages needle exchange programs for their access to opioid users and the significant trust developed by their staff.

CDC Prescription Drug Overdose Data Driven Prevention Initiative (DDPI)
DC DOH received a three-year planning and data-focused DDPI grant from CDC, which provides the District with additional resources to combat prescription drug abuse, diversion, and death related to opioids. This grant includes a needs assessment, stakeholder engagement and identification (and stakeholder meeting), enhancement of the PDMP analytic ability (discussed above), and a focus on the ability to work with broader stakeholders. DBH will partner with DOH to leverage STR and DDPI together and avoid duplication.

Opioid-Related Policy & Legislation

The District has pursued a host of opioid-related policy and legislative changes to combat the epidemic, most of which are discussed in their relevant sections above. This section will also be updated in future iterations of the needs assessment to reflect the full range of policy changes.

MAT Billing Policies and Related Efforts
For OTPs, DBH has issued clarifying guidance regarding Medicaid-funded MAT provided through DBH-contracted OTPs, further explaining required billing codes and procedures. Although MAT administration at OTPs can be billed directly to Medicaid (DHCF), DBH requires therapeutic guidance in each instance, which must be documented to DBH (and billed, as appropriate). DBH also requires a record of dose administration in the DBH system. And DBH clarified the District's requirement of per-encounter billing (vs. service roll up).

Notably, for OBOTs and FQHCs, DOH has issued awards this fiscal year (discussed in the appropriate sections of this report), which have the combined short-term goals of (1) securing a training and capacity building provider to support primary care providers to integrate buprenorphine-based treatment for opioid use disorders (2) supporting FQHCs to provide or increase provision of buprenorphine-based MAT and care coordination, (3) enabling FQHCs to obtain the Medicaid enhanced rate for behavioral health services, and (4) increasing the number of providers who are prescribing buprenorphine-based treatment by 300%.

Finally, in June 2016, DHCF issued policy in response to identified barriers to OBOT buprenorphine treatment, stating that (1) buprenorphine shall only be dispensed with prior authorization from DHCF (or the clients MCO); (2) prior authorization shall last 12 months; (3) a pharmacist may dispense a 7-day supply while authorization is pending; (4) practitioners must document the ability to provide linkages to counseling; however, strict adherence to regular counseling shall not be a requirement maintaining a patient in treatment or obtaining refills; (5) providers may exceed the standard 24mg/day if clinically justified (but that justification must be included with the prior authorization request); (6) practitioners shall conduct urine tests at least bi-monthly as a quality measure to assess other opiate use but not as a prerequisite for

treatment; (7) there shall be no lifetime limit on buprenorphine, naltrexone, or methadone under Medicaid (FFS or MCO).

Task Forces and Councils

The District has undertaken several efforts to convene the stakeholders to address the opioid crisis. At the regional level, in 2016, Mayor Muriel Bowser joined the governors of Maryland and Virginia in signing the *National Capital Region Compact to Combat Opioid Addiction*. The Compact pledges that DC, Maryland, and Virginia will work collaboratively to stop the damaging effects of the opioid epidemic and convened a regional opioid summit in May 2017.

In addition, the District has two notable intra-governmental efforts. The interagency *Heroin and Opioid Task Force* was established in 2014 to strategize solutions to reduce morbidity and mortality associated with District opioid use. On a monthly basis, the Task Force convenes stakeholders from District agencies and regional/federal partners to share data and develop strategies to curtail the heroin epidemic.[9] Data from stakeholders is presented at Task Force meetings and used to enhance syndromic surveillance, analysis, and policy development. DOH supports this task force. In addition, the United States Attorney's Office for the District of Columbia heads a *Heroin/Opioid Working Group* which aims to curtail the opioid crisis through grass-root initiatives (rather than the policy work of the Task Force). Working with local police, community-based organizations, and outreach teams from District Government agencies, the Working Group implements initiatives that directly target heroin/opioid users and those close to them (e.g., family members). Activities have included direct outreach and engagement and bringing resources directly to locations affected by use (e.g., parks). Staff and resources from the Attorney General's support this effort.

Good Samaritan Law & PDMP

In 2012, the District passed DC BILL 19-754, "Good Samaritan Overdose Prevention Amendment Act of 2012." The bill provides legal protections for individuals who were victims of overdoses and/or individuals who seek medical assistance for individuals who are victims of overdoses. Finally, District PDMP laws are discussed under the PDMP section above, and naloxone-related policies and legislation are discussed under Naloxone-Related Efforts.

Estimated Current Treatment Need

Calculating treatment need is difficult. Fortunately, a recent study provides an estimate of 2012 treatment need for the District (and the 50 States) using NSDUH and other SAMHSA data sources.[ix] The authors report a rate of past year opioid abuse or dependence of 6.7% (with a 95% confidence interval of 3.6% to 12.3% per 1000 resident population 12 years of age or greater) for 2012. **Applying that rate to the current District population age 12 and older yields**

[9] Participants include: DBH, DOH (Center for Policy Planning and Evaluation & Pharmaceutical Control Division), DHCF, FEMS, OCME, DC Department of Forensic Sciences (DFS), Metropolitan Police Department (MPD), DC Office of the Attorney General (OAG), the Washington Regional Threat Assessment Center/Fusion Team (WRTAC), the US Drug Enforcement Administration, and the Federal Bureau of Investigation.

a treatment need point estimate of 3,919 (with a 95% confidence interval ranging from 2,106 to 7,194). These findings are noteworthy given the 2,049 clients enrolled in methadone MAT in FY2016.

The same study also reports findings on opioid treatment capacity. It finds that the District's potential buprenorphine treatment capacity rate of 5.8 per 1,000 residents age 12 and older (95% C.I. is 5.6 to 6.0) exceeds the average rate for the nation of 4.1 per 1,000 (95% C.I is 4.1-4.1); likewise, they estimate that OTPs in the District are at 100% capacity compared with the 82.3% average for the rest of the nation. In fact, the District is one of only 13 states where the study reports that all OTPs are operating at full capacity. These findings suggest that the District's MAT system may be better equipped to manage its opioid epidemic, on average, as compared to other states. However, it also indicates that the District may lack the capacity to serve additional clients at current OTPs.

The District was not able to employ the Calculating for an Adequate System Tool (CAST) for this report but plans to utilize it in the future.

Opioid Service Gaps & Lessons Learned

Findings from overdose data (fatal and non-fatal) as well as data from DBH's public treatment system demonstrate that:

- The observable opioid-using population in the District is disproportionately older (roughly, age 40-65), African-American, and male.
- The observable opioid-using population is concentrated in Wards 5, 7, and 8 (and may be rising in Ward 6).
- A significant share (16%) of OUD clients receiving assessments through DBH's public SUD treatment were homeless, indicating that OUD is a significant problem in the District's homeless community.
- Opioid-related fatalities have risen significantly, driven in large-part by fentanyl and its analogs
- District hospitals (and FEMS) encounter a large number of opioid users (demographically consistent with the description above) and represent an area for improved collaboration to facilitate MAT enrollment.
    - Wards 6 and 8 lack hospitals yet have significant levels of individuals with OUD.
- Leading indicators such as youth use of prescription opioids in the YRBS and the doubling of TEDS admissions for prescription opioid abuse indicate a need to get out in front of a potential "new wave" of users.
- Less data is available on prescription opioid users outside of the publicly-funded treatment system and FEMS/overdose data, which makes it difficult to assess the extent of the problem in certain segments of the District population.

These data will be useful for targeting a myriad of STR efforts, including (but not limited to): prevention campaigns, treatment capacity (slots) expansion, improved access (including "warm

handoffs" to treatment from other points in the system), and treatment quality improvement (including care coordination). More detailed findings are discussed below.

OTP Methadone Clinics

- There are no OTPs in Ward 5 or Ward 7, despite the high concentration of need in these wards. DBH will further explore the implications of this finding.[10]
- All three OTPs that accept publicly funded clients appear to have operated at capacity (2,015) in FY2016. This indicates that OTPs may have limited capacity to expand without significant changes to staffing, structure etc. But it also indicates that the OTPs may be doing a good job responding to the increased need (relative to previous years).

OBOTs & FQHCs

- DOH is currently leading efforts to expand the capacity of OBOTs and work with FQHCs. However, relatively little information is available to DBH as of this writing. DBH will work through the Heroin Task Force to coordinate STR efforts across all relevant agencies.
- DBH will also seek to work with DOH to establish a baseline capacity for existing OBOTs and FQHCs against which to measure progress as well as furthering the expansion (and working to expand Medicaid-funded services).
- FQHCs represent an area ripe for MAT expansion and service coordination in the District.
- Though OBOTs and FQHCs are outside DBH jurisdiction, they are crucial to ensuring a high-quality MAT network. The strategic plan will outline DBH's STR-funded efforts in this regard.

RSS

- Data are not currently available to assess the extent to which DBH's RSS system is able to facilitate access to MAT and support individuals in recovery from OUD. This is a priority area.
- DBH and DOH will enhance collaboration around recovery-oriented efforts spearheaded by DOH through FQHCs.
- Peer-based efforts are crucial. DBH and DOH will work collaboratively to streamline peer-based outreach and RSS efforts and enhance existing peer services at DBH to better serve (and target) individuals with OUDs.

Areas for Further Exploration

- The data presented herein do not permit data-based assessments of the potential service gaps regarding: transportation and other access issues, community connections, integration with physical health, family treatment, or recovery supports (including employment/education assistance). Though DBH can provide anecdotal assessments of these needs, future iterations of this needs assessment will focus on these issues in

[10] The District's geographic size is a factor. At minimum, this highlights the importance of transportation and access.

more detail. In particular, DBH will seek to better assess the ability of OBOTs and OTPs to provide comprehensive, coordinated care—which DBH believes is an area of concern.

In addition, this needs assessment reveals both the early successes of the District's intra-governmental cooperation (e.g., the Heroin Task Force) and areas for increased cooperation and infrastructure improvement. Those areas include (not exhaustive):

- Developing and utilizing analytic capabilities for the District's PDMP, including intra-governmental sharing of aggregate date (in progress and also supported by DDPI)
    - After consultation with DOH, the District may also want to explore laws/policy that mandate PDMP utilization
- Further developing the collaboration between DBH and DOH's naloxone programs and other prevention efforts
- Further developing collaboration between DBH and DOH to better monitor, oversee, assess, and expand OBOTs using buprenorphine-based MAT

The Heroin Task Force appears to be the ideal forum for much of this enhanced coordination.

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[i] U.S. Census Bureau. District of Columbia Quick Facts. https://www.census.gov/quickfacts/DC Accessed July 28, 2017.

[ii] Muhur, P et al. (2013). Associations of nonmedical pain reliever use and initiation of heroin use in the United States. Rockville, MD: SAMHSA. http://archive.samhsa.gov/data/2k13/DataReview/DR006/nonmedical-pain-reliever-use-2013.pdf Accessed May 13, 2016.

[iii] SAMHSA. Key substance use and mental health indicators in the United States: Results for the 2015 NSDUH. https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2015/NSDUH-FFR1-2015/NSDUH-FFR1-2015.pdf

[iv] SAMHSA. NSDUH 2014-15 State Estimates, (https://www.samhsa.gov/data/sites/default/files/NSDUHsaeStateTabs2015B/NSDUHsaeSpecificStates2015.htm#tab27); and NSDUH 2012-13 (http://pdas.samhsa.gov/saes/state)

[v] DC Office of the Chief Medical Examiner. April 2017. Opioid Related Fatal Overdoses January 1, 2014 to February 28, 2017.

[vi] U.S. Census Bureau. District of Columbia Quick Facts Tables. https://www.census.gov/quickfacts/fact/table/DC/PST045216

[vii] SAMHSA. Number of Data-Certified Physicians. https://www.samhsa.gov/medication-assisted-treatment/physician-program-data/certified-physicians?field_bup_us_state_code_value=DC Accessed July 28, 2017.

[viii] Ruiz, M. (2016). Using capture-recapture methods to estimate the population of people who inject drugs in Washington, DC. *AIDS Behav.* 20(2): 363-8.

[ix] Jones, C. M., et al. (2015) National and state treatment need and capacity for opioid agonist medication-assisted treatment. *American Journal of Public Health*. 105(8): e55-63.

LIVE. LONG. DC.

WASHINGTON, DC'S STRATEGIC PLAN TO REDUCE OPIOID USE, MISUSE, AND RELATED DEATHS

DBH
DEPARTMENT OF BEHAVIORAL HEALTH

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

Updated as of March 2019

Mayor Muriel Bowser

Too many of our neighbors in Washington, DC lose their lives or family members and friends to a substance use disorder. Many of these cases involve opioid overdoses. The District's multi-stakeholder, public health approach has yielded progress in saving lives and reducing fatal overdoses, but there is still work to be done to reduce the impact of the epidemic on our city.

"LIVE.LONG.DC," Washington, DC's Strategic Plan to Reduce Opioid Use, Misuse and Related Deaths is our blueprint for how best to continue moving forward with urgency and thoughtfulness as we work towards reversing fatal opioid overdoses. The Plan reflects the input of a cross-section of public and private partners, including DC government agencies, hospital leaders, physicians, substance use disorder treatment providers, community-based service providers, federal partners, and individuals in recovery.

The updated Plan offers a comprehensive look at prevention, treatment, and recovery, detailing our goals and accompanying strategies to end Washington, DC's opioid epidemic. Our Plan offers additional details on how these goals and strategies will be accomplished in order to ensure District residents can thrive and move forward with the support they need.

Working together, the implementation of LIVE.LONG.DC has resulted in some early successes, which include:

- Reversing more than 1,000 overdoses through naloxone kits and training residents in naloxone use;
- Increasing the capacity of practitioners to provide Buprenorphine-based medication-assisted treatment (MAT);
- Monitoring trends in opioid use and tailoring responses and interventions based on real-time data;
- Increasing testing capacity via surveillance of synthetic opioids in the District, both to discover new synthetic opioids as well as characterize those currently present; and
- Revising innovative public education campaigns targeting those who are most likely to overdose on heroin and to educate young people on the dangers of misusing prescription opioids.

We will continue to work collaboratively to develop and implement strategies that help those facing opioid use disorder. We are devoted to tailoring our response in a manner that is specific to Washington, DC, based on our history, demographics, and trends in usage so that we can stem this epidemic facing our city.

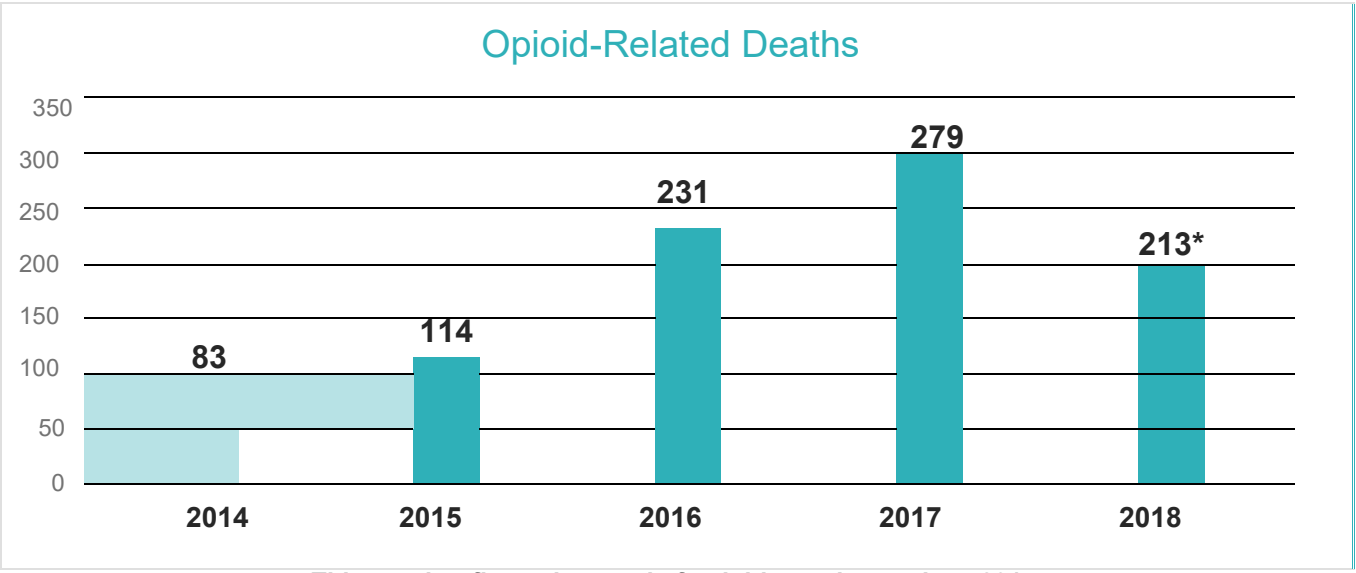
I want to thank all who contributed to this thoughtful Plan and those going forward for doing your part to reduce fatal overdoses. Together, we will help all Washingtonians live safer and stronger lives.

Muriel Bowser
Mayor

The Crisis

As opioid-related deaths continue to rise across the nation, Washington, DC has also experienced an alarming increase in fatal opioid overdoses. Overdoses hit a peak in 2017, with 279 overdoses total, and has since trended downward in 2018. National trends largely reflect new opioid users who are White (non-Hispanic) younger adults who begin their addiction by experimenting with prescription drugs, with the potential of progressing to heroin usage. However, Washington, DC's epidemic affects a unique demographic and presents different trends in use.

Washington, DC's Epidemic in A Snapshot



This graph reflects the trend of opioid overdoses since 2014.

***Data for 2018 is subject to change due to cases where cause and manner of death are pending further investigation.**

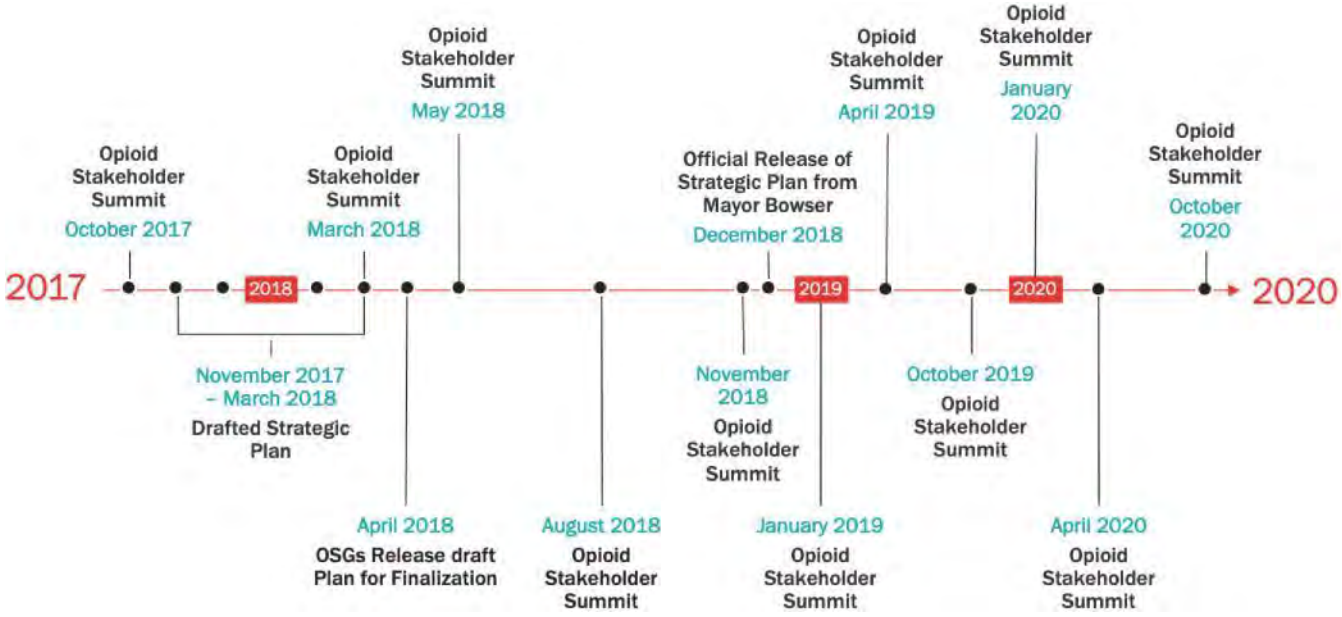
- There was a 178% increase in fatal overdoses due to opioid use from 2014 to 2016.
- In 2016, 62% of cases involved fentanyl or a fentanyl analog.
- In 2017, 71% of cases involved fentanyl or fentanyl analogs.
- Approximately 80% of all overdoses due to opioid drug use happened among adults between the ages of 40–69, and such deaths were most prevalent among people ages 50- 59.
- Overall, 81% of all deaths were among African-Americans. This trend has remained consistent across years.
- Fatal overdoses due to opioid drug use were more common among males (74% of deaths were males).
- From 2014 to 2017, opioid-related fatal overdoses were most prevalent in Wards 7 and 8.
- 89% of DC opioid users are over 40 years old and 58% are more than 50 years old.
- 22% have been using heroin (primary used opioid in Washington, DC) for more than 40 years, 59% for more than 25 years, and 88% for more than 10 years.

The Approach

To comprehensively address the unique opioid epidemic in Washington, DC, localized and coordinated public-private partners must work together. This kind of partnership yields expertise in creating agile, cross-discipline, public-private leadership coalitions, rapidly aligning on targets and coordinated actions, and maintaining accountability on outcomes that will cause short- and long-term impacts.

In October 2017, a group of 40 stakeholders, representing both the public and private sectors, convened for a summit focused on how to jointly address Washington, DC's opioid epidemic. Out of the summit, the Strategic Planning Working Group was created. In late November 2017, the working group members began to conduct stakeholder engagement sessions to assess what was needed regarding prevention and early intervention, harm reduction, acute treatment, sustained recovery, and criminal justice. The information from these sessions and the feedback from the working group members was used to draft the plan. The draft plan was finalized at the end of February 2018. In March 2018, the working group was convened and membership for the seven Opioid Strategy Groups (OSGs) that would map out the implementation of the goals and associated strategies in the Strategic Plan were formed. Leadership and membership of the OSGs were finalized in April 2018.

These groups have been actively working on the goals and related strategies since April 2018. The most recent stakeholder summit was in January 2019, where more than 100 stakeholders attended. The groups reflected on the accomplishments made in 2018 and established the key priorities of focus for 2019. All seven OSGs continue to meet regularly to address these strategies and move their efforts forward.



Opioid Strategic Planning Working Group Members Include:

The development and implementation of LIVE.LONG.DC. has been supported by more than 40 stakeholder groups, District government, and federal agencies since 2017, including:

Non-Governmental Agencies

- Aquila Recovery
- **Children's National** Health System
- DC Hospital Association (DCHA)
- Medical Society of the District of Columbia
- DC Prevention Center Wards 7 and 8
- DC Primary Care Association (DCPCA)
- DC Recovery Community Alliance (DCRCA)
- Medical Home Development Group (MHDG)
- George Washington University (GWU)
- Grubbs Pharmacy
- Helping Individual Prostitutes Survive (HIPS)
- Howard University
- McClendon Center
- Mosaic Group
- Oxford House
- Pathways to Housing
- Partners in Drug Abuse Rehabilitation Counseling (PIDARC)
- Psychiatric Institute of Washington (PIW)
- So Others Might Eat (SOME)
- Sibley Memorial Hospital
- United Planning Organization
- Unity Health Care
- Whitman-Walker Health
- Woodley HouseZane Networks LLC

- **DC Government Agencies**
- Criminal Justice Coordinating Council (CJCC)
- Council of the District of Columbia
- Department of Behavioral Health (DBH)
- Department of Corrections (DOC)
- Department of Health (DC Health)
- Department of Forensic Sciences (DFS)
- Department of Health Care Finance (DHCF)
- Department of Human Services (DHS)
- Department of Aging and Community Living (DACL)
- Executive Office of the Mayor (EOM)
- Fire and Emergency Services (FEMS)
- Homeland Security and Emergency Management Agency (HSEMA)
- Metropolitan Police Department (MPD)
- Office of the Chief Medical Examiner (OCME)
- Office of the Attorney General (OAG)

Federal Government Agencies

- Court Services and Offender Supervision Agency (CSOSA)Department of Justice (DOJ)
- Drug Enforcement Agency (DEA)
- Federal Bureau of Investigations (FBI)
- Pretrial Services Agency (PSA)

2018 Accomplishments and Highlights

Since the LIVE.LONG.DC. was published in December 2018, much work has been done to meet the goals set out in the plan. One of the biggest accomplishments has been the successful reversal of 85% of all reported overdoses due to the administration of naloxone. In addition, the following successes have helped move us closer to reaching our goal of reducing opioid use, misuse, and related deaths by 50% by 2020:

- Reduced the death rate due to opioids by 31% (subject to change once the fatal overdose data has been finalized).
- Enacted the provisions in the SAFE DC Act, which criminalizes synthetic drugs, including variants of fentanyl, based on the class of the chemical compounds, rather than the individual compound, strengthening law enforcement **officials' ability to test for and prosecute cases against sellers and distributors of** these drugs.
- Extended emergency legislation to make opioid testing kits legal.
- Better characterized the supply of illegal opioids, including the discovery of new opioids, through advanced testing at the Department of Forensic Sciences (DFS) opioid surveillance lab.
- Launched social marketing campaigns, including anti-stigma campaigns, to increase awareness about opioid use, treatment, and recovery.
- Awarded to contract for the implementation of Screening, Brief Intervention, Referral, and Treatment (SBIRT) in three emergency departments and the induction of MAT, in conjunction with peer engagement and referrals to community services and supports.

The Plan

Under the leadership of Mayor Bowser, the public-private Strategic Planning Working Group developed a comprehensive strategic plan aimed at reducing opioid use, misuse and opioid-related deaths by 50% by 2020. As a result, Washington, DC's Strategic Plan to Reduce Opioid Use, Misuse, and Related Deaths covers the full array of prevention, treatment, and recovery supports. The Plan consists of seven (7) goals, each with subsequent strategies. Investments to implement the plan in 2019 include grant and local funds totaling $32,255,028 and many hours of funded personnel services.

GOAL 1: Reduce legislative and regulatory barriers to create a comprehensive surveillance and response infrastructure that supports sustainable solutions to emerging trends in substance use disorder, opioid-related overdoses, and opioid-related fatalities.

GOAL 2: Educate District residents and key stakeholders on the risks of opioid use disorders and effective prevention and treatment options.

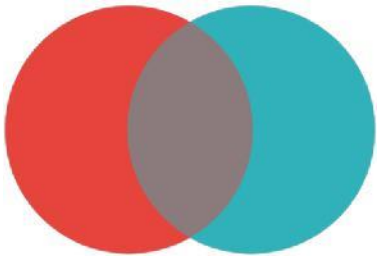
GOAL 3: Engage health professionals and organizations in the prevention and early intervention of substance use disorder among District residents.

GOAL 4: Support the awareness and availability of, and access to, harm reduction services in the District of Columbia consistent with evolving best and promising practices.

GOAL 5: Ensure equitable and timely access to high-quality substance use disorder treatment and recovery support services.

GOAL 6: Develop and implement a shared vision between the District's justice and public health agencies to address the needs of individuals who come in contact with the criminal justice system. Promote a culture of empathy for arrestees, inmates, returning citizens, and their families as they navigate the various entities in the criminal justice system.

GOAL 7: Develop effective law enforcement strategies that reduce the supply of illegal opioids in the District of Columbia.



Reduce legislative and regulatory barriers to create a comprehensive surveillance and response that supports sustainable solutions to emerging trends in substance use disorder, opioid-related overdoses, and opioid-related fatalities.

Total Budget Investment: $2,168,669

Opioid Strategy Group (OSG) Member Organizations: Office of the Chief Medical Examiner, Department of Health, Department of Behavioral Health, Department of Corrections, Howard University, DC Hospital Association, Department of Health Care Finance, Criminal Justice Coordinating Council, Executive Office of the Mayor

Strategy	Targeted Completion Date	Action Steps	Lead/ Supporting Agencies	Measures of Success	Funding
1.1: Establish an Opioid Fatality Review Board to review all opioid-related deaths that occur in Washington, DC.	March 30, 2019	• Submit Mayoral Order. • Identify funding options to staff the Board.	**OCME** DC Health	• Opioid Fatality Review Board established and convening regularly	$140,669
1.2: Coordinate with Washington, DC and federal regulators to revise laws and regulations that currently impose restrictions on the prescribing of medication-assisted treatment (MAT).	June 30, 2019	• Revise policy to loosen restrictions on prior authorizations for buprenorphine and vivitrol. • Publish transmittal regarding updated policy.	**DHCF**	• Prior authorization requirements removed for buprenorphine and vivitrol.	In-Kind
1.3: Coordinate with federal regulators to reverse policies and practices that restrict access to MAT to District residents while in the custody of the Federal Bureau of Prisons (BOP).	December 31, 2020	• Convene stakeholder working group to discuss and develop policy changes. • Implement policy changes.	**EOM** CJCC	• Policy implemented allowing continuation of MAT while in BOP	In-Kind
1.4: Strengthen the infrastructure for data and surveillance to understand the scope of opioid-related overdoses (fatal and nonfatal) and the demographics of population with opioid use disorder (OUD).	June 30, 2019	• Develop, implement, and evaluate pilot dashboard. • Establish MOUs with partnering agencies for data sharing. • Capture necessary data points. • Build EMS Data Repository. • Launch final data dashboard.	**DC Health** OCME FEMS DBH DCPCA DHCF	• Dashboard launched and processes implemented for maintaining data and surveillance • New CDC grant used by OCME for Laboratory Information Management System (LIMS) and equipment	$1,728,000

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Strategy	Targeted Completion Date	Action Steps	Lead/ Supporting Agencies	Measures of Success	Funding
1.5: Establish payment incentives for providers and organizations that implement models that improve patient outcomes, improve the patient experience, and decrease healthcare cost.	April 30, 2020	• Create working group to develop Pay for Performance payment model in partnership with community-based providers. • Explore opportunities within the 1115 Waiver to support Pay for Performance.	**DBH**	• Implementation plan is developed and payment incentives are established	In-Kind
1.6: Expand Department of Behavioral Health's Assessment and Referral (AR) sites to establish multiple points of entry and expedited access into the system of care for substance use disorder treatment services.	June 30,2019	• Engage substance use disorder providers on the decentralization of AR process and required activities. • In partnership with substance use disorder treatment providers, identify potential barriers to implementation of AR sites. • Develop and implement strategies to overcome barriers. • Release certification notice to current provider network to apply for AR sites. • Certify providers.	**D B H** D H C F	• Certified at least four substance use disorder treatment providers as AR sites	$100,000
1.7: Build the capacity of substance use disorder treatment providers by maximizing the use of Medicaid funds to support prevention, treatment and sustained recovery, and seeking the alignment of payment policies between Department of Health Care Finance (DHCF) and other local agencies.	May 31, 2019 - Submit 1115 waiver application January 1, 2020 - Begin implementation	• Establish joint DHCF-DBH working group and meet weekly to develop application. • Establish timeline and develop waiver content, obtain required supporting data, complete financial analysis, define quality measures and conduct stakeholder engagement forums. • Establish working groups to plan for implementation.	**D H C F** D B H	• Medicaid 1115 IMD substance use disorder/SMI-SED Waiver implemented	$200,000

Educate Washington, DC residents and key stakeholders on the risks of opioid use disorders and effective prevention and treatment options.

Total Budget Investment: $4,509,500

OSG Member Organizations: Department of Behavioral Health, Department of Corrections, Department of Health, DC Prevention Center Wards 7 and 8, Drug Enforcement Administration, Fire and Emergency Medical Services

Strategy	Targeted Completion Date	Action Steps	Lead/ Supporting Agencies	Measures of Success	Funding
2.1: Train youth and adult peer educators, in conjunction with people in recovery, to conduct education and outreach activities in schools and other community settings.	September 30, 2019	• Contract with a consultant to research existing local, state, and national training curricula developed in response to the opioid crisis. • Build upon existing DBH substance use disorder prevention education and outreach efforts (e.g., DC Prevention Centers expand work around opioid misuse). • Identify collaborators for a peer education curriculum for DC Public School and DC Public Charter School students. • Explore training youth and young adults through the DBH-certified peer specialist program or to become recovery coaches. • Train youth and young adults through DBH and Office of the State Superintendent for Education (OSSE). • Develop a sustainability plan for peer education programming.	**DBH** DC Health OSSE	• Curriculum identified • At least 20 peer educators (youth and adults) trained • Sustainability plan developed and implemented with ongoing trainings scheduled	$160,000

Strategy	Targeted Completion Date	Action Steps	Lead/ Supporting Agencies	Measures of Success	Funding
2.2: Provide age-appropriate, evidence-based, culturally competent education and prevention initiatives in all Washington, DC public schools regarding the risk of illegal drug use, prescription drug misuse, and safe disposal of medications.	December 31, 2019	• Purchase "Too Good for Drugs" evidence-based substance use disorder prevention curriculum for a pilot in 5th, 7th and 9th grade classrooms. • Pilot "Too Good for Drugs" curriculum in DC Public schools (DCPS) and DC Public Charter schools (DCPCS). • Identify and purchase additional curriculum based on pilot success. • Implement curriculum in remaining DC Public schools (DCPS) and DC Public Charter schools (DCPCS). • DC Prevention Centers and Community Prevention Sub-grantees plan and implement evidence-based prevention initiatives.	**DBH** DCPS DCPCS	The substance use disorder prevention curriculum implemented in at least 20 DCPS and DCPCS	$1,135,000
2.3: Conduct outreach and training in community settings (e.g., after-school programs, summer camps, churches, and community centers) to engage youth, parents, educators, school staff, and childcare providers on ways to effectively communicate regarding substance use disorder and engage/ support those impacted.	December 31, 2019	• Build upon existing District prevention efforts (e.g., annual prevention symposium, brown bag sessions, School Resource Fair series, Beat the Streets, DC Prevention Center outreach). • Develop a comprehensive outreach plan for training activities (e.g., leadership development opportunities, service projects, creative arts displays, implementation of opioid focused curricula). • Purchase off-the-shelf training materials or contract for course development. • Implement training. • Conduct outreach and facilitate a minimum of two presentations at each of the four DC Prevention Centers (DCPC).	**DBH**	Comprehensive outreach plan developed and implemented Training plan (curriculum and delivery methods) developed and implemented Conducted a minimum of three youth- and young adult-focused activities aimed at providing education around the health risks associated with opioid use and misuse and also effective alternatives to opioid misuse at each DCPC	$670,000

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Strategy	Targeted Completion Date	Action Steps	Lead/ Supporting Agencies	Measures of Success	Funding
2.4: Create multiple social marketing campaigns, including anti-stigma campaigns, using a variety of media with clear messages to multiple target audiences (i.e., youth and young adults, current users) to increase awareness about opioid use, treatment, and recovery.	Ongoing - March 1, 2018 through August 31, 2019	• DC Health to develop and launch 16-week multiphase prescription opioid awareness and prevention campaign. • Strengthen previous social marketing campaigns and develop new DBH campaigns. • Engage clients, family members, and other community stakeholders on the developed campaigns. • Launch the campaign across the District and coordinate with existing DBH events.	**DBH** DC Health and PIOs from partnering organizations	• Implemented Phase I and II of DC Health social marketing campaign • Implemented DBH campaigns (i.e., "More Harmful Than You Think", youth opioid awareness campaign, and naloxone campaign) • New campaigns launched to reach expanded audiences	$1,817,000
2.5: Increase the targeted advertisement of treatment and recovery programs throughout Washington, DC.	August 31, 2019	• Review existing online resource tools to determine if they can be enhanced to advertise and promote treatment and recovery resources. • Create an online navigator tool (if applicable). • Develop an advertising/social marketing campaign to direct individuals toward resources.	**DBH** DC Health	• Implementation online navigator tool marketing plan • Launched a marketing campaign focused on treatment and recovery	$725,000
2.6: Educate and promote the Good Samaritan Law (laws offering legal protection to people who give reasonable assistance to those who are, or who they believe to be, injured, ill, in peril, or otherwise incapacitated) for community and law enforcement.	Ongoing	• Educate the community on the Good Samaritan Law during each opioid-related outreach event training, etc.	**DC Health** DBH	• Launched monthly community education and outreach activities through various channels including events, naloxone training, social media, and others as needed	$2,500 Also see Strategy 2.3
2.7: Provide education and/or seminars about maintaining sobriety to patients receiving opioid medications and individuals in recovery.	September 30, 2019	• Peer-operated centers to host educational events in various community settings.	**DBH**	• Launched monthly peer-operated center education events for the community	See Strategy 5.6

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Engage health professionals and organizations in the prevention and early intervention of substance use disorder among Washington, DC residents.

Total Budget Investment: $5,817,569

OSG Member Organizations: Department of Behavioral Health, Howard University, Department of Aging and Community Living, Oxford House, Unity Health Care, Department of Health, Medical Society of the District of Columbia, DC Hospital Association, Sibley Memorial Hospital

Strategy	Targeted Completion Date	Action Steps	Lead/ Supporting Agencies	Measures of Success	Funding
3.1: Expand the use of Screening, Brief Intervention, Referral, and Treatment (SBIRT) programs among social service agencies that conduct intake assessments.	May 19, 2019	• Train emergency department (ED) MAT induction hospitals on SBIRT. • Provide opportunities for organizations to be trained on SBIRT, including updating their electronic health record (EHR) and creating a screening protocol. • Review continuing education regulations to explore SBIRT as a required topic. • Identify social service agencies that are already implementing SBIRT.	**DC Health** DBH	• ED staff at three hospitals trained on SBIRT • Monthly SBIRT training offered to providers • Implemented SBIRT in at least eight organizations with SBIRT embedded into respective EHRs	$979,823
3.2: Create 24-hour intake and crisis intervention sites throughout Washington, DC.	October 1, 2019	• DBH will integrate outreach and crisis teams to create 24-hour comprehensive coverage.	**DBH**	• Staff trained to conduct intake and crisis intervention 24 hours a day	$1,579,846
3.3: Mandate that all licensed providers in Washington, DC who are permitted to prescribe and/or dispense controlled substances be required to register with the Prescription Drug Monitoring Program (PDMP) and PDMP integration into health management system.	August 31, 2019 - All providers to be registered December 31, 2019 - PDMP integration	• Conduct outreach to all prescribers and dispensers of controlled substances to encourage physicians' registration in the PDMP. • Require mandatory registration and mandatory query by prescribers and dispensers. • Enhance PDMP technology.	**DC Health** PDMP Advisory Committee	• Completed congressional review to require mandatory PDMP registration by prescribers and dispensers • Registered all prescribers and dispensers with controlled substances PDMP • Integrated PDMP into electronic health records, pharmacy dispensing systems and health information exchanges	$578,000

Strategy	Targeted Completion Date	Action Steps	Lead/ Supporting Agencies	Measures of Success	Funding
3.4: Encourage the use of physician-pharmacist collaborative practice agreements to provide appropriate pain management to patients with chronic pain as well as palliative care patients, and to integrate pharmacists into methadone and buprenorphine/naloxone (Suboxone®) treatment programs.	August 31, 2019	• Provide education about the benefit of physician-pharmacist collaborative practice agreements.	**DC Health** DBH DC Board of Medicine DC Board of Pharmacy	• Increased the number of collaborative practice agreements	$150,000
3.5: Develop a comprehensive workforce development strategy to strengthen the behavioral health workforce's ability to provide services in multiple care settings including peer support specialists/recovery coaches, holistic pain management providers, and those trained to treat patients with co-occurring mental health diagnoses and substance use disorder.	September 30, 2019	• Develop memorandum of understanding (MOU) with the University of the District of Columbia (UDC) to develop courses. • Provide scholarships to individuals seeking Certified Addiction Counselor (CAC) certification. • Increase providers' use of technology advancements to strengthen behavioral workforce.	**DBH** UDC DC Health DHCF	• Developed, at a minimum, two courses at UDC that align with CAC required courses • Trained 30 individuals on CAC curriculum • Increased use of online courses	$373,500
3.6: Encourage provider continuing education on evidence-based guidelines for the appropriate prescribing and monitoring of opioids and other evidence-based/best practices such as warm hand-offs, 12-step model programs, Acceptance and Commitment Therapy, and SBIRT.	September 30, 2019	• Develop and conduct trainings focused on OUD for healthcare professionals.	**DC Health**	• A minimum of six modules created • Training provided to 3,000 healthcare professionals • End of course evaluation/ survey completed for learner to receive credit and provide feedback	$688,000

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Strategy	Targeted Completion Date	Action Steps	Lead/ Supporting Agencies	Measures of Success	Funding
3.7: Encourage provider continuing education on evidence-based guidelines for the appropriate prescribing of MAT, with a target audience of addiction treatment providers and primary care providers who are most likely to encounter patients who are seeking this therapy.	September 30, 2019	• Procure trainer to provide technical assistance, Buprenorphine Waiver Management and the DATA 2000 training to MAT prescribers. • Provide virtual expert consultation (e.g., ECHO) around clinical cases to increase practitioners' capability in dealing with individuals coping with OUD.	**DC Health** DBH	• Conducted two trainings with a minimum of 25 prescribers • Provided consultation to at least 100 individuals	$818,400
3.8: Encourage provider continuing education on increasing prescriptions of naloxone for persons identified with OUD or those at risk.	April 1, 2019	• Create and release a continuing education module on naloxone for prescribers and dispensers. • Encourage providers to administer naloxone through email blasts, seminars, trainings, etc.	**DC Health**	• Increased the frequency and amount of communications/ education targeted towards prescribers	$650,000

Support the awareness and availability of, and access to, harm reduction services in Washington, DC.

Total Budget Investment: $6,504,455

OSG Member Organizations: Metropolitan Police Department, Woodley House, Helping Individual Prostitutes Survive, So Others Might Eat, Department of Health, Department of Behavioral Health, Whitman-Walker Health, Department of Human Services, Fire and Emergency Medical Services

Strategy	Targeted Completion Date	Action Steps	Lead/ Supporting Agencies	Measures of Success	Funding
4.1: Increase harm reduction education to families and communities, including naloxone distribution for those most affected.	September 30, 2019	• Conduct opioid overdose prevention and naloxone administration trainings. • Develop a peer "train-the-trainer" toolkit for overdose prevention and naloxone. administration and implement trainings in community (e.g., apartment buildings, parks, community centers). • Increase number of funded providers that can distribute naloxone. • Expand overdose prevention program from six DHS shelters to seven more sites. • Train and equip MPD officers with naloxone.	**DC Health** DBH DHS MPD	• Bi-monthly Opioid overdose prevention and naloxone administration trainings implemented • Two community conversations conducted in all wards • Distributed at a minimum 66,000 naloxone kits • Patrol members and specialized units in the 5th, 6th, and 7th districts received training and are equipped with an initial doses of naloxone	$4,176,000
4.2: Make naloxone available in public spaces in partnership with a community-wide training initiative.	September 30, 2019	• Compile a list of community-based organizations, schools, non-profits, and governmental agencies where naloxone access points will be and devise a distribution plan. • Distribute kits.	**DC Health**	• Distributed 20,000 kits in public spaces • DC Health has trained individuals located in places where naloxone is available	$182,700
4.3: Consider safe injection sites with the following issues to be addressed: medical supervision, the definition of a site, location of a site, requirements for other services, and understanding with local law enforcement.	December 31, 2019	• Establish a working group of stakeholders specifically invested in this strategy. • Create a plan that will define sites' infrastructure and necessary resources. • Include "safe injection sites" as a topic in the community conversations.	**DC Health** DHS	• Created a plan outlining a safe injection site model for the District	$100,000

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Strategy	Targeted Completion Date	Action Steps	Lead/ Supporting Agencies	Measures of Success	Funding
4.4: Continue needle exchange program in combination with other harm reduction services (such as naloxone distribution) and continuous assessment for site selection including the development of community pharmacy-based needle exchange and safe disposal sites.	October 1, 2018	• Increase funding for needle exchange (NEX) providers in FY18 to include the purchase of naloxone kits and other harm reduction activities. • Collaborate with two NEX providers by giving them monthly FEMS naloxone administration data to assess outreach locations. • Offer naloxone and overdose prevention training to participants in the NEX programs.	**DC Health** FEMS	• Needle exchange programs continued with additional funding	$955,000
4.5: Permit the use of controlled substance testing kits by members of the general public to screen drugs for adulterants that may cause a fatal overdose.	May 31, 2019	• Draft legislation to legalize testing kits. • Introduce bill in the Council. • Council adopts the bill. • Adopted bill submitted for Mayoral Approval. • Bill (now Act) transmitted to the Congress for passive approval and becomes law.	NA	• Testing kits legalized	In-Kind
4.6: Use peers with lived experience to engage individuals with substance use disorders in harm reduction programs and services.	May 1, 2019	• Develop and implement internship program for peer-certified specialists. • Hire peers as team members of the new downtown day center, which uses a Housing First method to move individuals into housing by connecting them with support services. • Implement Rapid Peer Responder (RPR) program that includes peers who will be deployed to community-based organizations (CBOs), street outreach teams, and EDs to respond to opioid ODs and subsequently link OD victims to MAT and other wrap-around services. • Establish Specialized Street Outreach Team to visit homeless encampments and work to connect eligible individuals coping with OUD with available resources.	**DC Health** DHS DBH BID	• A module on harm reduction taught in the recovery coach certification training • Peer internship program established • Peers hired to work in places where individuals with OUD frequent • RPR team formed and responding to a minimum of two calls per day	$1,090,755

Ensure equitable and timely access to high-quality substance use disorder treatment and recovery support services.

Total Budget Investment: $9,063,929

OSG Member Organizations: Department of Behavioral Health, DC Hospital Association, Department of Health, Department of Health Care Finance, DC Primary Care Association, Partners in Drug Abuse Rehabilitation Counseling, Whitman-Walker Health, George Washington University, Pathways to Housing, DC Recovery Community Alliance, Medical Home Development Group, Howard University

Strategy	Targeted Completion Date	Action Steps	Lead/ Supporting Agencies	Measures of Success	Funding
SUB GOAL: TREATMENT AND REFERRAL					
5.1: Conduct a comprehensive assessment of the availability of treatment services slots/beds per American Society of Addiction Medicine (ASAM) criteria for patients by age, gender, and payer in Washington, DC for adequacy, and develop a plan for building capacity as may be required. In addition, assess the efficiency and effectiveness of the District's referral system and develop protocols (including training) that are patient-centered and practical for both the referring and receiving facility.	September 30, 2019	• Conduct assessment of treatment and referral system. • Assess the pool of waivered buprenorphine-based MAT providers and determine which ones are actively prescribing and explore barriers to prescribing. • Work with local hospitals and providers on training or re-training of prescribing providers and treating with MAT. • Strengthen capacity and provide support services for buprenorphine-based MAT in community health centers/primary care providers.	**DBH** DC Health	• Report produced on treatment and referral system • Number of providers prescribing MAT and treating are greater than 2018 numbers • At a minimum, two trainings provided to practitioners not currently prescribing/ treating	$1,145,096
5.2: Evaluate the effectiveness of programs providing MAT to identify opportunities for enhancing treatment and recovery.	July 15, 2019 – evaluation begins	• Procure contractor for evaluation services of the SOR grant. • Conduct SOR evaluation. • Work with District agencies on the evaluation of the Pay for Performance initiative.	**DBH** DC Health DOC	• Data collected and analyzed to determine effectiveness of MAT programs	$698,000
5.3: Explore ways to draw down federal dollars for stays in residential or inpatient treatment programs.	January 1, 2020	• Pursue an 1115 waiver from the Centers for Medicare and Medicaid Services, which would allow the District to draw down matching federal funds for Medicaid clients who require residential care	**D H C F** D B H	• 1115 waiver approved and implemented	In-Kind

Strategy	Targeted Completion Date	Action Steps	Lead/ Supporting Agencies	Measures of Success	Funding
SUB GOAL: COORDINATION OF CARE					
5.4: Develop and implement a model for initiating MAT in emergency departments (ED), ensuring a direct path to ongoing care (via a warm handoff from peer recovery coaches) that is patient-centered, sustainable, and takes in to consideration the demographics of the implementing health system.	September 30, 2019	• Develop plan for ED induction and release request for application. • Develop work plans with hospitals. • Identify peers to be hired by hospitals and provide ongoing training. • Establish Overdose Survivors Outreach Program (OSOP) for individuals refusing treatment at the ED. • Monitor and evaluate progress. • Eliminate barriers to accessing MAT for uninsured • Identify "fast track" MAT community providers for warm handoff. • Establish an electronic system for real-time assessment and referral, treatment availability, and two-way digital provider communication. • Develop a Geomap capturing the District's substance use disorder provider network. • Develop a plan for cross-agency integration of Health Information Exchange (HIE) systems (where possible).	**DBH** DC Health	• MAT induction launched in three hospitals • OSOP peers followed individuals for 90 days • ED induction expanded to at least one additional acute care hospital • Launched interactive electronic system • A policy is developed and a system is in place to assist the uninsured with MAT access • A document is produced that outlines how integration can occur between various organizations' HIE	$2,701,487
5.5: Incorporate emphasis on physical health (including intensive health screenings) and mental well-being in substance use disorder treatment and programming.	June 30, 2019	• Encourage partnerships between primary care and MAT providers. • Create clinical care coordination (CCC) learning collaborative to leverage lessons learned, best practices, etc. • Continue dental services in the Assessment and Referral Center and Saint Elizabeths Hospital. • Support the initiation of telehealth and provide training to multiple organizations.	**DBH** DC Health	• MOUs implemented between Federally Qualified Health Centers (FQHCs) and the DBH providers • A CCC collaborative is created • Increased number of clients receiving dental care and organizations using telehealth	$2,165,186

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Strategy	Targeted Completion Date	Action Steps	Lead/ Supporting Agencies	Measures of Success	Funding
SUB GOAL: EXPANSION OF		**PEER SUPPORT SERVICES**			
5.6: Increase the presence of peer support groups/programs (e.g., 12-step programs, clubhouses, 24-hour wellness centers, sober houses, peer-operated centers) throughout the community (e.g., faith-based institutions, community centers, schools) for people in recovery and monitor the quality and effectiveness of programming.	July 31, 2019	• Develop a plan for peer center expansion and release RFA. • Expand peer centers and peer-run organizations and award new peer centers. • New peer centers to hire certified peers with lived experience to engage individuals in recovery residing in the community or detention facilities in programs and services that assist them in sustaining their recovery. • Establish a Clubhouse (supportive environment that is member based) with a focus on substance use disorders.	**DBH**	• Three peer-operated centers expanded, two peer-run organizations expanded, four new peer centers established, and outreach peers hired • Clubhouse established	$1,450,000
5.7: Improve the quality and quantity of support services (e.g., education, employment, community re-entry, recovery coaching, transportation, dependent care, and housing) that are available to individuals in recovery.	September 30, 2019	• Continue to support Transgender Health Initiative, which focuses on individual success needs (e.g., housing, employment, self-sufficiency, financial management, etc.). • Expand and enhance Environmental Stability (ES) housing. • Open new recovery houses. • Implement Uber Health and Lyft Business program to support individuals to connect to OUD services and supports. • Expand and enhance Supported Employment (SE).	**DBH** DC Health	• At a minimum, three new recovery houses fully functioning • ES expanded and tracking system established • Protocols and processes for accessing transportation services established • SE expanded and tracking system established	$904,160

Develop and implement a shared vision between Washington, DC's justice and public health agencies to address the needs of individuals who come in contact with the criminal justice system to promote a culture of empathy for their families and residents.

Total Budget Investment: $3,120,592

OSG Member Organizations: Criminal Justice Coordinating Council, Department of Corrections, Council of the District of Columbia Department of Behavioral Health, Metropolitan Police Department, Federal Bureau of Investigation, Court Services and Offender Supervision Agency, Office of the Attorney General, Department of Health, Department of Justice, Pathways to Housing

Strategy	Targeted Completion Date	Action Steps	Lead/ Supporting Agencies	Measures of Success	Funding
6.1: Explore the expansion of drug court for diversion of individuals with substance use disorder who are arrested.	September 30, 2019	• Coordinate meetings with the U.S. Attorney, D.C. Superior Court, Office of Attorney General, Public Defender Service, and DBH to discuss feasibility of drug court expansion.	**CJCC**	• Determined viability of expansion	In-Kind
6.2: Conduct targeted education and awareness campaigns to criminal justice agencies focused on reducing the use of incarceration as a means of accessing substance use disorder treatment.	August 31, 2019	• Collaborate with District agencies on social marketing campaign and develop messages targeted to criminal justice agencies. • Conduct trainings.	**C J C C** D B H	• Implemented education and awareness campaigns focused on reducing the use of incarceration as a means of accessing substance use disorder treatment	In-Kind
6.3: Identify opportunities with judges, prosecutors, and defense attorneys on accepting MAT as a treatment option for offenders.	April 30, 2019	• Educate Criminal Division judges, Pretrial Services Agency, and Court Services and Offender Supervision Agency to understand MAT as an alternative to prison sentencing.	**CJCC** DBH	• Conducted three trainings	SAMHSA TA/In-Kind
6.4: Ensure individuals incarcerated with DOC continue to receive MAT as prescribed at the time of arrest or MAT is made available to individuals in need.	May 31, 2019	• Provide access to Vivitrol. • DOC obtains waiver from DBH to initiate methadone in jail. • Continue to provide buprenorphine in the jail. • Establish substance use disorder treatment unit at the jail and hire and train staff. • Create individual plans for inmates being released into the community. • Provide naloxone to individuals with OUD upon discharge from jail.	**D O C** D B H	• Vivitrol injections available onsite at DOC • Methadone initiative started • Substance use disorder unit established at the jail • Each inmate with substance use disorder has an individualized plan on release • Each individual that requested a naloxone kit receives one	$2,920,592

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Strategy	Targeted Completion Date	Action Steps	Lead/ Supporting Agencies	Measures of Success	Funding
6.5: Coordinate with DOC, Pretrial Services Agency, Court Services and Offender Supervision Agency, the Bureau of Prisons (BOP), and other relevant stakeholders, to develop a wraparound approach to reintegrating individuals with substance use disorder and a history with MAT into the community upon release.	December 31, 2019 - for local entities December 31, 2020 - BOP	• Work with the DOC Ready Center to ensure seamless integration into the community. • Engage the BOP on planning for those individuals returning through DOC. • Enhance planning and opportunities for individuals transitioning from BOP to DOC.	**D O C** D B H	• Comprehensive approach developed with all relevant stakeholders, mindful of each individual's unique circumstances or partners' relationships with the individual	In-Kind
6.6: Explore developing forums or mechanisms for people to discuss their road to recovery with individuals with substance use disorder, the community, and criminal justice stakeholders.	September 30, 2019	• Identify and use existing forums (e.g., monthly/quarterly meetings at DBH with peer specialists and recovery coaches) for individuals to discuss their road to recovery.	**D B H** C J C C	• Forums are established and available for individuals to discuss their road to recovery • By 2020, 2-3 cross-sector convenings are developed	In-Kind
6.7: Establish effective and coordinated communication channels between justice and public health agency partners to improve continuity of care.	June 3, 2019	• Leverage CJCC Substance Abuse Treatment/Mental Health Services Integration Taskforce (SATMHSIT) to ensure issues are regularly addressed.	**C J C C** D B H	• The SATMHSIT is used to discuss and address issues between all relevant partners.	In-Kind
6.8: Develop educational and motivational programs for individuals in the custody of the DOC with a history of substance use to encourage treatment and recovery.	September 30, 2019	• Review curricula being used in other jurisdictions. • Create substance use curricula for group sessions, treatment offerings, and dissemination through the jail. • Identify appropriate team to conduct programming for this group. • Purchase needed material for programing. • Conduct programming.	**D O C** D B H	• An evidence-based curriculum is developed and implemented in at least nine housing units with all inmates expressing signs/symptoms of substance use disorder • Trained a minimum of 150 individuals per month on substance use disorder curriculum	$200,000

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Develop effective law enforcement strategies that reduce the supply of illegal opioids in Washington, DC.

Total Budget Investment: $1,070,314

OSG Member Organizations: Homeland Security and Emergency Management Agency, Criminal Justice Coordinating Council, Department of Behavioral Health, Metropolitan Police Department, Office of the Attorney General, Department of Forensic Services, Drug Enforcement Agency, United States Postal Service

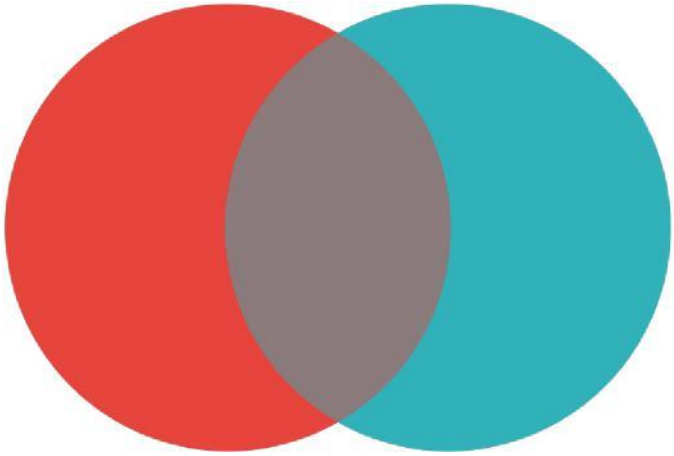
Strategy	Targeted Completion Date	Action Steps	Lead/ Supporting Agencies	Measures of Success	Funding
7.1: Enhance surveillance program and data collection efforts in order to determine and characterize the status of the regional supply of illegal drugs.	April 1, 2019	• Identify current joint agency (local, state, federal) task forces and working groups tasked with determining and characterizing the status of the regional supply of illegal drugs by surveying group. • Collect data characterizing drug supply by conducting surveillance testing of opioids. • Build surveillance program to be fully functioning by adding additional contract staff. • Share findings with stakeholders (hospitals, clinicians, FEMS, staff at homeless shelters, etc.).	**DFS** MPD DOC OCME	• Increased testing capacity via surveillance of synthetic opioids in the District, both to discover new synthetic opioids as well as characterize those currently present • Successful testing and reporting on at least 50% of submitted heroin evidence items in the District • Determination of composition of opioids distributed in DC • Discovery of new compounds to share with partners/ stakeholders	$1,070,314
7.2: Identify and fill resource gaps preventing law enforcement efforts from using existing laws to reduce the supply of illegal opioids.	June 30, 2019	• Appropriately staff units addressing opioid issues.	**MPD**	• Units restructured to address staffing issues	In-Kind
7.3: Identify any legislative gaps that may exist preventing or hampering law enforcement “best practices” to reduce the supply of illegal opioids.	December 18, 2018	• Introduce bill in the Council to address gaps. • Council adopts the bill and submitted for Mayoral Approval. • Bill transmitted to the Congress for passive approval and becomes law.	**DFS**	• Legislation (SAFE DC) passed and implemented	In-Kind

Strategy	Targeted Completion Date	Action Steps	Lead/ Supporting Agencies	Measures of Success	Funding
7.4: Coordinate investigative efforts with the United States Attorney's Office and Drug Enforcement Administration to utilize federal laws in cases involving individuals who sell opioids (heroin/fentanyl) that cause the death or injury of another.	March 31, 2019	• MPD will establish relationship with USAO and other federal law enforcement entities. • Identify individuals who supply heroin/fentanyl that cause the death or non-fatal overdose in others and utilize current federal laws to prosecute those individuals.	**MPD and USAO** DEA	• Decreased the presence of opioids • MPD assists in making arrests and collaborates on cases with the USAO and DEA • Successfully identified and intercepted packages being shipped through the US Mail and other parcel shipping agencies	In-Kind
7.5: Identify existing federal task force assets and ensure efforts are in place to investigate and disrupt the flow of illegal opioids into Washington, DC.	February 1, 2019	• Identify federal task force assets and efforts.			In-Kind
7.6: Coordinate MPD efforts to identify locations where opioids are illegally sold (street level trafficking) as well as individuals who traffic opioids to direct enforcement efforts toward these targets.	February 1, 2019	• MPD will establish relationship with other federal law enforcement agencies. • Target areas where heroin is the prominent drug being sold and identify individuals selling narcotics in those areas.	**M P D** F B I D E A		In-Kind
7.7: Coordinate with federal law enforcement agencies including the Department of Homeland Security Customs Enforcement and United States Postal Inspector to target opioid trafficking through the United States Postal Service and other parcel shipping companies.	February 1, 2019	• MPD will establish relationship with other federal law enforcement entities to identify and intercept packages being shipped through the US Mail and being trafficked other parcel shipping agencies. **MPD** • Develop and implement a clear strategy to investigate and disrupt the flow of illegal opioids • Decreased the presence of opioids in the District	**MPD** HSCE USPS		In-Kind

SUMMARY

LIVE.LONG.DC. serves as a roadmap for reversing Washington, DC's opioid epidemic. The Plan offers strategies with practical, achievable steps that, taken together, the public-private stakeholder group is confident will accomplish their goals and decrease the death toll caused by opioids in Washington, DC and improve the outcomes for those with opioid use disorders.

The public-private stakeholder group continues to meet regularly through 2020 to work together on each specific goal, track progress, and ensure the Plan's successful implementation.



Planning Steps

Quality and Data Collection Readiness

Narrative Question:

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

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

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

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

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

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

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

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

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

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

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

etc.).

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

4. If not, what changes will the state need to make to be able to collect and report on these measures?
   Please indicate areas of technical assistance needed related to this section.

Footnotes:

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Substance Abuse Prevention

Priority Type: SAP, SAT, MHS

Population(s): SMI, PWWDC, PP, ESMI, PWID, EIS/HIV, TB

Goal of the priority area:

Ensure the public behavioral health system is person-centered, and promotes and supports the leadership of peers with lived experience in recovery and the development of the system of care.

Objective:

Partner across DBH to incorporate the role of peers into different programs, projects and services. Engage mental health and substance use providers to understand the role and importance of peers.

Strategies to attain the objective:

% of certified peers employed
(a) A baseline measurement: 79%
(b) A first-year target/outcome measurement: 80%
(c) A second-year target/outcome measurement: 80%
(d) Data source: SharePoint
(e) Description of data: The number of active peers who self-reported employment during the quarter.
(f) Data issues/potential caveats that affect outcome measures: None identified

Priority #: 2

Priority Area: Mental Health Services

Priority Type: MHS

Population(s): SMI, SED, PWWDC, PP, ESMI, PWID, EIS/HIV, TB

Goal of the priority area:

Ensure individualized mental health disorder services across the entire continuum of care from community-based treatment and support services to inpatient hospitalization, including justice-involved consumer competency restoration, to support the behavioral health, wellness and recovery of District residents.

Objective:

(a) A baseline measurement: 71%
(b) A first-year target/outcome measurement: 75%
(c) A second-year target/outcome measurement: 75%
(d) Data source: Claims data will include all payor types (MCO and FFS)
(e) Description of data: Number of newly-enrolled child consumers who had a paid claim within 30 days of enrollment
(f) Data issues/potential caveats that affect outcome measures: None Identified

Strategies to attain the objective:

DBH and providers are working together ensure improvement of data quality for providers. There is a bulletin in process of being published that explains the discharge expectations for providers as well as expectations around Care Coordination. We feel that some of the data reporting may be “bad” due to a lack of understanding of the discharge definitions. DBH is also requesting provider level KPI data so that we can see how individual providers are doing and follow up accordingly. Once this happens we will provide TA to providers regarding how they are performing on the KPIs.

Priority #: 3

Priority Area: Substance Abuse Treatment

Priority Type: SAT

Population(s): PWWDC, PP, PWID, EIS/HIV, TB

Goal of the priority area:

We are trying to procure a MAT best practice training for providers as well as disseminate discharge definitions and expectations to the provider network. We are working with providers to get them an accurate census and a report that shows who has not been seen so that providers can follow up with clients. Also, we are encouraging other forms of Medication Assisted Treatment throughout the city.

Objective:

% of SUD withdrawal management clients who stepped down to a lower level of care

Strategies to attain the objective:

(a) A baseline measurement: 51%
(b) A first-year target/outcome measurement: 75%
(c) A second-year target/outcome measurement: 75%
(d) Data source: Data warehouse (WITS)
(e) Description of data: Number of clients who were discharged from withdrawal management who had an admission to a lower level of care within 15 days of discharge
(f) Data issues/potential caveats that affect outcome measures: None Identified

Priority #: 4

Priority Area: Mental Health Services & Substance Abuse Prevention/Treatment

Priority Type: SAP, MHS

Population(s): SMI, PWWDC, PP, ESMI, PWID, EIS/HIV, TB

Goal of the priority area:

Maximize housing resources and target the most vulnerable District residents with serious behavioral health challenges who are homeless, returning from institutions or moving to more independent living to prevent and minimize homelessness.

Objective:

% of consumers who remained in the CRF placement for at least 90 days from move-in date, with no psychiatric hospitalizations, incarcerations, crisis bed placements, or involuntary discharges. The Residential Care Manager will monitor residential programs, support services and work as part of a team to effectively communicate with the DBH Network of provider agencies and other external stakeholders. The Residential Care Manager will collaboration with DHCF regarding certification for CRF placement and processing of Optional State Payment (OSP). The Residential Care Manager will evaluate the mental health, medical, and substance use disorder needs and, in conjunction with the documentation in the CRF packet, review and provide recommendations regarding consumers' treatment needs. Collaborate with Information Technology Division and A.R.E. to design reporting algorithms and methodologies. Make adjustments to data captured and reporting protocols as needed. Collaboration with CSA, Hospital, and CRF in terms of following consumers once placed in a CRF to determine number of consumers who remained in a CRF for 90 days or more after placement.

Strategies to attain the objective:

(a) A baseline measurement: 85%
(b) A first-year target/outcome measurement: 90%
(c) A second-year target/outcome measurement: 90%
(d) Data source: Access Database
(e) Description of data: Number of consumers who remained in the CRF placement for at least 90 days, with no psychiatric hospitalizations, incarcerations, crisis bed placements, or involuntary discharges.
(f) Data issues/potential caveats that affect outcome measures: None Identified

Priority #: 5

Priority Area: Substance Abuse Prevention

Priority Type: SAP

Population(s): SMI, SED, PP

Goal of the priority area:

Heighten public awareness among District residents about mental health and substance use disorders and resources to increase their understanding of behavioral health, reduce stigma, and encourage prevention efforts and early identification and treatment

Objective:

In order to achieve the Synar related KPI, the SUD Prevention Branch conducts merchant education annually. In addition, a coverage study takes place periodically, stores are visited to ensure that the proper licenses are in place. This provides the opportunity for the Synar Compliance Specialist to provide further education on the Synar program and the District's laws prohibiting the sale of tobacco products to minors.

Strategies to attain the objective:

(a) A baseline measurement: % of vendors not selling tobacco to minors
(b) A first-year target/outcome measurement: 88%
(c) A second-year target/outcome measurement: 90%
(d) Data source:
(e) Description of data: Number of vendors assessed that did not sell tobacco to minors
(f) Data issues/potential caveats that affect outcome measures: None identified

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Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SA]

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2020/2021. ONLY include funds expended by the executive branch agency administering the SABG

Planning Period Start Date: 7/1/2019 Planning Period End Date: 6/30/2021

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment	$4,878,089		$0	$32,209,488	$41,414,906	$0	$568,000
a. Pregnant Women and Women with Dependent Children**	$348,435		$0	$0	$3,200,000	$0	$0
b. All Other	$4,529,654		$0	$32,209,488	$38,214,906	$0	$568,000
2. Primary Prevention	$0		$0	$0	$0	$0	$0
a. Substance Abuse Primary Prevention	$1,393,739		$0	$0	$816,059	$0	$0
b. Mental Health Primary Prevention							
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)							
4. Tuberculosis Services	$0		$0	$0	$50,000	$0	$0
5. Early Intervention Services for HIV	$348,435		$0	$0	$160,000	$0	$0
6. State Hospital							
7. Other 24 Hour Care							
8. Ambulatory/Community Non-24 Hour Care							
9. Administration (Excluding Program and Provider Level)	$348,435		$0	$0	$10,947,934	$0	$0
10. Total	**$6,968,698**	**$0**	**$0**	**$32,209,488**	**$53,388,899**	**$0**	**$568,000**

* Prevention other than primary prevention

** The 20 percent set-aside funds in the SABG must be used for activities designed to prevent substance misuse.

Footnotes:

The District's FY is 10/1-9/30. As such, projections are based on those periods as they are still over a 12 month period.
FY 2020 Projected award amount = Average of FY 18/19 Awards (6,968,698) as Allocation table has not been published

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

States must project how the SMHA will use available funds to provide authorized services for the planning period for state fiscal years 2020/2021.

Planning Period Start Date: 7/1/2019 Planning Period End Date: 6/30/2021

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention and Treatment							
a. Pregnant Women and Women with Dependent Children							
b. All Other							
2. Primary Prevention							
a. Substance Abuse Primary Prevention							
b. Mental Health Primary Prevention*		$0	$0	$0	$423,700	$0	$0
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)**		$160,565	$368,504	$0	$700,000	$0	$0
4. Tuberculosis Services							
5. Early Intervention Services for HIV							
6. State Hospital			$3,133,698	$7,586,150	$184,456,654	$0	$2,946,348
7. Other 24 Hour Care		$0	$6,109,944	$600,000	$29,064,000	$0	$0
8. Ambulatory/Community Non-24 Hour Care		$1,364,802	$12,728,148	$4,954,342	$0	$0	$9,693,380
9. Administration (Excluding Program and Provider Level)***		$80,283	$8,135,083	$2,718,356	$140,554,142	$0	$0
10. Total	**$0**	**$1,605,650**	**$30,475,377**	**$15,858,848**	**$355,198,496**	**$0**	**$12,639,728**

* While the state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED

** Column 3B should include Early Serious Mental Illness programs funded through MHBG set aside

*** Per statute, Administrative expenditures cannot exceed 5% of the fiscal year award.

Footnotes:

Planning Tables

Table 3 SABG Persons in need/receipt of SUD treatment

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	32	25
2. Women with Dependent Children	618	463
3. Individuals with a co-occurring M/SUD	1658	1459
4. Persons who inject drugs	900	787
5. Persons experiencing homelessness	6521	652

Please provide an explanation for any data cells for which the state does not have a data source.

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Footnotes:

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Expenditure Category	FFY 2020 SA Block Grant Award
1 . Substance Abuse Prevention and Treatment*	$4,529,654
2 . Primary Substance Abuse Prevention	$1,393,739
3 . Early Intervention Services for HIV**	$348,535
4 . Tuberculosis Services	$348,435
5 . Administration (SSA Level Only)	$348,435
6. Total	**$6,968,798**

* Prevention other than Primary Prevention

** For the purpose of determining the states and jurisdictions that are considered ?designated states? as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and Prevention (CDC,), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report will be published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be are required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services for regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a ?designated state? in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state a state?s AIDS case

rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would will be allowed to obligate and expend SABG funds for EIS/HIV if they chose to do so.

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Footnotes:

The District's FY is 10/1-9/30. As such, projections are based on those periods as they are still over a 12 month period.

FY 2020 Projected award amount = Average of FY 18/19 Awards (6,968,698) as Allocation table has not been published

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

A		B
Strategy	**IOM Target**	**FFY 2020 SA Block Grant Award**
1. Information Dissemination	Universal	$150,524
	Selective	$16,725
	Indicated	
	Unspecified	
	Total	**$167,249**
2. Education	Universal	$83,624
	Selective	
	Indicated	
	Unspecified	
	Total	**$83,624**
3. Alternatives	Universal	$83,624
	Selective	
	Indicated	
	Unspecified	
	Total	**$83,624**
4. Problem Identification and Referral	Universal	$41,812
	Selective	
	Indicated	
	Unspecified	
	Total	**$41,812**
	Universal	$915,653

5. Community-Based Process	Selective	
	Indicated	
	Unspecified	
	Total	**$915,653**
6. Environmental	Universal	$41,812
	Selective	
	Indicated	
	Unspecified	
	Total	**$41,812**
7. Section 1926 Tobacco	Universal	
	Selective	
	Indicated	
	Unspecified	$60,000
	Total	**$60,000**
8. Other	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
Total Prevention Expenditures		**$1,393,774**
Total SABG Award*		**$6,968,798**
Planned Primary Prevention Percentage		**20.00 %**

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

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Footnotes:

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Activity	FFY 2020 SA Block Grant Award
Universal Direct	$1,278,023
Universal Indirect	$55,751
Selective	$60,000
Indicated	
Column Total	**$1,393,774**
Total SABG Award*	**$6,968,798**
Planned Primary Prevention Percentage	**20.00 %**

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

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Footnotes:

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2020 and FFY 2021 SABG awards.

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Targeted Substances	
Alcohol	☑
Tobacco	☑
Marijuana	☑
Prescription Drugs	☑
Cocaine	☐
Heroin	☑
Inhalants	☐
Methamphetamine	☐
Synthetic Drugs (i.e. Bath salts, Spice, K2)	☑
Targeted Populations	
Students in College	☑
Military Families	☐
LGBTQ	☑
American Indians/Alaska Natives	☐
African American	☑
Hispanic	☑
Homeless	☑
Native Hawaiian/Other Pacific Islanders	☐
Asian	☐
Rural	☐
Underserved Racial and Ethnic Minorities	☐

Footnotes:

Planning Tables

Table 6 Non-Direct Services/System Development [SA]

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Activity	FY 2020 A. SABG Treatment	B. SABG Prevention	C. SABG Combined*
1. Information Systems			
2. Infrastructure Support	$137,044		
3. Partnerships, community outreach, and needs assessment		$50,000	
4. Planning Council Activities (MHBG required, SABG optional)			
5. Quality Assurance and Improvement			
6. Research and Evaluation			
7. Training and Education		$60,000	
8. Total	**$137,044**	**$110,000**	**$0**

*Combined refers to non-direct service/system development expenditures that support both treatment and prevention systems.
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Footnotes:

-1.0 Dedicated FTE for IT infrastructure support

-Partnership with MPD for Synar

- Partnership with NCCPUD for Synar training

Planning Tables

Table 6 Non-Direct-Services/System Development [MH]

MHBG Planning Period Start Date: 10/01/2019 MHBG Planning Period End Date: 09/30/2021

Activity	FFY 2020 Block Grant
1. Information Systems	$130,000
2. Infrastructure Support	$672,961
3. Partnerships, community outreach, and needs assessment	$499,000
4. Planning Council Activities (MHBG required, SABG optional)	$10,000
5. Quality Assurance and Improvement	$50,000
6. Research and Evaluation	$50,000
7. Training and Education	$193,689
8. Total	**$1,605,650**

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Footnotes:

Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

Narrative Question

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[22] Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.[23] It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.[24]

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.[25] SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.[26] For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.[27]

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and M/SUD with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.[28]

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[29] The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and M/SUD include: developing models for inclusion of M/SUD treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.[30] Use of EHRs - in full compliance with applicable legal requirements - may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow M/SUD prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes[31] and ACOs[32] may be important strategies used by SMHAs and SSAs to foster integrated care.

Training and assisting M/SUD providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.[33] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[34]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[35] Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[36] SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who experience health insurance coverage eligibility changes due to shifts in income and employment.[37] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with M/SUD conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.[38] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of M/SUD conditions and work with

partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.
SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.[39] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to M/SUD services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds.
The SSAs and SMHAs should collaborate with their states' Medicaid authority in ensuring parity within Medicaid programs.
SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.
Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.[40]
SAMHSA recognizes that certain jurisdictions receiving block grant funds - including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.[41] However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

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[36] Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, **http://www.cbo.gov/publication/44308**

[37] BD Sommers et al. Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options can Ease Impact. Health Affairs. 2014; 33(4): 700-707

[38] TF Bishop. Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care, JAMA Psychiatry. 2014;71(2):176-181; JR Cummings et al, Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States, JAMA Psychiatry. 2014; 71(2):190-196; JR Cummings et al. Geography and the Medicaid Mental Health Care Infrastructure: Implications for Health Reform. JAMA Psychiatry. 2013; 70(10):1084-1090; JW Boyd et al. The Crisis in Mental Health Care: A Preliminary Study of Access to Psychiatric Care in Boston. Annals of Emergency Medicine. 2011; 58(2): 218

[39] Hoge, M.A., Stuart, G.W., Morris, J., Flaherty, M.T., Paris, M. & Goplerud E. Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. Health Affairs, 2013; 32 (11): 2005-2012; SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, January 2013, **http://store.samhsa.gov/shin/content/PEP13-RTC-BHWORK/PEP13-RTC-BHWORK.pdf**; Creating jobs by addressing primary care workforce needs, **https://obamawhitehouse.archives.gov/the-press-office/2012/04/11/fact-sheet-creating-health-care-jobs-addressing-primary-care-workforce-n**

[40] About the National Quality Strategy, **http://www.ahrq.gov/workingforquality/about.htm**; National Behavioral Health Quality Framework, Draft, August 2013, **http://samhsa.gov/data/NBHQF**

[41] Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, **http://www.cms.gov/cciio/resources/letters/index.html**; Affordable Care Act, Indian Health Service, **http://www.ihs.gov/ACA/**

Please respond to the following items in order to provide a description of the healthcare system and integration activities:

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community -based mental and substance use disorders settings.

D.C. Healthy Communities Collaborative (DCHCC) Community Health Needs Assessment: The DCHCC includes: 1) a coalition of four (4) hospitals: Children's National Health System, Howard University Hospital, Providence Health System, and Sibley Memorial Hospital); 2) four (4) federally qualified health centers (Bread for the City, Community of Hope, Mary's Center, and Unity Health Care); and 3) two (2) 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 (4) 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).

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 health care and include low-income individuals, the uninsured and underinsured, immigrants, those who are homeless, and those who live in public housing. 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 (3) locations in the District. Elaine Ellis Center of Health – Provides comprehensive primary care and social services to residents in the District.

Family and Medical Counseling Services – employ community-based, culturally competent approaches to provide comprehensive services that promote the competent emotional 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 Mental Health Rehabilitation Services (MHRS) core services agency and has three (3) 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 clinics sites, 11 homeless sites, three school-based health centers, and two other specialty sites.
Whitman Walker Clinic- The mission is to provide high quality, culturally competent community health center services to 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 (2) 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 (2) centers in the District.

Integration of Behavioral Health and Primary Care
Health Homes/MY DC Health Home:
The District of Columbia's (District) Department of Health Care Finance (DHCF) is launching a care coordination benefit for Medicaid beneficiaries with multiple chronic conditions, called My Health GPS. As part of the District's My Health GPS program, interdisciplinary teams embedded in the primary care setting will serve as the central point for integrating and coordinating the full array of eligible beneficiaries' primary, acute, behavioral health, and long-term services and supports to improve health outcomes and reduce avoidable and preventable hospital admissions and ER visits. Unlike DHCF's initial Medicaid Health Home benefit (My DC Health Home) where individuals must have a severe mental illness to receive services, the My Health GPS program will deliver care coordination services to beneficiaries with multiple chronic conditions, enrolled in either Fee-For-Service or Managed Care. The District's My Health GPS program began in July 2017.

The Health Home State Plan benefit, which targets individuals with severe and persistent mental illness, and aim to: (1) improve the integration of physical and behavioral health care; (2) lower rates of hospital emergency department use; (3) reduce avoidable hospital admissions and re-admissions; (4) reduce healthcare costs; (5) improve the experience of care, quality of life and consumer satisfaction; and (6) improve health outcomes. Medicaid providers that deliver Health Home services are DBH certified Core Services Agencies and Assertive Community Treatment (ACT) providers that meet specific standards as part of DBH's Health Home certification process. Health Home providers serve as the central point for coordinating patient-centered and population-focused care and will be responsible for integrating behavioral and primary care for eligible individuals. Health Home providers utilize a team-based approach, built on evidence-based care management guidelines. Providers also collaborate with DC Medicaid Managed Care Organizations (MCOs), Dual-Eligible Special Needs Plans (D-SNPs), primary care providers (PCPs) and hospitals for the exchange of data critical to ensuring that the right people receive services, at the right time.

Health Homes 2/MYHealth GPS:
The District of Columbia's (District) Department of Health Care Finance (DHCF) is launching a care coordination benefit for Medicaid beneficiaries with multiple chronic conditions, called My Health GPS. As part of the District's My Health GPS program, interdisciplinary teams embedded in the primary care setting will serve as the central point for integrating and coordinating the full array of eligible beneficiaries' primary, acute, behavioral health, and long-term services and supports to improve health outcomes and reduce avoidable and preventable hospital admissions and ER visits. Unlike DHCF's initial Medicaid Health Home benefit (My DC Health Home) where individuals must have a severe mental illness.

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.

The Assessment and Referral Center (ARC), under the Clinical Services Administration, is the primary entry-point for adults (21 years and older), seeking publicly funded treatment for SUD and referrals for other services. The ARC is a walk-in and appointment-based facility which conducts treatment assessments, TB, HIV/HEP-C Testing services, HIV pre and post counseling, linkage, and referral to treatment. ARC clinicians conduct Substance Use Disorder (SUD) Assessments and referral to SUD Treatment. Also, DBH utilizes a Mobile Assessment and Referral Center (MARC) for same-day services where they can provide the same services as the ARC (conduct TB, HIV/HEP-C testing services, TB and HIV pre and post counseling and referral to treatment such as the TB clinic. Nurse conduct primary health assessment and referral to services as needed. Currently, DBH is in the process of expanding the intake and assessment services into the community provider network.

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, included 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. A follow-up consultation will be provided remotely as needed to help ensure successful the implementation of recommendations.

2. Describe how the state provide services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.

Approximately 70% of SUD clients have also received mental health services within the same year. This data has facilitated the need to fully integrate the two systems and address the client's needs for co-occurring care. DBH has made significant progress in building the necessary infrastructure and a coordinated, integrated system of care for substance abuse treatment and recovery services, since the merger of the two (2) agencies in FY 2014. The District continues to develop access to care for individuals needing co-occurring treatment.

The award of the State Youth Treatment (SYT) grant from SAMHSA has enabled the District to enhance co-occurring treatment within the adolescent treatment network; the Adolescent–Community Reinforcement habilitation Approach (A-CRA) was selected as the evidence-based practice to implement the SYT services. The A-CRA model incorporates primary care into the treatment modality as well as the various other family and community supports. The Adolescent Community Reinforcement Approach (A-CRA) is a behavioral intervention that seeks to replace environmental contingencies that have supported alcohol or drug use. This outpatient program uses pro-social activities and behaviors that support recovery and has guidelines for three types of sessions: adolescents alone, parents/caregivers alone, and adolescents and parents/caregivers together. Seventeen different A-CRA procedures address, for example, problem-solving skills to cope with day-to-day stressors, communication skills, and active participation in pro-social activities to improve life satisfaction and eliminate alcohol and substance use problems. Role-playing/behavioral rehearsal is a critical component of the skills training used in A-CRA, particularly for the acquisition of better communication and relapse prevention skills. Homework between sessions consists of practicing skills learned during sessions and participating in prosocial leisure activities. This initiative focuses on capacity building within both the adolescent and adult SUD treatment provider networks, as well as the workforce in the adolescent system. In FY 2017, continuing into FY 2018, DBH has expanded these services to the transitional aged youth (TAY) in the Adult Substance Abuse Rehabilitation Services (ASARS) programs, which is Medicaid reimbursable.

Additionally, in July 2017, D.C. Department of Health Care Finance (DHCF), the single state agency for Medicaid, launched My Health GPS. DHCF a per member per month payment to approved primary care providers who deliver comprehensive care management services to District Medicaid beneficiaries with three or more qualifying chronic conditions. Primary care providers through incentivized payments will be held accountable for providing and coordinating patient's care with others as defined in the individualized care plan. Services rendered are geared toward 1) improving the integration of physical and behavioral health care, and 2) reducing health care costs by the reduction of Medicaid beneficiaries' use of emergency department non-emergency visits, and 3) the reducing preventable hospital admissions and re-admissions. The primary care provider is also expected to improve the quality of care and quality of services delivered and improve health outcomes. Eligibility for Health Homes 1 is determined by an individual having a serious mental illness only.

A mental health provider is responsible for providing mental health services and coordinating care with the primary provider as well as family members and stakeholders as defined in the individualized care plan.
There is no incentive payment at this point for Health Home 1 providers.
The Medicaid beneficiary can choose the Health Home that best meets his or her needs. At present, a work group comprised of the Department of Behavioral Health and D.C. Department of Health Care Finance (DHCF), the single state agency for Medicaid, are currently utilizing the Centers for Medicare and Medicaid Services (CMS) requirements to analyze parity compliance.

3. **a)** Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs? (●) Yes ( ) No

b) and Medicaid? (●) Yes ( ) No

4. Who is responsible for monitoring access to M/SUD services by the QHP?

The DBH Accountability Administration oversees provider certification; mental health community residence facility licensure;
In FY 20, the Accountability Administration will oversee provider certification; mental health community-residence facility licensure; program integrity; quality improvement; incident management; major investigations; and compliance monitoring.

Administration components are described below:
Division of Program Integrity- conducts claims audits, investigations of potential false claiming, monitors provider compliance with DBH regulations and policies, and issues and monitors Corrective Action Plans for providers needing to remediate problems related to service provision or compliance concerns.

Investigations Division- conducts major investigations of complaints and specific unusual incidents and develops the final investigative report submitted to the agency Director, General Counsel, and other appropriate parties that includes recommendations for remedial action.

Licensure Division- reviews and processes applications for licensure for Mental Health Community Residence Facilities (MHCRF) for approval; monitors MHCRF compliance with agency regulations and policies; and generates and enforces statements of deficiencies and corrective action plans when necessary.

Certification Division- reviews and processes applications for certification and re certification for behavioral health providers for approval, monitors provider compliance with certification regulations and policies, and generates and enforces statements of deficiencies and corrective action plans when necessary.

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? (•) Yes ( ) No

6. Do the M/SUD providers screen and refer for:

a) Prevention and wellness education (•) Yes ( ) No

b) Health risks such as

ii) heart disease (•) Yes ( ) No

iii) hypertension (•) Yes ( ) No

iv) high cholesterol (•) Yes ( ) No

v) diabetes (•) Yes ( ) No

c) Recovery supports (•) Yes ( ) No

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care? (•) Yes ( ) No

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services? (•) Yes ( ) No

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

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 are currently revising regulations to ensure parity compliance.

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

There are no activities that the Department of Behavioral Health would like to highlight at this time.

Please indicate areas of technical assistance needed related to this section

Determining and implementing incentivized/alternative payment methodologies.

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Footnotes:

Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[42], **Healthy People, 2020**[43], **National Stakeholder Strategy for Achieving Health Equity**[44], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for **Culturally and Linguistically Appropriate Services in Health and Health Care** (CLAS)[45].

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

The HHS Secretary's top priority in the Action Plan is to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."[46]

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[47]. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations[48]. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBTQ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

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

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

[42] **http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf**

[43] **http://www.healthypeople.gov/2020/default.aspx**

[44] **https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf**

[45] **http://www.ThinkCulturalHealth.hhs.gov**

[46] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[47] https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status

[48] https://www.whitehouse.gov/wp-content/uploads/2017/11/Revisions-to-the-Standards-for-the-Classification-of-Federal-Data-on-Race-and-Ethnicity-October30-1997.pdf

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?

a) Race	(•) Yes ( ) No
b) Ethnicity	(•) Yes ( ) No
c) Gender	(•) Yes ( ) No
d) Sexual orientation	(•) Yes ( ) No
e) Gender identity	(•) Yes ( ) No
f) Age	(•) Yes ( ) No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? ( ) Yes (•) No

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? ( ) Yes (•) No

4. Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? (•) Yes ( ) No

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services(CLAS) Standards? (•) Yes ( ) No

6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care? ( ) Yes (•) No

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

The Department of Behavioral Health does not have anything to highlight at this time.

Please indicate areas of technical assistance needed related to this section

Technical Assistance is needed to provide guidance to providers to ensure they are Reducing disparities in access, service use and outcomes for sub-populations.

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Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, its purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ÷ Cost, (**V = Q ÷ C**)

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services.

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

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. SAMHSA's Evidence Based Practices Resource Center assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. SAMHSA's Evidence-Based Practices Resource Center provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General,[49] The New Freedom Commission on Mental Health,[50] the IOM,[51] NQF,and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC).[52]. The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[53] SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocol Series **(TIPS)**[54] are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation **(KIT)**[55] was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

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

[49] United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

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

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

[52] National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

[53] **http://psychiatryonline.org/**

[54] **http://store.samhsa.gov**

[55] **http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.pdf**

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? (●) Yes ( ) No

2. Which value based purchasing strategies do you use in your state (check all that apply):

- **a)** ☑ Leadership support, including investment of human and financial resources.
- **b)** ☑ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
- **c)** ☑ Use of financial and non-financial incentives for providers or consumers.
- **d)** ☑ Provider involvement in planning value-based purchasing.
- **e)** ☑ Use of accurate and reliable measures of quality in payment arrangements.
- **f)** ☑ Quality measures focus on consumer outcomes rather than care processes.
- **g)** ☑ Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
- **h)** ☐ The state has an evaluation plan to assess the impact of its purchasing decisions.

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

There are no additional activities the Department of Behavioral Health would like to highlight at this time.

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

Technical Assistance is needed to develop and evaluation plan to assess the impact of the State's purchasing decisions.

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Footnotes:

Environmental Factors and Plan

4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required 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 consumers 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 before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

SAMHSA's 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-5 (APA, 2013). 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 National Institute of Mental Health (NIMH) via its 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 with a first episode of psychosis (FEP). RAISE was a set of NIMH sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The NIMH 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.

State 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 with 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.

* 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 a SMI.

Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)? (•) Yes ( ) No

2. Has the state implemented any evidence-based practices (EBPs) for those with ESMI? (•) Yes ( ) No

If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI.

1. Transition to Independence Process (TIP): Provides a framework for conceptualizing and organizing services that are still billable under the traditional Medicaid structures.
2. TIP and Assertive Community Treatment (ACT): The integration of TIP and ACT has proven very successful with TAY.
3. 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.
4. Medication Management: Monitoring medications to confirm that the patient is complying with a medication regimen, while also ensuring he or she is avoiding potentially dangerous drug interactions and other complications.
5. Family Supports: Social support from family provides patients with practical help and can buffer the stresses of living with illness.
6. RA1SE and NAVIGATE-like Services: The RAISE Early Treatment Program (ETP) is a research study that compared two (2) different ways of providing treatment for people experiencing the early stages of schizophrenia and related illnesses. Both types of treatment emphasized a comprehensive initial evaluation at the earliest point after symptoms appear.

The ETP treatments approach is based on the NAVIGATE model, a comprehensive program designed to provide early and effective treatment to individuals who have experienced a first episode psychosis that includes medication, psychosocial therapies, and supportive services that address the multiple problems associated with these illnesses.
7. 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.
8. Cognitive Behavioral Therapy for Psychosis (CBTp): This is a new evidence-based practice in the District. DBH provided support to Community Connections to arrange an extensive training and supervision package for 20 mental health professionals in the District. The training was provided by the Institute of Cognitive Behavioral Therapy for Psychosis and occurred over four (4) days. The follow-up supervision is being provided by the four (4) trainers. The supervisors have completed 10 of the contracted 30 sessions. The CBTp introduces the standard CBT principles to a population of people that had not previously benefited from the techniques. Conceptualizing hallucination and delusions as symptoms that are amenable to treatment, CBTp successfully ameliorates some of the most profound symptoms suffered by the clients.

3. How does the state promote the use of evidence-based practices for individuals with ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?

DBH is committed to improving the lives of children, youth, transition-age youth, and families through the use of evidence-based practices. DBH contracts with Evidence Based Associates (EBA) to provide training, quality and fidelity reviews, and monitors EBPs. EBA also provides technical support to all District agencies implementing a DBH sponsored EBP. In this collaborative work, EBA and DBH promote the use of evidence-based practices for individuals with ESMI and offers guidance on the crafting of comprehensive individualized treatment plans. There are currently eight (8) EBPs that include the following:
1) Child-Parent Psychotherapy for Family Violence- For ages 0-6 with a history of trauma exposure or maltreatment and their caregivers.
2) Trauma Systems Therapy- For ages 0-19 who have experienced traumatic events and/or who live in environments with ongoing traumatic stress.
3) Parent-Child Interaction Therapy- For ages 2-6 who experience extreme behavioral difficulties with an emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns.
4) Trauma-Focused Cognitive Behavioral Therapy- For ages 4-18 and helps children, youth, and their parents overcome the negative effects of traumatic life events and address feelings.
5) Multi-Systemic Therapy- For ages 10-17 with emphasis on empowering parents/caregivers effectiveness as they assist the child/youth in successfully making and sustaining changes in individual, family, peer, and school systems.
6) Adolescent Community Reinforcement Approach- For ages 12-22 and seeks to replace environmental influences that have supported alcohol or drug use with prosocial activities and behaviors that support recovery.
7) Transition to Independence Process- An evidence-supported model for ages 14-29 that also engages their families and other informal key players in a process that facilitates their movement towards greater self-sufficiency and achievement of their goals.
8) Cognitive Behavioral Therapy for Psychosis (CBTp)- An evidence-based treatment primarily designed to target psychotic symptoms such as delusions and hallucinations that persist despite appropriate treatment with antipsychotic medication.

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with ESMI? (●) Yes ( ) No

5. Does the state collect data specifically related to ESMI? (●) Yes ( ) No

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

7. Please provide an updated description of the state's chosen EBPs for the 10 percent set-aside for ESMI.

See the description above about the eight (8) DBH EBPs. Some of the EBPs may be appropriate for use with the 10% set-aside for ESMI.

8. Please describe the planned activities for FFY 2020 and FFY 2021 for your state's ESMI programs including psychosis?

The planned transition-age youth activities for FFY 2020 and FFY 2021 include: 1) Now Is The Time-Healthy Transitions/ Our Time – focused on filling service and treatment gaps available for young adults 16-25; 2) Our Time Exploration - focused on filling service gaps that address the integration of substance use disorder and mental health treatment services specifically for young adults 16¬25; 3) It's Time to Let Help In – focused on reducing stigma around MH; 4) First Episode Psychosis /Youth Blossom Program – early interventions to address first psychotic break for young adults 16-25; 5) Transition Age Youth Housing- supportive independent housing for young adults 18-25 6) TAY Supported Employment – Focused on connecting young adults 16-25 with career-focused employment; 7) TAY Professional training – Focused on training DC providers who work with TAY population on better ways to connect and work with young adults; 8) Trauma, Intellectual Developmental Disabilities/Mental Illness; 9) Proposed Projects (services, training, resources).

9. Please explain the state's provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.

DBH, Community Connections of New York (CCNY) and Coordinated Care Services, Inc. (CCSI) are collaborating partners. This partnership draws upon the experience and expertise of all organizations in providing evaluation, data analysis, and technical assistance to the agencies supporting the efforts of ESMI. Utilizing existing databases, CCNY has created a platform that allows the pulling of information and data. CCNY pulls data and provides a monthly, quarterly and annual report to DBH on agreed-upon data points. These evaluation findings will be used to improve and promote an integrated system for youth and young adults. Evaluation services will provide the opportunity to identify successes and barriers encountered in the process of

identifying, referring, and early screening, to serve youth and young adults with serious mental illnesses. Evaluation services will allow continuous, quality improvement measurement and monitoring ensuring that the transition-age youth system of care is operating optimally.

10. Please list the diagnostic categories identified for 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

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

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

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5. Person Centered Planning (PCP) - Required MHBG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP 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.

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 consumers and their caregivers in making health care decisions, and enhance communication.

Following a comprehensive diagnostic assessment, results are reviewed with the consumer to ensure that there is a shared and agreed-upon understanding of the issues to address in treatment. Based on this shared understanding, the treatment planning process begins by orienting the individual and his/her natural supporters to the process. This process increases the likelihood that the consumer actively participates in all stages of plan development and implementation. Before the process of developing a treatment plan begins, the treatment team lead will encourage pre-planning activities and goal prioritization with the consumer. This step allows the consumer to not only prepare for their planning meeting but to empower them to be voice their choice of how they would like for their recovery to look with the treatment team. After completion of a comprehensive diagnostic assessment, assessment results are reviewed with the consumer to ensure that there is a shared and agreed-upon understanding of the issues to address in treatment. Based on this shared understanding, the treatment planning process begins by orienting the individual and his/her natural supporters to the process. This step increases the likelihood that the consumer will actively participate in all stages of the plan development and implementation. Before the process of developing a treatment plan begins, the treatment team lead will encourage pre-planning activities and goal prioritization with the consumer. This step allows the consumer to not only prepare for their planning meeting but to empower them to be voice their choice of how they would like for their recovery to look with the treatment team.

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

The following activities/areas warrant special attention in the person-centered planning process:
1. Conducting a comprehensive, strengths-based assessment;
2. Developing an interpretive summary as a result of the assessment;
3. Reviewing and considering 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; and
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.

A comprehensive person-centered initiative launched in 2015 that included multiple components: an advisory workgroup made up of consumer, providers and DBH employees; the development of person-centered treatment planning practice guidelines; and the launch of a system-wide person-centered treatment planning training, including a Training-of-Trainer component to ensure sustainability throughout the system. This year, DBH is also developing person-centered assessment practice guidelines and training to support high-quality assessments. Please indicate areas of technical assistance needed related to this section. Technical Assistance is needed to provide additional training to our provider network to support Person-Centered Planning.

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

Technical Assistance is needed to provide additional training to the DBH provider network to support Person Centered Planning.

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6. Program Integrity - Required

Narrative Question

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

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA 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 SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder 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 M/SUD services funded by the MHBG and SABG. 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 M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of M/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?

Mental Health Block Grant (MHBG) 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 MHBG funds. This information is also included in the Pre-Application Conference along with program, performance and fiscal expectations.

Mental Health Block Grant (MHBG) Sub-Grant Agreement: The MHBG Sub-Grant Agreement provides detail information about what is required and includes but is not limited to: 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.

Accountability Administration: In FY 20, the Accountability Administration will oversee provider certification; mental health community residence facility licensure; Medicaid claims audits; program integrity; quality improvement; incident management; major investigations; and compliance monitoring. The Administration components are described below.

Division of Program Integrity- conducts claims audits, investigations of potential false claiming, monitors provider compliance with DBH regulations and policies, and issues and monitors Corrective Action Plans for providers needing to remediate issues related

to service provision or compliance concerns.

Investigations Division- conducts major investigations of complaints and certain unusual incidents and develops the final investigative report submitted to the agency Director, General Counsel, and other appropriate parties that includes recommendations for remedial action.

Licensure Division- reviews and processes applications for licensure for Mental Health Community Residence Facilities (MHCRF) for approval; monitors MHCRF compliance with agency regulations and policies; and generates and enforces statements of deficiencies and corrective action plans when necessary.

Certification Division- reviews and processes applications for certification and re-certification for behavioral health providers for approval, monitors provider compliance with certification regulations and policies, and generates and enforces statements of deficiencies and corrective action plans when necessary.

Please indicate areas of technical assistance needed related to this section

Technical Assistance is needed to train providers in the importance and benefits of Program Integrity.

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7. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the **2009 Memorandum on Tribal Consultation**[56] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

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

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state?s plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

[56] **https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf**

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

   The Department of Behavioral Health (DBH) is an urban city and there are no federally recognized tribes present.

2. What specific concerns were raised during the consultation session(s) noted above?

   The Department of Behavioral Health (DBH) is an urban city and there are no federally recognized tribes present.

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

   The Department of Behavioral Health (DBH) is an urban city and there are no federally recognized tribes present.

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

   There are no areas of Technical Assistance at this time.

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Environmental Factors and Plan

8. Primary Prevention - Required SABG

Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. 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 disorder 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 SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. 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, abuse, and addiction 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 target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification*** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Process*** 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 abuse 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 target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Please respond to the following items

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) ( ) Yes (●) No

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

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

- ☐ Children (under age 12)
- ☑ Youth (ages 12-17)
- ☑ Young adults/college age (ages 18-26)
- ☑ Adults (ages 27-54)
- ☑ Older adults (age 55 and above)
- ☑ Cultural/ethnic minorities
- ☑ Sexual/gender minorities
- ☐ Rural communities
- ☐ Others (please list)

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

- [ ] Archival indicators (Please list)

- [x] National survey on Drug Use and Health (NSDUH)
- [ ] Behavioral Risk Factor Surveillance System (BRFSS)
- [x] Youth Risk Behavioral Surveillance System (YRBS)
- [ ] Monitoring the Future
- [ ] Communities that Care
- [x] State - developed survey instrument
- [ ] Others (please list)

5. Does your state use needs assesment data to make decisions about the allocation SABG primary prevention funds? (●) Yes ( ) No

If yes, (please explain)

The Community Conversation is a qualitative data collection tool used by the DC Prevention Centers (DCPC) to examine emerging trends and also assess needs within their respective wards.

If no, (please explain) how SABG funds are allocated:

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. 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 disorder 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 SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. 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, abuse, and addiction on individuals families and communities;
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4. ***Problem Identification*** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Process*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target 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 disorder prevention workforce? ○ Yes ◉ No

If yes, please describe

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

If yes, please describe mechanism used

The DC Department of Behavioral Health (DBH) has established an email account (suds.prevention@dc.gov) that serves as a repository for training and technical assistance requests. Once the request is received, a member of the Prevention team begins the process of preparing a response based on the expressed need(s). Also, sub-grantees can submit formal requests for training and technical assistance through progress reports submitted on an annual basis. Lastly, during site visits, sub-grantees have the opportunity to request training and technical assistance for their staff and/or key community leaders. The Network Development Division at DBH also serves as a liaison to each contracted behavioral health provider, and Network Development Specialists provide a variety of technical assistance and training to the provider network. Any provider can reach out to its Specialist with questions or a request for assistance.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies? ◉ Yes ○ No

If yes, please describe mechanism used

The DC Department of Behavioral Health (DBH) has developed an assessment tool that is used by sub-grantees to assess community readiness to implement prevention strategies formally.
The assessment tool used is the Strategic Prevention Framework (SPF) which a five (5) step planning process. The five (5) steps are assessment, capacity, planning, implementation, and evaluation. Following these steps allows for the assessing of community needs and strategically developing and setting a plan in place to address the needs.

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. 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 disorder 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 SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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5. ***Community-based Process*** 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 abuse 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 target 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 disorder prevention that was developed within the last five years? ○ Yes ◉ No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG? (N/A - no prevention strategic plan) ○ Yes ○ No ◉ N/A

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 SABG primary prevention funds
- **b)** ☐ Timelines
- **c)** ☐ Roles and responsibilities
- **d)** ☐ Process indicators
- **e)** ☐ Outcome indicators
- **f)** ☐ Cultural competence component
- **g)** ☐ Sustainability component
- **h)** ☐ Other (please list):
- **i)** ☐ Not applicable/no prevention strategic plan

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

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

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

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. 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 disorder 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 SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. 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, abuse, and addiction 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 target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification*** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Process*** 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 abuse 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 target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Implementation

1. States distribute SABG 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 SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

a) Information Dissemination:

The Strategic Prevention Framework State Incentive Grant (SPF SIG) supported the development of a new Department of Behavioral Health Prevention website (www.drugfreeyouthdc.com), the "There's a Reason" Underage Drinking Campaign (www.theresareasondc.com) website, and the Synthetic Marijuana Campaign website (www.K2Zombie.DC.com). Information on synthetic drugs was also included on the Prevention website to provide additional coverage. In FY2018, SABG Prevention Set-Aside resources continued to expand the DBH Prevention Website operations and made updates as needed. The DBH Community Engagement Branch Manager will continue to serve as the lead for information dissemination along with a team of other individuals supported by the SABG. The goal is to disseminate targeted prevention messages and resources to DC youth and adults via the four DC Prevention Centers (DCPCs), website, digital engagement, social media events, and other communication channels. Digital measures are to 1) increase the reach of synthetic drug, underage marijuana use, and underage drinking prevention messages by 20%, segment by local and acquisition channel; 2) increase the level of primary and target audiences by 1-2% each month; 3) maintain steady engagement with youth influencers (parents/caregivers, other adults); and 4) maintain steady engagement with youth. DBH prevention staff will collaborate with DC Prevention Centers (DCPC) to:

· Update drug facts each month using the best evidence from SAMHSA, NIDA, NIAAA, and ONDCP;

· Update new information and calendar/event notices from District, Ward, and community leaders;

· Include resource request sections and continue to make available digital versions of DC substance use prevention campaign materials;
· Add contact forms for questions and suggestions from the public who do not frequently use social media or are needing immediate assistance;
· Check social media pages (Facebook and Twitter) regularly and respond to immediate requests;
· Issue proactive posts describing events and activities, new resources, and digital campaign information;
· Use and create hashtags to identify new users and expand prevention messaging; and
· Repost follower and non-follower related prevention messages as appropriate.

DBH will continue to brand prevention as an integral component in achieving the agency mission. The resources for DCPC that were created and disseminated in FY 2016, such as signage, banners, table-top exhibits, and templates for business cards, newsletters, and flyers are being used into FY 2019
Information dissemination data is collected, analyzed and reported through the online Program Grant monitoring and evaluation system, Data Infrastructure and Reporting System (DIRS). Enhancements were made to DIRS during FY 2016 that has allowed for the better collection and reporting of data; specifically for annual SABG reporting. Non-SABG funds will support the evaluation of digital media strategies through a web metric tool.

b) Education:

SABG funded DBH prevention staff and DC Prevention Center staff will continue to support education strategies that are based on DC EOW data findings, emerging community trends, and approaches that have a plausible connection to target outcomes. DBH has invested SABG, SPF SIG, and local funds for ongoing education delivered to DBH prevention staff, DC Prevention Centers, and other sub-recipients. Educational strategies included:
· Sponsoring training and technical assistance on the DBH prevention conceptual and operational framework (cultural humility, risk, and protective factors Institute of Medicine Classification System, and the Strategic Prevention Framework five-step planning process).
· Developing data-driven logic models with culturally appropriate evidence-based preventive interventions for use in SPF planning.
· Using District and ward data and community conversation findings to make policy, program, and resource decisions.
· Supporting the development of the prevention workforce through another wave of IC&RC Prevention Specialist training and testing for certification.
· Training and technical assistance tailored to effective prevention approaches in working with selective and indicated populations.
· Training and technical assistance in using the online DIRS system for submitting and monitoring monthly prevention program grant reports.
· Increasing awareness and educating District and ward stakeholders on priority drug issues (underage drinking, underage marijuana use, synthetic drug use, and Initiative 71 laws).

The next two years, SABG funds will support the development of a more comprehensive and sustainable education strategy that builds needed workforce skills through structured learning processes. The priority audiences are: 1) DBH prevention staff; 2) DC Prevention Centers that reach and educate more than 35,000 community stakeholders annually; 3) key community leaders who work with the DC Prevention Centers; 4) other DBH substance use prevention sub-recipients; and 5) targeted District agency partners that are addressing risk and protective factors for anxiety and depression, violence, delinquency, and poor school performance.
Focused education strategies are to; and
· Develop a policy, program, and business plan to implement the DC Prevention Leadership Center that supports education and technical assistance for an expanded prevention workforce.

DBH prevention staff and the DCPCs will continue to support educational events based on identified substance use prevention need; in high need communities with low capacity; and with populations that have documented disparities. Also, to increase opportunities to implement education strategies, the District is preparing to expand its use of evidence-based curricula (Too Good for Drugs) to be implemented within additional schools throughout the District. These curricula aim to raise awareness around the health risks associated with substance use. The District's Substance Use Prevention team will work with school-based clinicians to identify the best method for school engagement whether with universal populations such as within the classroom or among selective and indicated populations that have been referred to the program.

c) Alternatives:

Alternative strategies will continue to be supported at the District level through DBH prevention staff and DCPCs at the Ward level. These activities coincide with the Marion S. Barry Summer Youth Employment Program (SYEP), a locally funded initiative sponsored by the Department of Employment Services that provides District youth ages 14 to 21 with enriching and constructive summer work experiences through subsidized placements in the private and government sectors. In 2015 SYEP expanded the program to include youth ages 22-24 years old. Since that change, the SUD Prevention Branch has sought to engage SYEP youth with more challenging tasks such as the planning and execution of prevention-related activities.

To be more intentional in planning and supporting alternative activities, DBH prevention will continue planning fun engagement events to creating a fun atmosphere for communities within the District that are at the highest risk for substance use and other anti-social activities. The team launched its "pop-up" events officially in FFY2019. To support these efforts, the DBH prevention team will work with District agency partners and DCPCs year-round. DBH will be pro-active in planning structured alternative strategies across the 8 Wards with the following partners:

· DBH DOES SYEP program planners
· DC Parks and Recreation and Roving Leaders Program
· After school activities
· DCPC Community Prevention Networks

Alternative activities will focus on increasing awareness of prevention and substance use disorder resources, risks of underage alcohol and marijuana use, ward-level data that lead to structured alternates at high-risk times (e.g., summer months, holidays, school breaks, after school). This approach will be data-driven, pro-active opposed to reactive requests, provide consistency across Wards, and have the potential for evaluation.

d) Problem Identification and Referral:

While the District has documented positive changes in some DC EOW data, the age of first use among middle school youth (cigarettes, alcohol, and marijuana) remains on average age 10. For DC high school youth, the average age is 13. There is also a decline in the number of youth assessed and treated through the four youth substance use disorders treatment programs, while behavioral health needs of transitional-age youth continue to increase. The most recent DBH Performance Plan includes substance use disorder objectives for prevention, treatment, and recovery. The first objective, "Reduce priority risk factors that place District children, youth and families, and communities at risk for substance use and interrelated problems," will help focus DBH efforts toward earlier problem identification and referral to services.
SPF SIG funds allowed DBH and DCPC to assess 500 individuals, community-based organizations, youth and parents/caregivers on challenges related to early risk reduction that results in delayed problem identification. One challenge is that consumers are not aware of how to fully access behavioral health services due to the merger of mental health and substance use disorders.

Other FY 2020 plans include:

· A public education campaign through treatment funds to increase consumer awareness of DBH system services;
· Broader awareness of the 24-hour DBH Access HelpLine that provides immediate information and assistance for prevention, treatment, and recovery behavioral health services; and
· Building upon the youth summit that took place in FY2019 to provide the supports for youth necessarily to increase protective factors and reduce risk factors associated with substance use.

e) Community-Based Processes:

DBH will continue to allocate SABG prevention set-aside funds for four DC Prevention Centers, dynamic hubs that engage, support, and help connect the many community elements needed for promoting healthy drug-free youth. Each Center serves two Wards each (Wards 1 and 2; Wards 3 and 4; Wards 5 and 6; Wards 7 and 8). Through their grants, DCPC focus on three core functions: 1) community education; 2) community leadership; 3) community changes. These functions provide a consistent strategy but have the flexibility to address the unique characteristics and priorities of the geographic area and populations in their designated Wards. Flexibility in this community prevention system allows partnerships across Ward boundaries to address shared and emergent substance use problems.

The Substance use prevention team will begin revisiting the activities included under community-based processes to ensure that the activities and requirements remain in alignment with the needs of the District and mission and vision of the DC Department of Behavioral Health (DBH). The FY 2020 scope of work will include the following requirements:
Administrative Leadership:

· Ensure staffing patterns that include one full-time Project Director/Coordinator and one Community Mobilizer FTE's that share responsibilities for the three core functions.
· Attend DBH required roundtables, technical assistance, and training.
· Submit and revise as needed monthly program reports through the online Data Infrastructure Reporting System.
· Submit quarterly financial reports and revise as needed.
· Participate in at least one DCPC grant site visit in cooperation with DBH.
· Attend the National Association of State Alcohol and Drug Directors Prevention Research Conference and the SAMHSA Prevention Day. DCPC funds to attend other conferences require written permission from DBH.
· Allocate a maximum of 10% of the grant funds for indirect or overhead costs.

Community Education: This function is designed to provide current, comprehensive, and relevant information for a wide range of audiences within the Prevention Center's respective geographic areas.

· Market as a DCPC using DBH provided templates (logo, business cards, letterheads, etc.)
· Provide an "early warning system," track and recommend actions to address new drug trends within the two Wards.
· Disseminate science-based substance abuse prevention education materials within two Wards.
· Coordinate and support District and National campaigns (e.g., SAMHSA Week, "Talk. They Hear You.", Synthetic Drug Campaign, and the Underage Marijuana Campaign).
· Use the Community Conversation Guidance document for implementing Community Conversations and submit findings

and recommendations in the monthly program progress report.
Community Leadership: This function is designed to identify, engage, and strengthen the capacity of community prevention partnerships to address the areas placing youth at risk for substance use disorders.
· Strengthen and maintain an accessible database of prevention partners involved in the DCPC scope of work.
· Strengthen and maintain an accessible database of prevention strategies that are currently being implemented by prevention partners within the two Wards.
· Identify and support the development of community prevention networks that broaden the reach of DCPC.
Community Changes: This function increases opportunities for pro-active prevention action planning around Ward specific DCEOW data and measurable changes in prevention policy, programs, and practices.
· Use the Strategic DC Strategic Prevention Framework (SPF) to mobilize and facilitate data-driven planning with community prevention networks.
· Support community prevention networks in the implementation of the SPF logic model and action plan.
· Document community changes by tracking changes in policies, programs, and practices related to the implementation of the action plan.

DCPC SABG scope of work and work plan will continue to target three levels of measurable outcomes: 1) priority risk and protective factors; 2) community changes in policies, programs and practices; and 3) distal or behavioral outcomes. DBH will modify the existing DCPC scopes of work based on DCEOW data and evaluation findings.
Within the community-based process strategy, DCPCs will continue to address the spectrum of prevention interventions: universal, selective, and indicated. DIRS program reports collect information on IOM categories and demographics. DBH has built on the DCPC core services for other discretionary grants such as SPF SIG and now the Strategic Prevention Framework Partnership for Success Grant. Each funding source requires a separate grant and grant scope of work. There are also separate DIRS modules for submitting online program grant reports to ensure better that SABG dollars are used to fund primary substance abuse prevention services not funded through other means.

f) Environmental:

Moving forward, SABG funded DBH prevention staff, and DCPCs will disseminate underage drinking prevention, underage marijuana prevention, synthetic narcotics prevention, and tobacco prevention social marketing materials to increase understanding of District laws about youth and adults. The preventing underage marijuana use social marketing campaign will focus on the laws about the passage of Initiative 71 and the behavioral health risks associated with underage use as this remains to be a need. Also, with the increase in the legal age to purchase tobacco products going from 18 to 21, the prevention staff will continue to engage retailers and District residents about the change in the law. Lastly, SABG funded DBH prevention staff will continue to serve on District task forces such as the Criminal Justice Coordinating Council New Psychoactive Substances Workgroup to identify policy and program environmental changes.

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

If yes, 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 $240,000 each ($960,000 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

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. 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 disorder 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 SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. 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, abuse, and addiction 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 target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification*** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Process*** 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 abuse 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 target 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 disorder prevention that was developed within the last five years? ○ Yes ◉ No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan

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 targeted benchmarks
- **b)** ☑ Includes evaluation information from sub-recipients
- **c)** ☑ Includes SAMHSA 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 list:)
- **g)** ☐ Not applicable/no prevention evaluation plan

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

- **a)** ☑ 30-day use of alcohol, tobacco, prescription drugs, etc
- **b)** ☑ Heavy use
- ☐ Binge use
- ☐ Perception of harm
- **c)** ☑ Disapproval of use

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

e) ☐ Other (please describe):

Footnotes:

Environmental Factors and Plan

9. 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-occuring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

The Clinical Services Administration (CSA) supervises the operation of all clinical programs and sets standards for the provision of clinical care throughout the public behavioral health system, which is system is community based. CSA set the standards for assessments, referrals, and clinical services; forensic services; the comprehensive emergency psychiatric program; and the disaster behavioral health program. The Administration oversees involuntary commitment at community hospitals, and coordinates services that assist individuals transitioning from psychiatric hospitals and nursing homes to community based behavioral health services. The Access HelpLine is the central point for accessing all DBH community-based services, and Behavioral Health Services Division provides same day urgent care; services include, assessments, counseling, medication management and psychiatric evaluations.

The Community Services Administration 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 Administration promotes and protects the rights of individuals with behavioral health disorders; encourages and facilitates consumer and client and family leadership of treatment and recovery plans, and ensures consumer and client voice in the development of the behavioral health system. The Administration also promotes consumer and client leadership, manages the peer certification training, and provides expertise on the consumer and client perspective. This Administration 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 in 2017 launched the D.C. Certified Peer Academy.

Evidenced Based Practices- DBH implements a number of 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.

District Agency and Other Partners- The DBH partners include but are not limited to:
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 Authority, 14) Department of Housing and Community Development, 15) Department of General Services, 16) District of Columbia 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 misuse prevention and SUD treatment services	(•) Yes ( ) No
h)	Medical and dental services	(•) Yes ( ) No
i)	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.)

The evidence-based practices were described in earlier sections of the Environmental Factors Plan. 3.

3. Describe your state's case management services

In the District of Columbia, Chapter 34 of DC Code describes the 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. Community Support services are rehabilitation and environmental supports considered 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 may include but are not limited to: 1) a variety of interventions; 2) provided by a team of staff that is responsible for an assigned group of consumers, or by staff who are individually responsible for assigned consumers; 3) services provided to children and youth will include coordination with family and significant others and with other systems of care; 4) services can be provided at the MHRS provider site, natural settings or a residential facility with 16 beds or less; 5) providers will have service specific policies and procedures; and 6) 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.

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

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

Saint Elizabeths staff has had an Improved Discharge Planning Initiative since FY18. The strategies focus on increasing the effectiveness of post discharge linkages with community-based treatment and support services. The measurement of effective linkages include the Interdisciplinary Recovery Plan (IRP) Observation Audit and the Discharge Plan of Care (DPOC) Audit. The IRP Audit examines if the family and/or Community Support Workers are invited to IRPs, and if there is active discussion about the discharge plan at each IRP. The DPOC Audit addresses whether patients are linked to a Core Service Agency/active treatment post discharge, and to appropriate housing.

The goal of this initiative is to assess the impact of in-hospital communication between individuals in care, community partners, and hospital treatment team members on the discharge planning process, in the hopes that this will result in positive impacts/outcomes for individuals in care as they transition from the Hospital back into the community.

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

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate 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	30,548	
2.Children with SED	4,471	

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. The information DBH receives is provided by SAMHSA, from the Center for Behavioral Health Statistics and Quality (CBHSQ).

Criterion 3

Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care?

a)	Social Services	(•) Yes ( ) No
b)	Educational services, including services provided under IDE	(•) Yes ( ) No
c)	Juvenile justice services	(•) Yes ( ) No
d)	Substance misuse preventiion 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 system	(•) Yes ( ) No

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 targeted services to rural population.

The District of Columbia is an urban area.

b. Describe your state's targeted services to the homeless population.

These services are described in detail under Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults in the District's Application.

c. Describe your state's targeted services to the older adult population.

These services are described in detail under Criterion 4: Targeted Services to Older Adults in the District's Application.

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

Describe your state's management systems.

These activities are described in detail under Criterion 5 in the District's Application.

Footnotes:

Environmental Factors and Plan

10. Substance Use Disorder Treatment - Required SABG

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

i)	Screening	(•) Yes ( ) No
ii)	Education	(•) Yes ( ) No
iii)	Brief Intervention	(•) Yes ( ) No
iv)	Assessment	(•) Yes ( ) No
v)	Detox (inpatient/social)	(•) Yes ( ) No
vi)	Outpatient	(•) Yes ( ) No
vii)	Intensive Outpatient	(•) Yes ( ) No
viii)	Inpatient/Residential	(•) Yes ( ) No
ix)	Aftercare; Recovery support	(•) Yes ( ) No

b) Services for special populations:

Targeted services for veterans?	(•) Yes ( ) No
Adolescents?	(•) Yes ( ) No
Other Adults?	(•) Yes ( ) No
Medication-Assisted Treatment (MAT)?	(•) Yes ( ) No

Criterion 2: Improving Access and Addressing Primary Prevention -See Narrative 8. Primary Prevention-Required SABG.

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. 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 DBH Accountability Administration oversees provider certification; incident management; major investigations; claims audits; and compliance monitoring and corrective actions. DBH Community Based Services and Network Development staff also work with providers to provide technical assistance, training, and performance feedback to the system of care.
The District is in the process of implementing a results-based accountability (RBA) process. The RBA process will provide the structure for the Continuous Quality Improvement (CQI) process to identify and track critical outcomes and performance measures. The RBA measures are being developed with stakeholders using valid and reliable data. The RBA measures will continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The District's CQI process will track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. Policies and procedures include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

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)** Syringe services programs — (●) Yes ( ) No
- **e)** 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. DBH Community Based Services and Network Development staff also work with providers to provide technical assistance, training, and performance feedback to the system of care.

The District is in the process of implementing a results-based accountability (RBA) process. The RBA process will provide the structure for the continuous quality improvement (CQI) process to identify and track critical outcomes and performance measures. The RBA measures are being developed with stakeholders using valid and reliable data. The RBA measures will continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The District's CQI process will track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. 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.

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 the 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

Syringe Service Programs

1.	Does your state have in place an agreement to ensure that SABG funds are NOT expended to provide individuals with hypodermic needles or syringes(42 U.S.CÂ§ 300x-31(a)(1)F)?	(•) Yes ( ) No
2.	Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program?	(•) Yes ( ) No
3.	Do any of the programs use SABG funds to support elements of a Syringe Services Program?	( ) Yes (•) No

If yes, plese provide a brief description of the elements and the arrangement

No, not at this time.

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 memebers, veterans, tribal entities, older adults, sexual and gender minorities) — (•) Yes ( ) No
- **e)** Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations — (•) Yes ( ) No
- **f)** Explore expansion of services for:
  - **i)** MAT — (•) Yes ( ) No
  - **ii)** Tele-Health — (•) Yes ( ) No
  - **iii)** Social Media Outreach — (•) Yes ( ) No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person -centered and person-directed 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 systems, adult criminal justice systems, 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

d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background — (●) 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 include 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.

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)

DBH works closely with providers to ensure the delivery of quality services to their consumers. As part of this effort, DBH assesses community behavioral health best practices and compliance with DBH policy requirements within our network. The Quality Improvement activities reside within the Accountability Administration, which has instituted a number of internal and external workgroups, compliance and monitoring activities that informs the continuous quality improvements process.

DBH provides SABG funding to 15 providers annually. To ensure independent peer review requirements are met, DBH has accepted the Commission on the Accreditation of Rehabilitation Facilities (CARF) and or Joint Commission (JCO) certification in lieu of an independent peer review of the funded providers. The state follows Federal regulations for block grant sub-recipients who must have CARF or JCO certification to operate the business. All MAT's must apply for and receive accreditation from an independent accreditation organization, e.g., Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion certification and to receive block grant funds.

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 opertunity 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) Preformance-based accountability (●) Yes ( ) No

d) Data collection and reporting requirements (●) Yes ( ) No

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 (TTCs)?

a) Prevention TTC? ( ) Yes (●) No

b) Mental Health TTC? ( ) Yes (●) No

c) Addiction TTC? ( ) Yes (●) No

d) State Targeted Response TTC? (●) Yes ( ) No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924. and 1928 (42 U.S.C.§ 300x-32 (f)).

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

a) Allocations regarding women ( ) Yes (●) No

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:

a) Tuberculosis ( ) Yes (●) No

b) Early Intervention Services Regarding HIV ( ) Yes (●) No

3. Additional Agreements

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.

DBH rules can be found at: https://dbh.dc.gov/node/288362. This includes Chapter 34 (Mental Health Rehabilitation Services Provider Certification Standards) and Chapter 63 (Certification Standards For Substance Use Disorder Treatment And Recovery Providers).

Footnotes:

The Assessment and Referral Center (ARC), under the Clinical Services Administration is the primary entry-point for adults (21 years and older), seeking publicly funded treatment for SUD and referrals for other services. The ARC is a walk-in and appointment-based facility which conducts treatment assessments, TB, HIV/HEP-C Testing services, HIV pre and post counseling, linkage and referral to treatment. ARC clinicians conduct Substance Use Disorder (SUD) Assessments and referral to SUD Treatment. In addition, DBH utilizes a Mobile Assessment and Referral Center (MARC) for same day services where they are able to provide the same services as the ARC (conduct TB, HIV/HEP-C testing services, TB and HIV pre and post counseling and referral to treatment such as the TB clinic. Nurse conduct primary health assessment and referral to services as needed.

In FY 2018, the DBH system conducted 6,008 unique client assessments, of which 2,460 (41%) identified heroin as the primary drug of abuse, while another 116 (2%) identified other opiates and synthetics as the primary drug of abuse. Taken together, individuals whose primary SUD problem was either heroin or other opiates constituted 43% (n=2,576) of all assessments conducted in the DBH SUD treatment system.

For FY2018, 52% of these individuals were between the ages of 50 and 69.5 Individuals using opioids were 70% male (n=1,716) and 89% African American (n=2,293). In addition, 16% reported a housing status of “homeless”, another 27% reported “dependent living”, and 56% were living independently. These housing status data serve to further highlight the challenges faced by the District’s opioid users as well as by the public SUD system serving them.

Medication Assisted Treatment, Program Capacity & Demographics

The District’s SUD treatment system is partially bifurcated. DBH certifies “providers” but does not have jurisdiction over private physicians or physician groups. DBH’s treatment and recovery system has 34 certified substance abuse treatment providers. The 34 certified providers operate 61 facilities throughout the city. The District currently has four (4) DBH-certified Opioid
Treatment Programs (OTPs), three of which have Human Care Agreements with the department.

Opioid Treatment Programs (OTPs)

The three DBH-certified methadone OTPs are located in Wards 2, 3, 6, and 8. They have a cumulative capacity of 1825. DBH has contracts with Good Hope Institute, United Planning Organization (UPO), and Partners in Drug Rehabilitation Counseling (PIDARC) to provide publicly funded methadone MAT. All OTPs provide psychosocial interventions either in-house or on a contract basis, per the terms of their certification and as required by District law. Additionally, the District has over 100 Office-Based Opioid Treatment (OBOT) providers and 75 DC prescribers; however, OBOTs are not certified by DBH and therefore are not counted as “providers” above.

Good Hope Institute- Ward 8; 1320 Good Hope Road SE, Washington, DC 20020 (Capacity: 700)
• FY2018 public enrollment: 616
UPO- Ward 6: 1900 Massachusetts Ave, SE Washington, DC 20003 (Capacity: 400)
• FY2018 enrollment: 420
PIDARC- Ward 2 2112 F St. NW, #102 Washington, DC 20037 (Capacity: 725)
• FY2018 enrollment: 716

Enrollment at the three OTPs accepting public pay clients decreased 9.3% from FY2017 to FY2018, from 1932 clients to 1752 clients. These decreases were driven by a significant reduction at Good Hope (from 720 to 616) and PIDARC (from 841 to 716). Enrollment at UPO continued to decline from previous FY2016 - FY2017 period (from 488 to 420). Enrollment at the three contracted OTPs was 59% male in FY2018.

Office-Based Opioid Treatment (OBOTs)

According to SAMHSA and DC DOH, there are 77 office-based opioid treatment (OBOT) locations in the District, spread across all 8 Wards (See map). Seven of the OBOT practitioners are also certified by DC Department of Health Care Finance (DHCF) to provide office-based MAT through Medicaid. As indicated on the map, the Medicaid-certified OBOTs are located in Wards 2, 5, 6, 7, and 8. There are currently no OBOTs accepting Medicaid clients in Wards 1, 3, or 4.

Detoxification & Hospitals

There are 10 hospitals in the District, in Wards 1, 2, 3, 5, & 8. The eight primary hospitals are:
• Children’s National Medical Center (Ward 5) • Georgetown Univ. Hospital (Ward 2)
• George Washington Univ. Hospital (Ward 2) • Howard University Hospital (Ward 1)
• Providence Hospital (Ward 5) • Sibley Memorial Hospital (Ward 3)
• United Medical Center (Ward 8) • Wash. Hospital Center (Ward 5)

In addition, there are two psychiatric hospitals:
• Psychiatric Institute of Washington (PIW) (Ward 3) • St. Elizabeth’s Hospital (Ward 8 and operated by DBH
Only Providence and PIW offers detoxification services, however DBH contracts only with PIW, however, DBH is working to expand the Short-term Medically Monitored Intensive Withdrawal Management services in the community.
Focusing on the growing number of opioid overdoses, in 2017 DOH continued the Heroin Overdose Taskforce. Each month, key stakeholders within the DC government convene to share information regarding current public health and law enforcement efforts related to heroin and other opioids. The stakeholders include members from DOH, as well as the Department of Behavioral Health (DBH), Office of the Chief Medical Examiner (OCME), Office of the Attorney General (OAG), Department of Forensic Sciences (DFS), Fire and EMS Department

(FEMS) and the Metropolitan Police Department (MPD). The Heroin Task Force is, hosted monthly by DOH and focuses on collecting and reporting on epidemiological data and information to address issues; identify processes, systems, interventions and collaborations that will support a system-wide approach to addressing opioid use and misuse.

Charitable Choice

In October of 2002, the District implemented the Drug Treatment Choice Program (DTCP) pursuant to the District of Columbia Choice in Drug Treatment Act of 2000 (D.C. Law 13-146; D.C. Official Code § 7-3001 et seq.); which allowed the consumer the right to choose the treatment provider that would meet the consumers individual needs.

Referrals

DBH finalized new certification standards for all substance use disorder (SUD) treatment and recovery providers in September 2015.
These new standards are designed to:
1) Increase the standard of care and enhance person-centered treatment given by providers
2) Enforce the utilization of ASAM criteria standards with required treatment services by qualified practitioners
3) Support implementation of reimbursable Medicaid services for eligible individuals
4) Align the certification standards with other DBH programs to effectively link and refer clients to the proper level of treatment adhering to;
a. Chapter 63 - ASARS
b. Electronic Health Record (DATA/WITS)
c. DBH assessment and placement criteria based on the American Society of Addiction Medicine (ASAM), and Treatment and Assessment Protocol assessment tool (TAP)
d. Person-Centered Model of care

The Districts identified workforce has increased overtime, however with the new Chapter 63 regulatory standards reinforcing the need for qualified practitioners the SUD Provider network is experience several challenges. The Department of Behavioral Health (DBH) oversees a network of 76 certified behavioral health service providers. DBH conducts numerous trainings for ancillary partners such as police and attorneys through the DBH Training Institute. The District and DBH currently have a shortage of licensed mental health and substance use disorder clinicians. With a rapidly growing consumer-bases and city-wide population growth, the District has a relatively low number of licensed clinicians to serve the clients in treatment and recovery.

The recent change in the District regulation call for Clinical Care Coordination, a licensed or certified Qualified Practitioner who has the overall responsibility for the development and implementation of the client's treatment plan, is responsible for identification, coordination, and monitoring of non-SUD-treatment clinical services, and is identified in the client's treatment plan. In the Districts efforts to address the whole person from a person centered lens are supported by this enhanced requirement for client's continuity of care needs for both M/SUD services across of the Behavioral Health Network.

DBH has developed a no wrong door system of care to ensure that client needs are met and access and referral to treatment is seamless. The Person-centered Cultural diversity strategic framework sets future strategic priorities and directions for in policy and service delivery processes. These polices and services are: integrate cultural and linguistic diversity into planning; monitoring and evaluation n build organizational capacity to work within culturally diverse communities, and provide culturally and linguistically responsive services and programs in behavioral health services. A very important part of this framework is planning for the future of DBH. The training institute has been an intricate part of the implementation of the Person-centered training, .the development of assessment practice standards, and trauma informed care system standards.

The District has two formal agreements to improve referral process, thus ensuring individuals are assessed and placed in the appropriate the treatment modality of care based on individual need. Specifically the District is in the process of implementing an electronic system to enhance medical necessity, access and authorization processes for SUD treatment. This effort includes updating the current E.H.R. system, to include a new Recovery module.

Patient Records

DBH currently maintains consumer health records within an electronic health records (EHR) system, which contains all PHI information for consumers who access the network of providers. DBH requires that all behavioral health records be maintained in a manner that complies with applicable state and Federal (42 CFR Part 2) HIPPA regulations, accreditation standards, professional practice standards, and legal standards. Furthermore, the department provides ongoing training for staff and community partners regarding client confidentiality and requirements, training on responding to requests asking for acknowledgement of the presence of client. On an ongoing basis the Office of the General Council and the Transformation Systems Administration update Departmental regulations, policies and procedures which regulate and control access to records, under current Federal HIPAA laws and policies. Specifically, the Records Management Division,manages the medical records program and maintains official medical records for DBH all consumers and clients; oversees the development, implementation, maintenance of, and adherence to DBH policies and procedures covering the privacy of, and access to, patient health information in compliance with federal and state laws and the provider's information privacy practices. While, the Network Development and Community based Services provide ongoing site technical assistance, workgroups, small committees, workshops and WebEx demonstrations.

Syringe Service Programs

Utilizing the Human Care Agreement process (State level contracting vehicle the District ensures that SABG funds are NOT expended to provide individuals with hypodermic needles or syringes (42 U.S.C.§ 300x-31(a)(1)F). The Department's SUD network refers client to DOH's HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA) needle exchange program in the District as a collaborative effort to develop the continuum of care model to support treatment and recovery. DOH/HAHSTA's policies and procedures have been developed for use by approved needle exchange programs (NEX) as guidelines for People Who Inject Drugs (PWID). Development and implementation of these policies and procedures provides direction to organizations engaged in hypodermic needle and syringe exchange in the District, and supports compliance with regulations governing the operation of such programs.

Naloxone-Related Efforts
Naloxone is administered in the community and through DC Fire and EMS Department (FEMS). Currently, the District's community naloxone distribution system is handled primarily by DOH. DOH has also worked with DHCF to ensure open prescription for naloxone (removing prior authorization) under both fee-for-service Medicaid and all three of the District's Medicaid Managed Care Organizations (MCOs). DBH's prevention branch is beginning to work much more closely with DOH, given the importance of naloxone in avoiding fatal opioid overdoses.
Community-Level Naloxone Efforts
In an effort to curb the number of deaths due to opioid overdoses, HAHSTA established a Naloxone Pilot Program in late FY16. Partner agencies distribute Naloxone to bystanders and other community members in particular "hotspots" or areas where overdoses have frequently occurred. Naloxone is an FDA- approved medication that temporarily reverses the effects of opioids such as heroin, methadone and morphine. It can be administered via various modes: intravenously, intraosseously, intrasmuscularly, and intranasally. The DOH procures Narcan for its partner agencies, Family and Medical Counseling Service (FMCS) and HIPS, as it can be easily administered by laypersons intranasally. It works relatively quickly, is painless, requires no assembly, contains pre-measured dose (reduces medication dosing errors), and avoids the use of needles.

In FY18, HAHSTA expended approximately $235,000 in the purchasing of 3,133 Narcan kits for distribution in the community. HAHSTA provided 4,005 Narcan kits to both partner agencies (a sum of Narcan kits were ordered and remaining from late FY '17) of which 3,902 were distributed, and over 3,100 clients were served. Partner agencies reported 734 overdoses where narcan was administered and approximately 85% (N=625) were successfully reversed during FY18. In terms of training District residents on identifying overdoses and administering naloxone, DC Health held 10 trainings and trained 172 unique individuals in FY 18. HAHSTA has seen an increase in demand for Narcan kits to date in FY19 from multiple governmental and community-based agencies. Five additional community and governmental agencies were added to HAHSTA's portfolio of Naloxone providers in FY 2019. With increased funding from the DC DBH in FY 2019, HAHSTA significantly enhanced its distribution efforts, with 21,735 Narcan kits circulating the community. In the first quarter of FY 19, community-based organizations reported a total of 86 overdoses where narcan had been administered and 83 successful reversals (97%).Group Homes
Professional Development

Through the Training Institute Division and the collaborative efforts from each administration, District wide trainings are offered on an on-going basis. The administrations collaborate to discuss information regarding formularies of evidence based practices, recommend trainings, provide technical assistance/guidance, and construct policy according to best practices for substance abuse standards.

The Department requires the use of EBP's to support the delivery of substance use disorder prevention and treatment services. DBH has implemented training opportunities to support the development, improvement and sustainability of methods related to evidence-based practices. Under ASARS, Chapter 63 regulations all Substance Abuse treatment and recovery programs are required to be certified through DBH's Certification Division under the Accountability Administration, including private, non-contracted substance abuse treatment and recovery programs. EBP's, governed by Chapter 63, are required by the Department in accordance with the regulations. Implementation of EBP's are reinforced through both education opportunities for providers, as well as the service review process implemented by the Accountability Administration. All EBP's qualifying of Medicaid funding are required to be registered or approved by SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP).

Regulatory standards need to be met as reporting requirements for DBH certification standards. The Systems Transformation Administration is responsible for ensuring there is an EHR in place to collect the data and report TEDS/NOMS. While, DBH's Training Institute Division provides a comprehensive list of trainings in accordance with recommendations and needs to address new/emerging trends.

The Department has developed and implemented additional trainings and workshops designed to increase employee understanding of recovery support services. The Department contracted with a vendor to develop a curriculum for which providers, staff and MH/SUD peers could participate. Trainings have been and will continue to be established to address state office staff across departments and divisions. The goal is to increase staff knowledge of develop innovative programs and initiatives to support the delivery of quality services. Trainings implemented to date supports integration efforts, between internal, co-located and external staff under M/SUD.

The "Executive Dashboard," (a daily data report which summarizes key critical agency data points), will beis accessible daily for Department staff, particularly management to review. Specifically, the dashboard will allow management to make data-driven decisions and related recommendations for improvements such as trainings, based on the Departments overall performance. This information will further enhance the department's ability to ensure quality services are provided DC Residents eligible for DBH services.

DBH has a robust Consumer and Family Affairs Administration that is headed by an individual with lived experience. This division has staff

that are persons in recovery/peers/family members and they are involved in planning, implementation, and evaluation of the impact of the state's mental health/SUD system. The Consumer and Family Affairs Administration also has a training program for certified peer specialist. They do outreach across the city to enlist the voices of families and consumers in everything that DBH does.

The Behavioral Health Council has representation from individuals and providers from diverse racial, ethnic, and LGBTQ populations as well as family members, peers in recovery, consumers (young adults and adults), SUD and mental health providers, and family run organization reps.

Environmental Factors and Plan

11. Quality Improvement Plan- Requested

Narrative Question

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

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2018-FFY 2019? (•) Yes ( ) No

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

The Department of Behavioral Health (DBH) has adopted a quality management process, Continuous Quality Improvement (CQI), to address the need for improving the quality behavioral health services District-wide. The Department has developed and continues to revamp a process for developing a structured approach for identifying gaps and analyzing and improving service delivery, including through the use of a quality electronic health record (EHR) system. The Department uses the DATA-WITs system, an open -source practice management system, to help the agency to capture data efficiently and effectively.

Several internal and external workgroups provide data-driven reports that inform the continuous quality improvement process (CQI). DBH's CQI process also promotes and encourages a Total Quality Management (TQM) environment. The TQM philosophy supports the development of strategies and techniques, which assist in the exploration of how the department can and will continue restructuring an integrative behavioral system, city-wide. These efforts will further inform how the Department will continue promoting growth and sustainability, build partnerships, and meaningful collaborations with community agencies. Application of data-driven decisions will further enable the agency to thrive in a changing healthcare environment and provide personal job satisfaction for internal and external staff by allowing for their input, creativity, and efficiency in the work that they do.

Primarily Quality Improvement (QI) activities reside within the DBH Accountability Administration (AA), Program Integrity Division, which includes both the Accountability Branch and the Community Services Review Branch, and the Systems Transformation Administration, which includes the Data and Performance Management (DPM) Division. The Data and Performance Management Division works with DBH departments, both those that provide clinical services directly and those that liaise with contracted providers, to ensure data quality and performance improvement on priority metrics. DPM creates dashboards that give leadership access to meaningful information that allows for data-driven decisions to be made. DPM is implementing a project management process that will ensure key initiatives are carried out.
The Information Technology team provides and maintains high-quality hardware and software applications that support the provision and monitoring of consumer and client services. In terms of capturing data for the substance use services, the Department uses the system DATA-WITS, which supports DBH in the development and production of data to inform the decision-making process.

The DBH Accountability Branch is responsible for performing continuous reviews of provider service delivery in multiple ways. The branch performs a yearly claims audit that is used to assess whether services are being delivered according to regulation and policy promulgated by DBH. While this is largely a compliance review, the data collected is also important for CQI activities. For instance, audits often determine that a given agency or agencies are not performing timely assessments or treatment planning. DBH issues Corrective Action Plans based on audit results that direct providers to address these issues. DBH works closely with providers to ensure the delivery of quality services to their consumers. As part of that effort, DBH assesses community behavioral health best practices and compliance with DBH policy requirements within our system. These data sources allow DBH to assess provider performance. Program Integrity also holds quarterly Quality Council meetings that include all providers as participants. These meetings allow providers to communicate concerns about quality issues affecting the system, as well as for DBH to inform providers of issues of which they should be aware.

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12. Trauma - Requested

Narrative Question

Trauma [57] is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective M/SUD service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated M/SUD problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with. These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive M/SUD care. States should work with these communities to identify interventions that best meet the needs of these residents.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing ?business as usual.? These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[58] paper.

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

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

1. Does the state have a plan or policy for M/SUD providers that guide how they will address individuals with trauma-related issues? (●) Yes ( ) No

2. Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers? (●) Yes ( ) No

3. Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care? (●) Yes ( ) No

4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations? (●) Yes ( ) No

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

As part of the screening and assessment process with DBH, whether through the agency's primary assessment site (the DBH-Assessment and Referral Center (ARC)), the contracted court system assessment center, the contracted detox service providers, the Department of Corrections' (DOC) assessment office, or the HIV-EIS contracted provider, under the auspices of a local Federally Qualified Healthcare Center (FQHC), there is a thorough biopsychosocial assessment conducted on each individual entering our system. This process consists of a GAIN SS for adults, which supports the identification of severity of need for further substance use or mental health challenge assessment. If the need for a more comprehensive assessment is identified, consumers are then assessed using the Treatment Assessment Protocol (TAP), which is a combination of the American Society of Addictions Medicine

Patient Placement Criteria (ASAM-PPC) and the GAIN-I. The TAP includes several trauma assessment questions, which directly correlate to the identified problems and subsequent goals on the individual treatment plan. All individuals receiving District funded substance use treatment services are assessed using the TAP, either at the ARC or one of the two designated detox entry sites into the treatment system. At present, District Providers implement the use of Trauma Recovery and Empowerment Model, Cognitive Behavioral Therapy (CBT), and Cognitive Behavioral Interventions (CBI). Additionally, DBH is reviewing the state regulations for adult substance use services, under Chapter 63 regulations, to include explicit policies to support the use of specific EBP's, including those addressing trauma concerns.

All District funded substance use providers are governed by the agency's Title 22A, Chapter 63 Certification Standard, which speaks to the need for providers to coordinate individualized care for the population seeking services, and for providers to ensure that consumers connect to services based on individualized needs identified in their treatment plans. Also, specific policies incorporate the requirement that individuals are placed in the appropriate level of care (modality) and that treatment interventions and techniques which address trauma are included in the individualized treatment plans.

DBH provides the provider network with training, which includes Integrated Dual Diagnosis Treatment, Patient-Centered Training, and other treatment-related trainings to support trauma-informed care.

The Department has partnered with Child and Family Services (CFSA) the District's child welfare agency to provide trauma-informed care training to the adolescent substance abuse providers. The DC CFSA is in their last year of a five-year federal grant, which was designed to establish and strengthen trauma-informed care as the foundation of serving children and youth in the District's child welfare system. In collaboration with other youth-serving community agencies, CFSA chose the Trauma Systems Therapy (TST) Model. The TST model focuses on (1) a traumatized child or youth who cannot regulate his/her emotional state and (2) a social environment/system of care that cannot help contain this regulation.

National data shows that identified adverse childhood experiences (ACE) have had a negative impact, on youth and adults, with approximately 70 percent of the population having documented ACE experiences. The Department's Office of Prevention is focusing the DC Epidemiological Outcomes Workgroup on collecting and analyzing ACE data to identify early childhood risk and protective factors that can be used to target early preventive interventions. DCEOW representatives include a cross-cutting team of District leaders from the Alcoholic Beverage Regulation Administration, Child and Family Services Administration, Department of Youth Rehabilitation Services, Metropolitan Police Department, Office of the State Superintendent of Education, Department of Health, and the Children and Youth Investment Trust Corporation. This work will set the stage for a renewed look at the risk and protective factor mode, especially in urban areas and culturally diverse populations. As the developers of the Social Immunization Approach to Public Health and Substance Abuse stated in an editorial published in the Journal of the National Medical Association

Overall data on illicit drug use hides the fact that residents of some communities are at higher risk than those living elsewhere. For example, we know there is a substantially higher prevalence of illicit drug use among inner-city residents than among those who reside in suburban or rural areas. These high-risk communities must be explicitly identified to receive priority consideration for drug control resources. The editorial also supported an analysis of epidemiological and census data the zip code level in order to clearly identify affected areas. While ACE is generally considered a tool to assess individual adult trauma, DBH is focusing prevention efforts on universal, selective and indicated strategies that prevent and reduce the effects of trauma in stressful and high risk community environments.

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

Technical Assistance is needed to educate providers on providing services in a trauma informed system of care. DBH Network Development Division will provide ongoing TA to support the implementation of SAMHSA's guidelines after the training.

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13. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[59]

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.[60]
A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or the Health Insurance Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

[59] Journal of Research in Crime and Delinquency: *: Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice.*Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Ren?e L. Binder. **OJJDP Model Programs Guide**
[60] **http://csgjusticecenter.org/mental-health/**

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to M/SUD services? (●) Yes ( ) No

2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, M/SUD provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms? (●) Yes ( ) No

3. Does the state provide cross-trainings for M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD issues involved in the justice system? (●) Yes ( ) No

4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances? (●) Yes ( ) No

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

While Medicaid cannot be used to pay for an individual's health care services while incarcerated (other than inpatient treatment in a community medical facility), people are eligible for Medicaid while incarcerated and can apply/reapply for Medicaid before release. Therefore, when someone is incarcerated, DC implements a provision to suspend rather than terminate Medicaid coverage. This provision allows DC to reinstate benefits if an individual receives inpatient care at a community medical institution while incarcerated, and facilitates more seamless reinstatement of full benefits when an individual is released back into the community.

DBH certifies of 85 providers that treat approximately 35,000 residents for mental health or substance use disorders; eleven providers are dually certified for both SUD and MHRS. DBH ensures that pre-trial providers are competent to assess for both mental health and substance use disorders at the same time, to ensure proper treatment. DBH implements a process that sustains clinical services and maintains an infrastructure within the mental health and substance abuse systems to support integrated pre-trial service delivery. Services provided prior to adjudication and/or sentencing for individuals with mental health and/ or substance use disorders include the following:

The GAIN Short Screener (GAIN SS): The Short Screener, screens to determine the severity of substance abuse. Mental health disorders A positive result initiates a referral for a full assessment using the Treatment Assignment Protocol (TAP).
TAP provides a person with the appropriate assessment for placement into substance abuse treatment. Many Courts will rely on DBH's assessment, which can be incorporated into a court order or probation requirement. With client consent, we release the assessment and drug screens to the court, along with the appropriate referral information.

Court Urgent Care Clinic (CUCC): Individuals receive immediate access to mental health services in the courthouse. CUCC provides screenings and mental health assessments for the Pre-trial Services Agency (PSA). PSA recommends release conditions and makes referrals for mental health services to DBH, contacts CSAs for mental health information, and screens candidates for the Options Program. Individuals who are not currently linked to a CSA and have a history of non-compliance with court dates are referred to the Options Program.

Competency Assessments and Restoration Services: Competency Restoration* occurs on an inpatient or outpatient basis, based upon the profile of the specific need of the client, here in D.C.
* Competency restoration is the process used when an individual charged with a crime is found by a court to be incompetent to stand trial, typically due to an active mental illness or an intellectual disability. A criminal defendant must be restored to competency before the legal process can continue.

In an effort to serve District residents who have become involved with the criminal justice system, substance abuse system, and/or the mental health system, DBH and other District departments responsible for addressing the criminal justice system, have developed, incorporated and implemented recommendations proposed by the Substance Abuse Treatment and Mental Health Services Integration Taskforce (SATMHSIT, 2009-2015). These policies were designed to improve treatment options available to defendants and ex-offenders.

The CUCC specifically implemented the policies to expand their array of services by offering assessments and referrals to substance abuse treatment programs for individuals with substance use disorders. As it relates to juveniles, the Juvenile Behavioral Diversion Program (JBDP) was established as a problem-solving court. To participate in the program, the juvenile or status offender must have an Axis I mental health disorder or be at significant risk of receiving an Axis I diagnosis. The respondent may also have an Axis II developmental disability as long as he or she can participate in the program, but they cannot solely have an Axis II diagnosis. The Program is an intensive non-sanction based program designed to link juveniles and status offenders to, and engage them in, appropriate mental health services and supports in the community to reduce behavioral symptoms that result in contact with the court and to improve the juvenile's functioning in the home, school, and community.

DBH's Training Institute provides learning opportunities to employees, consumers, providers, criminal justice partners, and other partners who support mental health services in the District. The Training Institute mission is to continually strengthen the knowledge, technical skills, and the quality of services and supports through the development of a dynamic, culturally and linguistically responsive, performance-based, and data-driven learning environment. All courses offered through the Training Institute address co-occurring competent applications of service delivery. With the assistance of DBH, the Metropolitan Police Department (MPD) has trained over 1369 officers from various District-area law enforcement agencies since the program's inception in April 2009. Approximately 125 new Crisis Intervention Officers (CIO) are trained every year, including people from other law enforcement agencies in the District, such as the Capitol Police, Protective Services Division, and the Metropolitan Police. In addition to these specially-trained officers, every MPD officer must receive mental health training to learn appropriate techniques to use when responding to calls-for-service involving mentally ill residents.

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

None at this time.

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14. Medication Assisted Treatment - Requested (SABG only)

Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], and 49[4].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate.

SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders? (●) Yes ( ) No

2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly pregnant women? (●) Yes ( ) No

3. Does the state purchase any of the following medication with block grant funds? ( ) Yes (●) No

- **a)** ☐ Methadone
- **b)** ☐ Buprenophine, Buprenorphine/naloxone
- **c)** ☐ Disulfiram
- **d)** ☐ Acamprosate
- **e)** ☐ Naltrexone (oral, IM)
- **f)** ☐ Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately*? (●) Yes ( ) No

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

DBH certifies four (4) medicated assisted treatment (MAT) providers in the District, three of which DBH contracts to provide methadone, while the fourth non-contracted provider has a primary care physician on-site to prescribes suboxone. All MAT providers serve consumers across the eight (8) Wards, delivering opioid replacement therapy (ORT), and counseling services. During the initial client intake process, located at an ARC location, counselors provide educational materials and guidance on the availability of MAT services in the District. Instructional materials include informing the client about his/her rights and supporting the decision to access services based on individual need.

The District continues to develop and implement various marketing tools to educate the community on the use and abuse of opioids and other synthetic drugs. Mediums for communicating information include public services ads (PSA's), handbills, social media, and television and fact sheets. The message targets both access, use, and treatment, such as medication-assisted treatment therapies, related to opioid use. Many of the campaigns focus on a targeted population, to ensure the appropriate message is delivered and received by the audience. Currently, DBH has on-going communications with the provider network, through scheduled monthly provider meetings and or conference calls and monthly meetings specifically for MAT providers. During a planned series of educational outreach efforts, DBH clinical and non-clinical outreach teams, in collaboration with the local Fire and Emergency Services (FEMS), used the Screening, Brief, Intervention, and Referral to Treatment (SBIRT) tool to conduct brief screenings and provide a referral to treatment, including MAT.

In the District, women with children and pregnant women have priority access to treatment. Under the District Court system in the Court Urgent Care Clinic (CUCC), clinicians test for pregnancy, and if positive, link the client to SUD treatment and primary care for the unborn child and mother. In addition, DBH has co-located a Licensed Clinical Social Worker (LICSW) to be the local Mobile Assessor (Social Worker) at the Child and Family Services Administration (CFSA), the District's agency focusing on women's needs for SUD screening and assessment for treatment. Thus, access to SUD treatment for women has increased in that the women can be screened in multiple locations.

DBH requires that all certified MAT providers follow the requirements under SAMHSA, DEA and FDA to ensure that approved medications are prescribed and dispensed appropriately. Providers must be certified through the DBH Accountability Administration, which includes submission of all certifications supporting the Providers application for providing MAT and other control medicated assisted treatment therapies used to treat consumers within the MAT network system.

DBH was awarded the Opioid State Targeted Response (STR) grant to implement the District Opioid Targeted Strategy (DOTS), which addressed all individuals in the District with, or at risk for, Opioid Use Disorders (OUDs). DOTS specifically targeted middle-aged, \African-American males using heroin because local data indicated they are most affected.

Through the STR Program, 985 clients were served. While no new clients received methadone under the STR grant, 882 clients receiving methadone received STR-funded clinical care coordination (CCC) and peer services directly through their OTP. There have been several notable accomplishments of this program. First, individuals receiving MAT had improved access to primary care. Through December 2018, the STR-funded OBOT conducted 553 well exams, performed 773 EKGs, administered 53 vaccines, conducted 622 TB screenings, provided 176 podiatry care visits, and performed either Hep C testing and/or provided Hep C treatment for 595 clients.

Second, in Year 2 of the grant, OTP-based CCCs peers helped 46 individuals who received methadone obtain vital records, 70 obtained food/income benefits (e.g., SNAP), 25 obtained durable medical equipment, 16 obtained health insurance, 12 received utility assistance, 13 obtained a job, 8 obtained permanent housing, 14 obtained temporary housing, 1 obtained a childcare voucher, and 118 received transportation assistance.

Third, 58 individuals received the Connecticut Community for Addiction Recovery (CCAR) training, which included a MAT competency module. And lastly, in December 2018, the DC Hospital Association (DCHA) was awarded a sub-grant to implement an Emergency Department (ED) Induction program in the District. The program will use SBIRT-trained peers in four (4) EDs (MedStar Washington Hospital Center, Howard University Hospital, United Medical Center, and George Washington University Hospital) to screen and refer persons entering the ED who are experiencing an overdose or a reversal of an overdose to the hospital physicians for induction. The program has gone live in United Medical Center, MedStar Washington Hospital Center, and Howard University Hospital. The program is in the startup stages at George Washington Hospital and is positioned to implement in two additional District hospitals.

Forth, for the adult, Opioid Awareness Campaign creative content was finalized during the summer of 2017 and launched in January of 2018. The campaign consisted primarily of guerilla marketing and printed ads posted in targeted areas throughout Wards, 5 7, and 8. The primary message of the campaign was to encourage the use of Naloxone, especially amongst individuals at higher risk of overdose, while also educating District residents on The Good Samaritan Overdose Amendment Act of 2012. After the campaign was developed, it was tested with OUD consumers at the opioid treatment programs (OTPs) and received controversial feedback on the visuals and messaging. To this end, the no-cost-extension has provided the opportunity to continue decreasing incidences of opioid used disorder through refining a more robust and refreshed prevention media campaign that appeals to a broader audience in collaboration with a local radio station.

In September 2018, the District was awarded a State Opioid Response (SOR) grant, known locally as the District of Columbia Opioid Response (DCOR) initiative. Through this grant, the District will build and expand upon the many successes accomplished under the STR grant. Broadly, the DCOR grant is focused on increasing access to medication-assisted treatment (MAT), reducing unmet treatment needs, and reducing opioid overdose-related deaths in DC, through the provision of prevention, treatment, and recovery support services (RSS) to individuals with opioid use disorder (OUD). Through this grant, and the city-wide LIVE. LONG. DC. Strategic Plan, the District is building a model with multiple access points to a coordinated network of treatment and RSS providers that will collaborate around the assessment, stabilization, and ongoing treatment of individuals with OUD.

*Appropriate use is defined as the use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and diversion of controlled substances used in the treatment of substance use disorders, and advocacy with state payers.

**Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.*

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15. Crisis Services - Requested

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful.[61] SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with M/SUD conditions and their families. According to SAMHSA's publication, **Practice Guidelines: Core Elements for Responding to Mental Health Crises**[62],

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

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

[61] **http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848**

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

Please check those that are used in your state:

1. Crisis Prevention and Early Intervention

- **a)** ☑ Wellness Recovery Action Plan (WRAP) Crisis Planning
- **b)** ☑ Psychiatric Advance Directives
- **c)** ☑ Family Engagement
- **d)** ☑ Safety Planning
- **e)** ☐ Peer-Operated Warm Lines
- **f)** ☐ Peer-Run Crisis Respite Programs
- **g)** ☑ Suicide Prevention

2. Crisis Intervention/Stabilization

- **a)** ☐ Assessment/Triage (Living Room Model)
- **b)** ☐ Open Dialogue
- **c)** ☑ Crisis Residential/Respite
- **d)** ☑ Crisis Intervention Team/Law Enforcement
- **e)** ☑ Mobile Crisis Outreach
- **f)** ☑ Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. Post Crisis Intervention/Support

- **a)** ☑ Peer Support/Peer Bridgers
- **b)** ☑ Follow-up Outreach and Support
- **c)** ☐ Family-to-Family Engagement
- **d)** ☑ Connection to care coordination and follow-up clinical care for individuals in crisis
- **e)** ☑ Follow-up crisis engagement with families and involved community members

f) ☑ Recovery community coaches/peer recovery coaches

g) ☑ Recovery community organization

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

As part of the Child Fatality Review Commission Report, DBH has a Key Performance Indicator: Of the individuals referred to the Resiliency Specialist percentage who received bereavement services. Follow up with children and families occurs within the school mental health program after a crisis response.

Effective July 1, 2019, DBH established a 24/7 Community Response Team (CRT), which merges four existing community outreach teams (Homeless Outreach, Mobile Crisis, Pre-Arrest Diversion, and Crisis Outreach Services) to expand access to care.

The Community Response Team will:
• Provide low or no barrier assessment and referral for individuals presenting with developing or untreated mental illness and substance disorders;
• Engage with individuals who are connected to care, but not actively engaged with services due to other barriers, and short term support in resolving the crisis to reduce barriers and increase access to available care.

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

Technical Assistance is needed to provide guidance to the Department of Behavioral health to infuse Care Coordination and Crisis intervention in Behavioral Health settings.

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16. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and 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 recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

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

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

In addition, SAMHSA identified 10 guiding principles of recovery:

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

Please see **SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.**

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations 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 M/SUD treatment system.

Please respond to the following:

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)	Block grant funding of recovery support services.	(●) Yes ( ) No
d)	Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD 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.

DBH certifies 15 recovery support service (RSS) providers who operated a total of 33 facilities. Of the certified RSS providers, nine currently provide District-funded RSS. Also, all but 2 of the certified RSS providers, are DBH-certified SUD treatment providers. There are certified RSS providers in every ward except Wards 3 and 4.

In the District of Columbia, adults with SMI and youth with SED are eligible for the same standard non-clinical as individuals in substance use treatment. Our system of care encourages integrated and coordinated care between substance use and mental health providers. Consumers seeking SUD Recovery services must be admitted to SUD services. Additionally, DBH implemented youth peer certification process that will allow youth peers to support other youth in treatment.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

In the District of Columbia, non-clinical services are provided to an individual by a certified RSS provider to assist him/her in achieving or sustaining recovery from an SUD. There are eight (8) Medicaid billable recovery support services:

1. RECOVERY SUPPORT EVALUATION
2. RECOVERY SUPPORT MANAGEMENT
3. RECOVERY COACHING (Recovery Mentoring & Coaching)
4. RECOVERY SUPPORT SERVICE: LIFE SKILLS SUPPORT SERVICES
5. SPIRITUAL SUPPORT SERVICES
6. EDUCATION SUPPORT SERVICES
7. RECOVERY SOCIAL ACTIVITIES
8. ENVIRONMENTAL STABILITY

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

The 1115 demonstration application submitted to the Centers for Medicaid and Medicaid Services provides Medicaid coverage for Recovery Support Services (RSS), some of which may be provided by peers. RSS is currently funded by local dollars, and the new Medicaid funding may help increase access to this service. DBH is also planning to propose regulation changes that will encourage providers at all levels of care to offer peer and recovery supports services.

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

None at this time.

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Footnotes:

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

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

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

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

Please respond to the following items

1. Does the state's Olmstead plan include :

Housing services provided.	(•) Yes ( ) No
Home and community based services.	(•) Yes ( ) No
Peer support services.	(•) Yes ( ) No
Employment services.	(•) Yes ( ) No

2. Does the state have a plan to transition individuals from hospital to community settings? (•) Yes ( ) No

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

Department of Health Care Finance (DHCF)- The DHCF is the District's Medicaid agency and the primary payer for all long term services and supports (LTSS) the city provides. LTSS can be accessed through a network of five District of Columbia Government agencies and non-profit organizations that will take part in person and family-centered planning and offer information about and recommendations for LTSS. The information will allow people with disabilities, seniors and their families to make choices about the LTSS they need to live with dignity in their homes and be fully included in their communities for as long as possible. The Department of Health Care Finance (https://dhcf.dc.gov/), Department on Disability Services (https://dds.dc.gov/), Department of Behavioral Health (https://dbh.dc.gov/), Department of Human Services (https://dhs.dc.gov/), DC Office on Aging (https://dcoa.dc.gov/) and nonprofit organizations work together to update access to LTSS from different sources. LTSS is related to any persons, of any age or need, who are looking for or planning LTSS. The District spends local and Medicaid dollars on LTSS services and supports based on local and federal annual allocations. D.C. Office on Aging (DCOA)- The DCOA manages the Aging and Disability Resource Center (ADRC) and funds the Senior Service Network. Together these programs consist of more than 20 community-based organizations, operating 37 programs for District residents age 60 and older, people with disabilities (age 1859), and their caregivers. Also, ADRC provides information, coordinates service access, and provides direct social work services to help people move to the community and stay in the community for as long as possible.

Department on Disability Services (DDS)- The DDS oversees and coordinates services for District residents with disabilities through a network of community-based service providers. Within DDS, the Developmental Disabilities Administration (DDA) coordinates person-centered home and community services so each person can live and work in the neighborhood of his or her choice. DDA promotes health, wellness, and high quality of life through service coordination and monitoring, clinical supports, and a robust quality management program.

DDS's Rehabilitation Services Administration (RSA) provides comprehensive, person-centered employment services and supports for people with disabilities, pre-employment and transition services for youth with disabilities, independent living services and services for people with visual impairments.

Office of Disability Rights (ODR) - The ODR assesses and evaluates all District agencies' compliance with the ADA and other disability rights laws, providing informal pre-complaint investigation and dispute resolution. ODR also provides expertise, training, and technical assistance regarding ADA compliance and disability sensitivity and rights training to all D.C. agencies. ODR's current initiatives include efforts to increase access to District-owned and leased facilities, worksites, and community spaces; leading monthly disability-wellness seminars; and managing the District's Mentoring Program for students with disabilities.
The Olmstead Conference is an annual event created by ODR in conjunction with the Department of Behavioral Health and other stakeholders to promote these legislative rulings. DBH consumers have been responsible for producing the conference since 2008. The conference brings together providers who teach consumers about the rights and privileges created by the Olmstead ruling. The information shared by presenters and vendors helps promote the critical aspects of community-based treatment. Shared information allows consumers the necessary knowledge to help guide their treatment. The choices and decisions of providers on received treatment should support a plan to engage consumers with services in the community. The conference has been an enormous success in the dissemination of positive information about community integration.

District of Columbia Olmstead Plan 2017-2020 Since 2007, the District's Office of Disability Rights (ODR) has had the responsibility of developing and submitting the city's Olmstead Compliance Plan to the Mayor for approval. In August 2015, Mayor Muriel Bowser created an Olmstead Working Group charged with making recommendations for revisions to future iterations of the District's Olmstead Plan to support this effort, and to include a broad array of voices in the process. In 2016, during its first full year of existence, the Olmstead Working Group focused its efforts on determining what data the District should track to allow for a comprehensive picture of what transition looks like for individuals leaving institutionalized care and attempting to access long-term services and supports in the District. The Group concentrated its efforts and discussion around data collection that would aid the District in its effort to create a seamless system across agencies that tracks a person's progress toward independence in a meaningful, understandable way. Improving Long-Term Care in the District- The District is engaged in a multi-year effort to design and implement a seamless process for accessing Long Term Services and Supports. The new system embraces the principles of "No Wrong Door" and will ensure that individuals receive accurate information regardless of where they enter the system . Efforts are underway to streamline and simplify the eligibility process. These efforts are supported by federal grants including a three year, No Wrong Door Implementation Grant awarded by the Administration on Community Living and CMS, as well as a major grant awarded to the Department of Health Care Finance to support the procurement of a new, multi-agency case management system. These system improvements will reduce fragmentation, and the time it takes to connect to needed services.

The Olmstead Plan details remaining system challenges and lays out specific action steps in nine (9) strategic areas. That work will take place within a number of on-going District-level initiatives aimed at systems improvement. These include Age-Friendly DC; DHCF's system reform efforts; Employment First State Leadership Mentoring; National Core Indicators work; and DC's No Wrong Door Initiative. Also, an active advocacy community lends its support and oversight, led by groups such as the DC Developmental Disabilities Council (DDC), Project ACTION! the DC State Rehabilitation Council (DC SRC), and the DC Statewide Independent Living Council (SILC).

The 2017 Olmstead Plan- The Olmstead Working Group created a multi-year Plan based on the same nine (9) priority areas that were the focus of the 2016 Plan: 1) A Person-Centered Culture; 2) Community Engagement, Outreach, and Training; 3) Employment; 4) Housing; 5) Intake, Enrollment and Discharge Processes; 6) Medicaid Waiver Management and Systems issues; 7) Quality of Institutional and Community-Based Services, Providers and Workforce; 8) Supporting Children and Youth; and 9) Wellness and Quality of Life.

Each action step in each priority area has a measurable, trackable, and meaningful goal that will lead the District into 2020 with a cross-agency system that is more relatable, comprehensive, and based on an individual's preferences and concrete goals while in transition.

The District's service system for people with disabilities is comprised of multiple government agencies, public and private institutions that provide residential care, as well as local organizations that receive District and federal funds to provide home- and community-based services.

Department of Behavioral Health (DBH) DBH provides prevention, screening and assessment, intervention, and treatment and recovery services and supports for children, youth, and adults with mental health and substance use disorders. Services include emergency psychiatric care, residential services, and community-based outpatient care. DBH also operates Saint Elizabeths Hospital, which is the District's public inpatient psychiatric facility.

Department of Health (DOH), the DOH Health and Intermediate Care Facility Divisions, administer all District and federal laws and, regulations governing the licensure, certification, and regulation of all health care facilities in the District of Columbia. In this role, Health Regulation and Licensing Administration (HRLA) staff inspect health care facilities and providers who participate in the Medicare and Medicaid programs, certified per District and federal laws, respond to consumer and self-reported facility incidents and/or complaints, and conduct investigations, if indicated. When necessary, HRLA takes enforcement actions to compel facilities,

providers, and suppliers to come into compliance with District and Federal law. DHCF is the District's Medicaid agency and the primary payer for all long term services and supports the city provides. In fiscal year 2016, the District spent a total of $796 million in Medicaid funds on these services; $241 million (or 30%) were local dollars. These funds pay for care in institutional settings including nursing facilities and Intermediate Care Facilities for Individuals with Intellectual and Developmental Disabilities (ICF/IDDs), as well as a variety of home and community-based services (HCBS), described below. Approximately 44% of total Medicaid funds spent on LTSS were spent on institutional care, while 56% were spent on home and community-based services.

Department of Human Services (DHS) Across its extensive range of programming, DHS routinely serves people with disabilities. For example, in fiscal year 2014, approximately 17% of applicants were assessed as likely to have a mental disorder of some magnitude, and 4% to have a learning disability in income-based programs such as TANF, SNAP, and Medicaid. In the homeless services program, 40% of singles and 16% of adult heads of families entering shelters were assessed by DHS to have a disability in at least one of eight categories. In the Adult Protective Services program -- which investigates reports of abuse, neglect, exploitation and self-neglect, and provides temporary services and supports in some founded cases -- an estimated 45% of those served were assessed to have a disability.

D.C. Office on Aging (DCOA) DCOA manages the Aging and Disability Resource Center (ADRC) and funds the Senior Service Network, which together consist of more than 20 community-based organizations, operating 37 programs for District residents age 60 and older, people with disabilities (age 18-59), and their caregivers. Also, ADRC provides information, coordinates service access, and provides direct social work services to help people move to the community and stay in the community for as long as possible. In fiscal year 2015, the ADRC served 11,290 people, 9.38% of whom were 18 to 59 years old, living with a disability. The remaining individuals served by ADRC are people age 60 and older who may also have a disability.

Department on Disability Services (DDS) DDS oversees and coordinates services for District residents with disabilities through a network of community-based, service providers. Within DDS, the Developmental Disabilities Administration (DDA) coordinates person-centered home and community services so each person can live and work in the neighborhood of his or her choosing. DDA promotes health, wellness, and high quality of life through service coordination and monitoring, clinical supports, and a robust quality management program. In fiscal year 2016, DDA served 2,363 people. DDS's Rehabilitation Services Administration (RSA) provides comprehensive, person-centered employment services and supports for people with disabilities, pre-employment and transition services for youth with disabilities, independent living services and services for people with visual impairments. In fiscal year 2016 RSA served 7,309 people.

Office of Disability Rights (ODR) ODR assesses and evaluates all District agencies' compliance with the ADA and other disability rights laws, providing informal pre-complaint investigation and dispute resolution. ODR also provides expertise, training, and technical assistance regarding ADA compliance and disability sensitivity and rights training to all DC agencies. ODR's current initiatives include efforts to increase access to District-owned and leased facilities, worksites and community spaces; leading monthly disability-wellness seminars and managing the District's Mentoring Program for students with disabilities.
Office of the State Superintendent for Education (OSSE) The office of the State Superintendent of Education (OSSE) is the District's state education agency. OSSE is responsible for ensuring that all education-related public agencies identify and evaluate children who may have a disability and provide an education that meets the children's individualized needs alongside peers without disabilities to the maximum extent appropriate. OSSE also has oversight of nonpublic special education schools -- the most restrictive educational placements for children with disabilities. In fiscal year 2015, 12,173 children with qualifying disabilities ages 3- 21 were served. Also, OSSE oversaw IDEA Part C early intervention services for approximately 700 infants and toddlers. Finally, OSSE operated hundreds of buses that traveled 34,000 miles per day to transport more than 3,000 students with disabilities to their schools across the region.

Other Government Agencies
Many other agencies in the District of Columbia serve and support people with disabilities. In doing so, they interface on a regular basis with the agencies listed above. These other government agencies include:
o The DC Housing Authority (DCHA) (Independent agency)
o The DC Public Libraries (DCPL)
o The DC Public Schools (DCPS)
o The Department of Child and Family Services (CFSA)
o The Department of Corrections (DOC)
o The Department of Housing and Community Development (DHCD)
o The Department of Employment Services (DOES)
o The Department of Parks and Recreation (DPR)
o The Department of Youth Rehabilitation Services (DYRS)
o DC Department of Transportation (DDOT)

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

None at this time.

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Footnotes:

Environmental Factors and Plan

18. Children and Adolescents M/SUD Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG 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 condition 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.[63]. 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.[64]. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death.[65].

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[66]. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on 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 child, youth and young adult functioning in home, school, and community. 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.[67].

According to data from the 2015 Report to Congress[68] on systems of care, services:

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

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

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

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

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

[64]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.

[65]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.

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

[67]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**

[68] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

Please respond to the following items:

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

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

b) The recovery and 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) Juvenile justice? (●) Yes ( ) No

c) 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 misuse 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

6. Describe how the state provide 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 Adolescent Substance Abuse Treatment Expansion Program (ASTEP) is the District of Columbia's adolescent substance abuse treatment. ASTEP has made substance abuse treatment more accessible by giving adolescents, as well as their families and caregivers, the ability to go directly to any ASTEP treatment program for a substance abuse assessment. Every adolescent accessing substance abuse treatment through ASTEP will be screened for indicators of a mental health disorder. Adolescents can choose the program that best fits their lives; whether the program they choose is closest to home, offers convenient hours, or provides recovery support services to help them maintain sobriety. DBH was awarded the State Youth Treatment grant from SAMHSA to enhance co-occurring treatment within the adolescent treatment network. The Evidence-based practice selected to implement the SYT Services in our jurisdiction is the Adolescent –Community Rehabilitation Approach (A-CRA). The A-CRA model incorporates primary care into the treatment modality as well as the various other family and community supports. This initiative has built capacity within the network as well as the workforce in our adolescent system. In FY17 and continuing into FY18 DBH is expanding these services to the Transitional Aged Youth (TAY) in our Adult Substance Abuse Rehabilitation Services (ASARS) programs, which is Medicaid reimbursable.

Currently, DBH has a Memorandum of Understanding (MOU) between DBH and the Child and Family Services Agency (CFSA), the public child welfare agency in the District of Columbia responsible for protecting child victims, and those at risk of abuse and neglect and assisting their families. CFSA personnel conducts screenings on selected cohorts of youth and adults with child

• residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).
63Centers for Disease Control and Prevention (2013). Mental Health Surveillance among Children? United States, 2005-2011. MMWR 62(2). 64Kessler, 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. 65Centers 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. 66The National Center on Addiction and Substance Abuse at Columbia University. (June 2011). Adolescent Substance Abuse: America's #1 Public Health Problem. 67Department 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-ProgramEvaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM 68 http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf Welfare involvement using the Global Assessment of Individual Needs Short Screener (GAIN-SS). For positive screening results, an electronic referral is made to the appropriate SUD treatment provider for a full assessment and, corresponding, treatment services as clinically appropriate.

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

None at this time.

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

None at this time.

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Footnotes:

Environmental Factors and Plan

19. Suicide Prevention - Required for MHBG

Narrative Question

Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies 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 in the last 2 years? ○ Yes ◉ No

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

Access HelpLine Division (AHL)- This Division is located within the Clinical Services Administration. One of the AHL roles is to provide telephonic suicide prevention and other counseling as appropriate. The AHL responds to incoming suicide and related calls on behalf of the: 1) Department of Behavioral Health, and 2) Washington Metropolitan Area Transit Authority.

Systems Transformation Administration- During 2017, DBH developed and published a Suicide Prevention and Intervention Policy. As DBH goes through its regular reaccreditation process for its Access HelpLine to operate as a National Suicide Prevention Lifeline, DBH is reviewing this policy, which would help to lay the foundation for the development of the Department of Behavioral Health Suicide Prevention and Intervention Plan.

As well, DC's school mental health initiative provides suicide prevention in the form of two evidence-based programs. Signs of Suicide is a program for middle and high school students that involves screening and classroom based prevention sessions. As well, QPR, Question Persuade and Refer, focuses on how to intervene with someone who may be exhibiting sign of suicide. There is also a program for elementary students, Let's Talk, which focuses more on risk factors that can be precursors of suicidality, such as bullying.

3. Have you incorporated any strategies supportive of Zero Suicide? ○ Yes ◉ No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? ○ Yes ◉ No

5. Have you begun any targeted or statewide initiatives since the FFY 2018-FFY 2019 plan was submitted? ◉ Yes ○ No

If so, please describe the population targeted.

This law requires the Office of the State Superintendent for Education (OSSE) to adopt a rule requiring all District teachers and principals in public and charter schools to undergo training on suicide prevention, intervention, and prevention every 2 years. It also requires OSSE to develop and publish online written guidance to assist local education agencies (LEAs) in developing policies and procedures for handling various aspects of student mental and behavioral health. OSSE must examine and evaluate its guidance every 5 years, at a minimum, and notify LEAs within 30 days of updating the guidance. The law also requires OSSE to establish and implement a pilot program to collect school climate data (data regarding engagement, safety, and environment) through school climate surveys, and report school climate data to the Mayor and Council annually.

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

The Department of Behavioral Health (DBH) has developed a Suicide Prevention and Intervention Guidelines Policy. DBH would like to seek technical assistance related to developing a Suicide Prevention and Intervention Plan.

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Footnotes:

Environmental Factors and Plan

20. Support of State Partners - Required for MHBG

Narrative Question

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

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with 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 target risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of homeland security/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 conditions 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.

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: 1) Early Childhood Innovative Network (ECIN) that is part of the Children's National Health System to develop new strategies to support and improve services in child development centers and schools; 2) D.C. SEED a SAMHSA grant awarded to DBH that focuses on the system of care for children age 0-6 who are at risk of and/or experiencing serious emotional disturbances which also includes community partners; and 3) Office of the State Superintendent of Education (OSSE) continues to include DBH and other agencies in various initiatives such as the State Early Childhood Coordinating Council work groups (Data Committee and Health and Well Being Sub-Committee) and the Quality Improvement Network (QIN) that focuses on building high quality, comprehensive early childhood development and family engagement services for infants and toddlers and OSSE was awarded this year a Pre-School Development Grant and DBH has received funding from OSSE to implement an expansion of the early childhood mental health consultation program, Healthy Futures.

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 Disabilites Education Act.

The Department of Behavioral Health (DBH) coordinates services through interagency partnerships, its provider network, and other community-based programs. The Department maximizes the efficiency, effectiveness, quality and cost-effectiveness of services and programs through both buyer and seller relationships. DBH provides its consumers/clients a variety of behavioral health treatment services and supports that allows them to move appropriately through inpatient, residential and community-based options. This may also include opportunities such as job training, employment, and housing.
Also, DBH works closely with the Office of the State Superintendent of Education on matters related to the Individuals with

Disabilities Education Act and with the Project AWARE grant for improving the provision of school mental health services.

Also, DBH works closely with the Office of the State Superintendent of Education on matters related to the Individuals with Disabilities Education Act.

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

There are no technical assistance needs related to this section at this time.

Footnotes:

Environmental Factors and Plan

21. State Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application- Required for MHBG

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 meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC).SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created **Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.**[69]

Planning Councils are required by statute to review state plans and implementation 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 an advocate for individuals with M/SUD problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

[69] **https://www.samhsa.gov/sites/default/files/manual-planning-council-best-practices-2014.pdf**

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

1. How was the Council involved in the development and review of the state plan and report? Please attach supporting documentation (meeting minutes, letters of support, etc.) using the upload option at the bottom of this page.

a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery 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. In the latter role DBH: 1) operates four (4) community prevention centers each serving two (2) of the 8 District wards; 2) provides services and contracts with community providers for substance use disorder (SUD) services and supports; 3) assess and refer adults seeking treatment for SUD to appropriate services; 4) the Mobile Assessment and Referral Center (MARC) visits communities throughout the District to conduct assessment, referral, and HEP-C and HIV testing; 5) annual prevention symposium; 6) adults, young adults and youth substance youth campaigns (marijuana use, synthetic drug use, opioid use); and 7) recovery coaching training.

Launched in 2018, LIVE. LONG. DC., the District's Strategic Plan to Reduce Opioid Use, Misuse, and Related Deaths, will the foundation for a city-wide effort to ensure equitable and timely access to high-quality substance use disorder treatment and RSS through a network of treatment services to meet demand consistent with the criteria of the American Society of Addiction Medicine; educate District residents and key stakeholders on the risk of opioid use disorder (OUD) and effective prevention and treatment; engage health professionals and organizations in the prevention and early intervention of substance use disorder among District residents; support the awareness and availability of, and access to, harm reduction services in the District of Columbia consistent with evolving best and promising practices; develop and implement a shared vision between the District's justice and public health agencies to address the needs of individuals who come in contact with the criminal justice system; and prepare for program sustainability through evaluation, planning, and performance monitoring and training. Further, the Mayor of the District of Columbia, Muriel Bowser, participates with the leadership of Maryland and Virginia to address the regional opioid crisis.

Also, the District has an Epidemiological Outcomes Workgroup (DC EOW).

b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work? (●) Yes ( ) No

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)? (●) Yes ( ) No

3. 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 overall goals of the DBH/BHPC is to advise the Department of Behavioral Health as follows:
1. To ensure that individuals in need of mental health and/or substance use disorder services have access to services;
2. To ensure that consumer and family directed services and supports for the prevention and treatment of mental health and substance use disorders maintain a focus on recovery and resilience;
3. To advocate for District residents with serious emotional disturbances, mental health issues, and substance use disorders;
4. To support the integration of mental and substance use disorder prevention, treatment and recovery services and supports into overall health services;
5. To reduce disparities in the prevention and treatment of mental health and substance use disorders;
6. To strengthen the coordination and collaboration with relevant state and community organizations in order to develop systems of care; and
7. To provide input for the development of the SAMHSA Mental Health and Substance Abuse Block Grants.
The DBH/BHPC has achieved this primarily by sharing information, inviting relevant agency presentations and participation, and whenever asked or invited to relevant Departmental endeavors.

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

Technical assistance is needed to fulfill the federal mandate to monitor, review, and evaluate at least once each year the allocation and adequacy of mental health and substance use disorder services within the District, and use the findings to review the Block Grant Plans and make recommendations.

The Behavioral Health Planning Council would benefit from Technical Assistance focused on participatory-based discussions and input concentrating on continuous improvement and training to develop its relationship to integrated planning in Citywide councils and work groups.

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.[70]

[70]There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

DISTRICT OF COLUMBIA
Behavioral Health Planning Council

August 19, 2019

Barbara J. Bazron, Ph.D.
Director, Department of Behavioral Health
64 New York Avenue, NE, 3rd Floor
Washington, DC 20002

Dear Dr. Bazron:

I am submitting this letter on behalf of the District of Columbia Department of Behavioral Health (DBH) Behavioral Health Council (BHPC) to convey our general support of the District of Columbia FY 20/21 Mental Health/Substance Abuse Block Grant Application (MHBG). However, we believe that there are long-standing concerns which need to be addressed and wish to provide input on those issues.

D.C. DBH View of Departments of Mental Health/ Substance Use Initiatives, Programs, and Services

Our Council believes that DBH's initiatives, programs, and services as a whole are generally sound and indicate noble intentions. However, the implementation strategies continue to be problematic and need attention.

We strongly support the Department's: 1115 demonstration; Expansion of the Community Response Team; Expansion of Children's Services through the School-Based Mental Health programs and community supports; Expansion of Children's Services through the enhanced School-Based Mental Health programs and community supports; the Behavioral Health Needs Assessment and certainly Technical Assistance to support this Behavioral Health Planning Council.

We believe that any initiatives specifically funded by the Block Grant, should: 1) directly benefit children and youth with serious emotional disturbances (SED) and or comorbidity and their families; as well as 2) adults with serious mental illness (SMI),and or Substance use disorders; 3) be innovative and use evidence-based, best and/or promising practices; 4) identify measurable results; 5) describe consumer outcomes; 6) are monitored and evaluated and 7) address the serious shortage of qualified, culturally competent providers. These beliefs guide our Council's deliberations, activities, and participation in DBH and other planning initiatives, as we review and critique the Department's performance throughout the year.

DBH Noteworthy Initiatives

Several noteworthy DBH initiatives are department-wide and address the adult and child systems of care and represent the continuity of successful endeavors. These include, but are not limited to the efforts that follow:

Departmental Initiatives
The system-wide noteworthy initiatives include:
1) Citywide conferences such as the annual Olmstead Conference held in collaboration with the D.C. Office of Disability Rights; The DBH 2019 Recovery Conference and Live Long Community Conversations,
(2) Consumer-oriented initiatives such as the Peer Specialist Certification program producing Peer Transition Specialists who assist persons leaving the hospital with community reintegration; the funding of consumer-run organizations to provide advocacy, obtain consumer feedback, provide training and outreach to consumers. Also, consumer training enabled persons to create and operate a self-help center,
(3) Expansion of the Crisis Intervention Collaborative so that not only police officers are trained to interact positively with persons with mental illnesses, but training is also provided on this initiative to 911 call takers, dispatchers, and coordinators, and
4) Most importantly, the Department has remained out of Court Sanctions and Oversight.

Adult System: The adult system of care noteworthy initiatives include: 1) the work of the Integrated Care Division on behalf or individuals leaving the hospital and/or in the community who require intensive care management to remain in the community; 2) the Mobile Crisis Services Homicide Survivor Response Project in collaboration with the Office of Victim Services and the Police Department that will ensure the availability of mental health assistance for homicide survivors; and 3) creating a Quality Improvement Plan for Assertive Community Treatment (ACT) services, including conducting fidelity assessments.

Child System: The child system of care noteworthy initiatives include: 1) the Early Childhood Mental Health Consultation Project that focuses on child and family-centered, and program consultation, which received some funding from the FY 2010 Mental Health Block Grant; 2) establishment of the Parent-Infant Early Childhood Enhancement Program (P.I.E.C.E.) that primarily serves children age 5 and under: 3) expansion of the Primary Project that serves children with mild school adjustment issues in kindergarten through first grade,
4) implementation of the Transition-Age Youth, Development Project that adopted the Transition to Independence Process (TIP) model, an evidence-based practice, funded by FY' 2009 Mental Health Block Grant funds, and5) Implementation of Capital CARES (Citywide Approach Reduce Risk for And Eliminate Youth Suicide) grant that focuses on preventing suicide behaviors among all District youth.

Status of Concerns in the FY' 20-21 Mental Health and Substance Use Block Grant

Some of the concerns our Council raised related to the FY 20-21- Mental Health and Substance Health Block Grant are as follows:

1. A deep concern that our members, the Planning and Accountability Committee specifically, and the consumer community generally, were not involved in the pre-planning of this Block Grant Application as early as practical for a volunteer organization. Family and consumer-run organizations (regardless of contract status) need to be involved in the pre-planning process, so the needs of the whole community are heard, understood, and incorporated into any planning process and the resultant policies and services. The recent administration changes indicate that this concern will be addressed and ameliorated.

2. There appear to be some gaps in services as outlined in the MHGB application. A major concern centered on the heavy emphasis on opioids and opioid treatment policies. The council is concerned that this disproportionate funding of substance use may have the unintended consequence of decreasing the much-needed funding for mental health services and attention.

3. The Planning and Accountability Committee believed that there was a lack of emphasis on the needs of youth and young adults with ESMIs and/or substance use disorders.

4. The most important unmet service needs or critical gaps in the adult service systems were identified as:

- Still cumbersome access of consumers and families who are not skilled technology users or who lack access to technology
- Hours of operation for many services are often 9-5 and absent during holidays or weekends.
- High turnover of providers serving both the children and adult population
- No easily accessible reports to public about complaints, sanctions, etc., of service providers, including hospitals.
- Satisfaction survey instruments too cumbersome, and delayed with no evidence of the influence of the results.
- Lack of coordination, resource sharing, and addressing of duplication of services with the private sector.
- Too many ombudsmen who appear to have overlapping, duplicate missions which confuse consumers, family members, and the general public.

5. Monitoring of DC CSA system: Our Council's concerns included the process for addressing issues when the consumer expresses dissatisfaction with the new provider and the types of post-transfer variables that might be assessed that signal a red flag and those that indicate positive adjustment.

6. Transition Age Youth and Older Adults: Our Council has long believed that services for transition-age youth and older adults represent two (2) major service system gaps due primarily to the lack of a conceptual framework that addresses the service needs of these populations.

8. Housing for Mental Health Substance Use Consumers: Our Council's primary concern was how the DBH housing initiatives and other housing initiatives in the District come together in a

way that expands the housing options for mental health consumers and other disability categories.

9. Older Adults: There appears to have been no activities during FY 2018 that would move DBH closer to articulating a service strategy for older adults. Particularly those with dual diagnoses. Our Council would like to reiterate the questions that were raised for many years. Some may have been addressed, but the data has not been shared with the Council, and the information is not clear to the community at large.

Some of the questions are:

- What is currently known about older adults?
- How many are in the system?
- Where are they in the system?
- What unique service needs do they represent?
- What services do they receive?
- What is the relationship between the services they need and those they receive?
- What public and private community resources are available to assist DBH in addressing their service needs?
- What partnerships can DBH form related to avail resources for these populations?
- How do other states address the service needs of these populations?
- What resources will be identified to implement the planned service strategies for these populations?

Our Council looks forward to continuing to work with DBH programs to improve the delivery of Mental Health and Substance Use services for District residents. We welcome your leadership and look forward to a long and productive tenure.

Sincerely,

Senora D. Simpson

(Electronically Signed)
Senora D. Simpson PT, Dr. PH
Behavioral Health Planning Council Chair
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GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF BEHAVIORAL HEALTH

Department of Behavioral Health Behavioral Health Planning Council (BHPC)
Regularly Scheduled Meeting
Friday, November 30, 2018 10:00am-12:00pm
64 New York Avenue NW Washington DC 20002

MINUTES

Meeting Participants:

The in-person participants: Senora Simpson, Effie Smith, Jocelyn Route, James Wotring, Senior Deputy Director, Tonia Gore, Elizabeth Maldorado, Nicole Gilbert, Harry Willis, Mark LeVota, Esther Ford, Maurice Gibson, Sabrina Slater, Jaclyn Verner, Cheryl Doby-Copeland, Jackie Richardson, Shandra Wilkerson, Jennifer Cannistra, Charles Gervin, Tia Marie Brumsted, Donna Flenory, Jenise Jo Patterson, Michael Grier

Call to Order, Chair Department of Behavioral Health (DBH) Behavioral Health Planning Council (BHPC)

The BHPC was called to order by the Chair, Senora Simpson at 10:05 am. A quorum was ascertained by roll call.

Agenda

Motion to approve agenda Senora Simpson, Seconded Tonia Gore

Minutes

Motion to approve minutes seconded Senora Simpson, Seconded Mark Lavota

Old Business

I. 5K FEP Project presented by Jocelyn Route

Early Episode Psychosis Project the presentation was opened briefly for suggestions and recommendations, after a brief dialogue members where moved to present further comments and recommendations to Jocelyn Route via email

II. Bylaw revision was made on November 30, 2018 by a majority vote. (see attached)

To place 4 standing committees and 1 executive committee with the previous language of original committees.

Motion to accept Bylaw Amendment Tonia Gore; all in favor none opposed

III. Recommendation from Connection to Care Committee (see attached)

A letter was drafted to present to then Acting Department of Behavioral Health Director Dr. Tanya Royster requesting immediate attention to recommendations from the Connection to Care Committee regarding services at 35 K Street.

New Business

I. 35 K Presentation Dr. Black, Director of Behavioral Health Services Division and Shandra Wilkerson, Deputy Director

Dr. Black and Shandra Wilkerson, presented on navigating services at 35 K Street the presentation was based what services where provided at 35 K.

Dr. Black reported that 35 K is for urgent care as a walk in

Shandra Wilkerson reported that Urgent care walk-in process

1. residency verification (referrals form agencies)
2. intake with Waiver and eligibility
3. benefits coordinator
4. nurse
5. on Site Psych visit

Dr. Black and Shandra Wilkerson, where reminded that the BHPC are aware of the process and that the issues that concerns the BHPC where not addressed.

II. DBH Ombudsman Presentation Patricia Thompson

Department Updates

I.	Free Standing Mental Health Clinics	Randy Raybon
II.	Chapters 34/63	Jennifer Cannistra
III.	Strategic Plan	

Status Report of Standing Committees

1.	**Advocacy and Outreach**	**No Report**
2.	**Planning and Accountability**	**No Report**
3.	**System & Benefit design**	**No Report**
4.	**Connection to Care**	Action to move forward by 12/07/2018 to complete Letter then Acting Department of Behavioral Health Director Dr. Tanya Royster requesting immediate attention to recommendations from the Connection to Care Committee regarding services at 35 K Street.

Announcements:

It was suggests by Mark LeVota to update committee members by surveying council members to identify which committee members would like to serve on

An announcement was sent out via Jocelyn Route talk about committees and the assigned DBH staff person that has been assigned to your committee.

Public Comments No Comments

Adjournment 12:11pm

Government of the District of Columbia
Department of Behavioral Health

Department of Behavioral Health
Behavioral Health Planning Council (BHPC)

January 25, 2019 MINUTES

Call to Order, Chair Department of Behavioral Health (DBH) Behavioral Health Council (BHC)

The BHPC was called to order by the Chair, Senora Simpson at 10:05 am. A quorum was ascertained by roll call.

The in-person participants: Senora Simpson, Mark LeVota, Cherryl Doby-Copeleand, Effie Smith, Jocelyn Route, Alisa Mathias, Gail Avent, James Wotring, Senior Deputy Director, Tonia Gore, Donna Flenory, Michael Sterling, Charles Gervin, Harry Willis, Daijuan Wade, Esther Ford, Ann Chauvin, Elizabeth Maldonado,

The minutes of November 30 ,2018 were adopted as presented .

Interim Director Nesbitt addressed the Behavioral Health Planning Council.

Old Business

I. 5K FEP Project
Presentation of updates to Early and Serious Mental Illness Project by Jocelyn Route, Strategic Planning Policy and Engagement Officer. Jocelyn Received information for youth and youth adults in the TAY program regarding symptoms and signs of psychosis that will be incorporated into ESMI program.

II. Behavioral Health Planning Council Bylaw Amendment
   a. Changes to the bylaws were made to include information on committees and roles of DBH staff that supports committees.
      i. Bylaw revision was made on November 30, 2018 by a majority vote.

New Business

I. 35K Presentation

i. Dr. Black & Ms. Wilkerson presented to council an overview of 35K clinic's role, and function of the urgent care clinic. Questions were ascertained. Consensus among staff and BHPC members a workgroup should be

II. DBH Ombudsman Presentation

i. Patricia Thompson oriented the Behavioral Health Planning Council on the role and function of the Ombudsman's office.

Status Report of Standing Committees

1. Advocacy and Outreach
2. Planning & Accountability
3. System & Benefit Design
4. Connection to Care

Public Comments **No Comments**
Adjournment **12:07 pm**

Government of the District of Columbia
Department of Behavioral Health

Department of Behavioral Health
Behavioral Health Planning Council (BHPC)

March 29, 2019 MINUTES

Call to Order, Chair Department of Behavioral Health (DBH) Behavioral Health Planning Council (BHPC)

The BHPC was called to order by the Chair, Senora Simpson at 10:02 am. A quorum was ascertained by roll call.

The in-person participants: Senora Simpson, Cherryl Doby-Copeleand, Nicole Gilbert, Gail Avent, Donna Flenory, Jacqueline Verner, Charles Gervin, Harry Willis, Esther Ford, Jenise Patterson, & Maurice Gibson

Telephone Members: Effie Smith.

Visitors: Jackie Richardson, Jocelyn Route, Trina Dutta, Raessa Singh, Navena Minor, Teresa Mannuch, Corey Ordonald.

Motion was made to approve the agenda. No minutes were available.

Old Business

III. 35K Street Adhoc Work group
Presentation of workgroup led by Jackie Richardson. Group has decided to meet weekly to address issues and concerns presented by the Behavioral Health Planning Council. Members are made up of representatives from the System and Benefits Design and Connection to care committee. This ad hoc workgroup will be examining experiences of individuals who receive services, wait times, and a satisfaction survey. The group will be meeting on Wednesdays.

New Business

I. 1115 Waiver Presentation

DHCF Director of Health Care Policy and
Research Administration provided a detailed presentation of the 1115 Demonstration project. Questions and suggestions were ascertained.

III. Technical Assistance for BHPC

Jocelyn Route, DBH Strategic Planning Policy & Engagement Officer informed the Behavioral health planning council that a Request for Quotations would soon be released for the submission of proposals for Technical Assistance for the Behavioral Health Planning Council to provide technical assistance and guidance in streamlining the BHPC's committee work and to develop an annual work plan. Block Grant funds will be used to pay for the Technical Assistance.

IV. MHBG application and review

Jocelyn Route, DBH Strategic Planning Policy & Engagement Officer informed the Behavioral Health Planning Council that the DC Department of Behavioral Health has chosen to submit a combined Substance Abuse Block Grant and Mental Health Block Grant application for 2020-2021. Jocelyn Route and her supervisor Jackie Richardson will be leading the efforts to write the combined application and they would like a draft to be made available to the Behavioral Health Planning Council for review. The Behavioral Health Planning Council will have the Planning & Accountability Committee lead efforts of reviewing the draft and providing feedback.

V. Needs Assessment for Mental Health

The DC Department of Behavioral Health updated the Behavioral Health Planning Council on the various needs assessments that have been completed. In the last meeting, James Wotring, Senior Deputy Director agreed to share the results of the most recent Children's Services study. The Behavioral Health Planning Council Members would like to review all Needs Assessments to determine if they are interested in conducting their own needs assessment of the State of Behavioral Health services in Washington DC.

VI. DC Healthy Communities

Presentation by Gail Avent on The DC Healthy Community communities. This collaborative shares a common goal amongst members which includes the reduction of health disparities and increase healthy equity for the most vulnerable DC populations. The

last two Needs Assessments has identified Behavioral Health as a health disparity in DC. The next report will be released in June 2019.

Status Report of Standing Committees

1. Advocacy and Outreach
2. Planning & Accountability
3. System & Benefit Design
4. Connection to Care

Public Comments **No Comments**
Adjournment **12:15 PM**

Government of the District of Columbia
Department of Behavioral Health

Department of Behavioral Health
Behavioral Health Planning Council (BHPC)
Friday, May 31, 2019 10 AM to 12 PM
Where:
64 New York Avenue NE Washington DC 20002
In Person DBH-Conference Conference Room 242
Conference Line 1866-803-2312 Participant Code: 27325876

May Minutes

10 AM Call to Order, Welcome, Introductions and Roll **S. Simpson**

10:10 -10:15 Approvals of Agenda & Minutes

10:15-10:50 **Old Business**

IV. 35K Ad hoc Workgroup **J. Richardson/E.Ford**

Report from committee and questions were ascertained. Council requested a more up to date report when the final report will be released.

V. Mental Health Block Grant; FY19 **J. Cannistra**

Funding decisions are with the current director. Presentation of current spend plan was presented to council Questions were asked of the Department. Planning and Accountability Committee requested to be a part of the planning process prior to decisions being made.

VI. 1115 Demonstration Update **T. Dutta**

The Department's joint application with DHCF was successfully submitted in the stages of public comment.

10:50-11:20 **New Business**

VII. 20-21 Combined Block Grant Application **J. Route**

Presently a team working on the Combined application. This is the District's first time submitting a combined application. After draft is completed, Jocelyn will work with planning and Accountability committee for review and comment on the plan, gaps, and noted services.

VIII. Technical Assistance for BHPC **J. Richardson**
The Clearing will be conducting Technical Assistance which will be an all-day meeting. Al members requested to attend.

IX. DBH Behavioral Health Recovery Conference/ **J. Route**
Early and Serious Mental Illness

11:35- 11:45 Status Report of Standing Committees & Breakouts

1. Advocacy and Outreach
2. Planning & Accountability
3. System & Benefit Design
4. Connection to Care

11:45 Announcements
11:50 Public Comments
12:00 PM Adjournment

Note:
If any council member or public attendee needs an accommodation, please contact Ms. J. Route, Strategic Planning and Policy Officer, at Office: (202) 671-3204 Cell: (202) 236-4555 prior to the meeting date.

Government of the District of Columbia
Department of Behavioral Health

DRAFT July MEETING MINUTES

Behavioral Health Planning Council

Regularly Scheduled Meeting

Monday, July 22, 2019 2 PM – 3 PM

64 New York Avenue NE, Room 285, Washington DC 20002

Call to Order and Roll:

The meeting was called to order at 2:10 PM.

Chair Senora Simpson took roll. Jocelyn Route confirmed there was a quorum.

Approvals of Agenda and Minutes – No minutes were available from the previous meeting. Committee Reports were made available.

Committee Reports:

- Advocacy and Outreach Committee – Committee provided updates on Status of Chapters 34 and 63, Listening Sessions, DBH Recovery Conference, Update on 1115 Waiver, Clearing Technical Assistance, Presentation on 2nd Annual Peer Meeting, Forensic Peers. Chair Simpson commended the entire report to the BHPC for its review.
- Planning and Accountability Committee – No report
- System and Benefit Design Committee – Mark LeVota reported the committee has newly assigned staff support from DBH and is scheduling a meeting in August.
- Connection to Care Committee – The committee reported it has become, in effect, the ad hoc 35 K work group. Mentioned pilot survey for consumers. Chair Simpson requested instantaneous reports and analysis of results from surveys to date. The committee's written report was extensively referenced. Elizabeth Moldanado reported as follow up from previous business that ID check has been eliminated from the initial intake process at 35 K and also raised

concern that mobile crisis has been responding to child calls because Catholic Charities does not have enough ChAMPS teams.

Before proceeding to Old Business, Chair Simpson made requests of BHPC members. She urged that BHPC members provide responses to requests for feedback made in writing between BHPC meetings. She also encouraged BHPC members to review their ability and commitment to engage in BHPC business and either to participate or to resign; she stated that she realized she was 'preaching to the choir', since those in attendance had demonstrated their intention to participate and her message needed to reach those not in attendance.

Old Business – 35 K Work Group:

Jackie Richardson provided a report on the activities of the 35 K work group. She made a reminder that Dr. Nesbitt, while interim DBH director, created the work group in response to BHPC recommendations. Ms. Richardson expressed concern about accelerating the consumer experience survey, with need to collect sufficient data to consider the sustainability of any proposed changes.

Chair Simpson stated we need to know metrics of consumer experience being measured and performance expectation for staff.

Charles Gervin stated the ad hoc workgroup had developed a process that has allowed development of transparency and buy-in. He called on BHPC to remember the work so far has been building pilots, and sometimes that requires making changes. He stated the work group took complaints about 35 K seriously and that people at 35 K took complaints about 35 K seriously

Chair Simpson reiterated that she would like to see preliminary survey tools being developed and preliminary results of the reported consumer experience.

Elizabeth Maldonado expressed concern that there was a lack of Spanish-language support at DC detox sites, which Chair Simpson indicated should be considered at some other time and was not part of the scope of the 35 K ad hoc work group.

New Business – Forensic Peer Specialist Curriculum

Johnny Howard made a presentation about Forensic ACT and Forensic Peers. Regarding Forensic ACT, Mr. Howard referred to SAMHSA information provided and stated, "If I had a FACT Team, it would be more helpful to me," compared to traditional ACT teams or other services. Mr. Howard referred to Forensic Peers slides that he also presented, making major points that there was need for Forensic Peers to make FACT part of successful use of the Sequential Intercept Model and that there was need for Forensic Peers with lived experience. Mr. Howard requested for DBH to create a FACT program in DC, by written report of the BHPC to Dr. Bazron and requested to review forensic service use of Social Detox models to assist with opioid use disorder or other substance use disorder populations.

Atiya Frame stated that DBH Family and Community Affairs would review creation of Forensically Certified Peer Specialists, and she noted Live.Long.DC / State Opioid Response federal grant funds might provide support to launch that initiative. She stated that DBH would also review whether FACT is supported under the current Medicaid State Plan as a specialized version of ACT or if any State Plan Amendment would be needed and that DBH would review if changes to DBH regulations would be needed to specifically certify FACT providers.

Chair Simpson entertained a motion to accept Ms. Frame's proposed plans for DBH Family and Consumer Affairs to explore Forensically Certified Peer Specialists and for DBH to consider any necessary changes to the Medicaid State Plan or DBH certification regulations to allow creation of FACT teams for the District. The motion passed unanimously by voice vote, with abstention by Nicole Gilbert.

Announcements – There were no public announcements.

Public Comments – No members of the public offered public comments.

Chair Simpson and Jocelyn Route confirmed the next meeting is the last Friday in September. BHPC will review work plans to be created as follow up from the BHPC planning retreat.

Adjournment – The meeting was adjourned at 2:47 PM.

Environmental Factors and Plan

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 Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Health (MH) Agency.

Start Year: 2020 End Year: 2021

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Gail Avent	Parents of children with SED/SUD		1214 I Street SE Washington DC, 20003 PH: 202-747-8878	Totalfamilycarecoalition@gmail.com
Cavella Bishop	State Employees	Department of Health Care Finance	441 4th Street NW Washington , 20001 PH: 202-724-8936	cavella.bishop@dc.gov
Tia Brumstead	State Employees	Office of the State Superintendent of Education	1050 First Street NE Washington , 20002 PH: 202-714-9812	Tia.Brumsted@dc.gov
Ann Chauvin	Providers		6856 Eastern Ave NW Washington DC, 20012 PH: 202-830-3556	achauvin@woodleyhouse.org
Donao Cousar	Youth/adolescent representative (or member from an organization serving young people)		2413 14th Street NE Washington DC, 20010	donao.cousar@yahoo.com
Tony Crews	Providers		4130 Hunt Place, NE Washington DC, 20019 PH: 202-388-4301	tcrews@mbihs.com
Nicole Denny	State Employees		323 Quackenbos St NE Washington DC, 20011 PH: 202-365-0654	nicole.denny@dc.gov
Luis Diaz	State Employees	Criminal Justice Coordinating Council	441 4th Street NW washington , 20003	
Cheryl Doby-Copeland, PhD, ATR-BC, LPC, LMFT	State Employees		821 Howard Road, SE Washington DC, 20032 PH: 202-698-1836	Cheryl.copeland@dc.gov
Donna Flenory	Parents of children with SED/SUD		510 Division Ave NE Washington DC, 20019	dlflenory@gmail.com
Esther Ford	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health		4805 first street, SW Washington DC, 20032	estherford777@gmail.com

	services)		PH: 240-640-3903	
Atiya Frame	State Employees		64 New York Avenue NE, 3rd Floor Washington DC, 20002 PH: 202-673-2245	atiya.frame@dc.gov
Charles Gervin	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		3636 16th Street NW Washington DC, 20010 PH: 202-677-0231	cagervin@gmail.com
Maurice Gibson	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1610 16th street NW Washington DC, 20009 PH: 240-210-6776	maurice.gibson@dc.gov
Nicole Gilbert	Youth/adolescent representative (or member from an organization serving young people)	Child and Family Services Agency	200 I Street, SE Washington DC, 20003	
Dena Hasan	State Employees	Department of Human Services	64 New York ave NE Washington DC, 20002 PH: 202-698-5281	Dena.Hasan@dc.gov
Mark LeVota	Others (Advocates who are not State employees or providers)		PO Box 33515 Washington DC, 20033	Mark.LeVota@dcbehavioralhealth.org
Dianne Lewis	State Employees	DC Health Benefit Exchange Authority	1225 I Street NW Washington DC, 20005	DLewis@acg-cos.com
Elizabeth Maldonado	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		2212 40th Street NW Washington DC, 20007 PH: 410-908-9642	jpjnewpost@gmail.com
Alisa Mathias	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		5003 Hunt Street NE Washington DC, 20019	alisajayone68@gmail.com
Jenise Patterson	Parents of children with SED/SUD		2421 18th Street NE, Washington DC, 20018 PH: 202-718-4834	parentwatch2010@gmail.com
Senora Simpson	Family Members of Individuals in Recovery (to include family members of adults with SMI)		323 Quackenbos St. NE Washington DC, 20011 PH: 202-529-2134	Ssimps2100@aol.com
Sabrina Slater	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1224 I Street S.E Washington DC, 20003 PH: 240-510-7461	miracleventureblessings@yahoo.com
E. Effie Smith	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1300 L Street, NW DC, 20005 PH: 202-842-0001	esmith@can-dc.org
Heather Stowe	State Employees	Department of Aging and Community Living	500 K Street, NE Washington DC, 20002 PH: 202-535-1367	Sara.tribe@dc.gov

Agnes Venson	State Employees	Department of Human Services	2100 Martin Luther King Jr. Ave SE Washington DC, 20020 PH: 202-698-1714	agnes.venson@dc.gov
Jaclyn Verner	Others (Advocates who are not State employees or providers)		220 I Street NE Washington DC, 20002 PH: 202-547-0198	jverner@uls-dc.org
Tamara Weisman	Youth/adolescent representative (or member from an organization serving young people)		1104 Allison Street NW Washington DC, 20011	TWeissman@hscsn.org
Harry Willis	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		3722 Ely Pl. SE Washington DC, 20019 PH: 202-638-9231	hwillis38@comcast.net

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

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Footnotes:

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2020 End Year: 2021

Type of Membership	Number	Percentage of Total Membership
Total Membership	**26**	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	8	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	1	
Parents of children with SED/SUD*	3	
Vacancies (Individuals and Family Members)	0	
Others (Advocates who are not State employees or providers)	2	
Persons in recovery from or providing treatment for or advocating for SUD services	0	
Representatives from Federally Recognized Tribes	0	
Total Individuals in Recovery, Family Members & Others	**14**	**53.85%**
State Employees	10	
Providers	2	
Vacancies	0	
Total State Employees & Providers	**12**	**46.15%**
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	27	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	5	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	**32**	
Youth/adolescent representative (or member from an organization serving young people)	3	

* States are encouraged to select these representatives from state Family/Consumer organizations or include individuals with substance misuse prevention, SUD treatment, and recovery expertise in their Councils.

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Footnotes:

Environmental Factors and Plan

22. Public Comment on the State Plan - Required

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, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

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:		
c)	Other (e.g. public service announcements, print media)	( ) Yes	(•) No

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Footnotes: