District of Columbia

UNIFORM APPLICATION
FY 2016/2017 - STATE BEHAVIORAL HEALTH ASSESSMENT AND PLAN

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

OMB - Approved 06/12/2015 - Expires 06/30/2018
(generated on 10/21/2016 5.35.23 AM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

State Information

State Information

Plan Year

Start Year 2017

End Year 2018

State DUNS Number

Number 014384031

Expiration Date

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

Agency Name Department of Behavioral Health

Organizational Unit Addiction Prevention and Recovery Administration

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

City Washington, DC

Zip Code 20002

II. Contact Person for the Grantee of the Block Grant

First Name Tanya

Last Name Royster

Agency Name Department of Behavioral Health

Mailing Address 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 tanya.royster@dc.gov

III. Expenditure Period

State Expenditure Period

From

To

IV. Date Submitted

Submission Date 9/30/2016 1:28:27 PM

Revision Date

V. Contact Person Responsible for Application Submission

First Name Marquitta

Last Name Duvernay

Telephone 202-727-8953

Fax 202-727-0092

Email Address marquitta.duvernay@dc.gov

Footnotes:

State Information

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

Fiscal Year 2017

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
Section 1921	Formula Grants to States	42 USC § 300x-21
Section 1922	Certain Allocations	42 USC § 300x-22
Section 1923	Intravenous Substance Abuse	42 USC § 300x-23
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	42 USC § 300x-24
Section 1925	Group Homes for Recovering Substance Abusers	42 USC § 300x-25
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	42 USC § 300x-26
Section 1927	Treatment Services for Pregnant Women	42 USC § 300x-27
Section 1928	Additional Agreements	42 USC § 300x-28
Section 1929	Submission to Secretary of Statewide Assessment of Needs	42 USC § 300x-29
Section 1930	Maintenance of Effort Regarding State Expenditures	42 USC § 300x-30
Section 1931	Restrictions on Expenditure of Grant	42 USC § 300x-31
Section 1932	Application for Grant; Approval of State Plan	42 USC § 300x-32
Section 1935	Core Data Set	42 USC § 300x-35
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53

Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the 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.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

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

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

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

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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

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

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

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

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

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

Name of Chief Executive Officer (CEO) or Designee: Tanya Royster

Signature of CEO or Designee[1]: _____

Title: State Director

Date Signed: _____

mm/dd/yyyy

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

Footnotes:

LIST of CERTIFICATIONS

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

Name of Chief Executive Officer (CEO) or Designee: Tanya Royster

Signature of CEO or Designee[1]: 

Title: State Director

Date Signed: 09/30/2015
mm/dd/yyyy

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

State Information

Disclosure of Lobbying Activities

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

Standard Form LLL (click here)

Name	
Title	
Organization	

Signature: _____ Date: _____

Footnotes:

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2016 Planning Period End Date: 9/30/2018

Expenditure Category	FY 2016 SA Block Grant Award	FY 2017 SA Block Grant Award
1 . Substance Abuse Prevention* and Treatment	$4,877,457	$4,877,457
2 . Substance Abuse Primary Prevention	$1,393,559	$1,393,559
3 . Tuberculosis Services	$0	$0
4 . HIV Early Intervention Services**	$348,390	$348,390
5 . Administration (SSA Level Only)	$348,390	$348,390
6. Total	$6,967,796	$6,967,796

* Prevention other than primary prevention

** 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 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 CDC, National Center for HIV/AIDS, Hepatitis, STD and TB Prevention. The HIV Surveillance Report, Volume 24, will be used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective FY 2016 SABG allotments to establish one or more projects to provide early intervention services for 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 does not meet the AIDS case rate threshold for the fiscal year involved. 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 be allowed to obligate and expend FY 2016 SABG funds for EIS/HIV if they chose to do so.

Footnotes:

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2016 Planning Period End Date: 9/30/2018

Strategy	IOM Target	FY 2016	FY 2017
		SA Block Grant Award	SA Block Grant Award
Information Dissemination	Universal	$278,530	$278,530
	Selective	$0	
	Indicated	$0	
	Unspecified	$0	
	Total	$278,530	$278,530
Education	Universal	$153,550	$153,550
	Selective	$187,673	$187,673
	Indicated	$0	
	Unspecified	$0	
	Total	$341,223	$341,223
Alternatives	Universal	$0	
	Selective	$0	
	Indicated	$65,542	$65,542
	Unspecified	$0	
	Total	$65,542	$65,542
Problem Identification and Referral	Universal	$0	
	Selective	$68,245	$68,245
	Indicated	$68,245	$68,245
	Unspecified	$0	
	Total	$136,490	$136,490

Community-Based Process	Universal	$449,081	$449,081
	Selective	$0	
	Indicated	$0	
	Unspecified	$0	
	Total	$449,081	$449,081
Environmental	Universal	$0	
	Selective	$0	
	Indicated	$0	
	Unspecified	$62,693	$62,693
	Total	$62,693	$62,693
Section 1926 Tobacco	Universal	$0	
	Selective	$60,000	$60,000
	Indicated	$0	
	Unspecified	$0	
	Total	$60,000	$60,000
Other	Universal	$0	
	Selective	$0	
	Indicated	$0	
	Unspecified	$0	
	Total	$0	$0
Total Prevention Expenditures		$1,393,559	$1,393,559
Total SABG Award*		$6,967,796	$6,967,796
Planned Primary Prevention Percentage		20.00 %	20.00 %

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2016 Planning Period End Date: 9/30/2018

Activity	FY 2016 SA Block Grant Award	FY 2017 SA Block Grant Award
Universal Direct	$363,756	$363,756
Universal Indirect	$580,098	$580,098
Selective	$315,918	$315,918
Indicated	$133,787	$133,787
Column Total	$1,393,559	$1,393,559
Total SABG Award*	$6,967,796	$6,967,796
Planned Primary Prevention Percentage	20.00 %	20.00 %

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

Planning Period Start Date: 10/1/2016 Planning Period End Date: 9/30/2018

Targeted Substances	
Alcohol	þ
Tobacco	¢
Marijuana	þ
Prescription Drugs	¢
Cocaine	¢
Heroin	¢
Inhalants	¢
Methamphetamine	¢
Synthetic Drugs (i.e. Bath salts, Spice, K2)	þ
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 6a SABG Resource Development Activities Planned Expenditures

Planning Period Start Date: 10/1/2016 Planning Period End Date: 9/30/2018

Activity	FY 2016 SA Block Grant Award				FY 2017 SA Block Grant Award			
	Prevention	Treatment	Combined	Total	Prevention	Treatment	Combined	Total
1. Planning, Coordination and Needs Assessment	$0	$0	$0	$0				$0
2. Quality Assurance	$0	$565,052	$0	$565,052		$565,052		$565,052
3. Training (Post-Employment)	$0	$97,733	$0	$97,733		$97,733		$97,733
4. Education (Pre-Employment)	$0	$0	$0	$0				$0
5. Program Development	$0	$0	$0	$0				$0
6. Research and Evaluation	$0	$0	$0	$0				$0
7. Information Systems	$0	$118,393	$0	$118,393		$118,393		$118,393
8. Total	$0	$781,178	$0	$781,178	$0	$781,178	$0	$781,178

Footnotes:

Environmental Factors and Plan

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application

Narrative Question:

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating mental health and substance abuse agencies, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance abuse, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance abuse prevention and treatment advisory council to ensure that the council reviews issues and services for persons with, or at risk for, substance abuse and substance use disorders. To assist with implementing a BHPC, SAMHSA has created Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.[97]

Additionally, Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. 300x-51) applicable to the SABG and the MHBG, requires that, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

For SABG only - describe the steps the state took to make the public aware of the plan and allow for public comment.

For MHBG and integrated BHPC; States must include documentation that they shared their application and implementation report with the Planning Council; please also describe the steps the state took to make the public aware of the plan and allow for public comment.

SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

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

1. How was the Council actively involved in the state plan? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.).
2. What mechanism does the state use to plan and implement substance abuse services?
3. Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?
4. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders, and how it has advocated for individuals with SMI or SED.

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.[98]

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[97] http://beta.samhsa.gov/grants/block-grants/resources

[98] There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

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

Footnotes:

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application

1. How was the Council actively involved in the state plan? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.).

Behavioral Health Council Review and Comment on Mental Health Block Grant Application: The Department of Behavioral Health/Behavioral Health Council (DBH/BHC) reviewed and provided comments that were included in the District of Columbia FY 2016 - FY 2017 Mental Health Block Grant Application. Their comments focused on the Behavioral Health Assessment and Plan. The DBH/BHC used the *Behavioral Health Assessment and Plan Review Comment Guide* to express their views about: 1) the most important adult service system strengths; 2) the most important unmet service needs or critical gaps in the adult service system; 3) the most important child and youth service system strengths; 4) the most important unmet service needs or critical gaps in the child and youth service system; 5) other performance indicators the Behavioral Health Council would like DBH to consider in the future; and 6) the evidence-based practice plan related to early intervention. The DBH/BHC comments related to these issues are below.

A. Overview of Adult Service System

1. ***Most important adult service system strengths:***
    - Accessibility/availability of mental health services.
    - Health Homes Initiative, Evidence based practices, Supported Housing services.
    - Having the ability to select providers of choice.
    - Partnering with providers to develop recovery oriented treatment plans.
    - Education, Employment, Housing.
    - Evidence Based Practice/ACT.
    - Mental Health Services Division-particularly multicultural services.

2. ***Most important unmet service needs or critical gaps in the adult service system:***
    - Services for people with mental health issues and intellectual/developmental disabilities.
    - Being re-traumatized by agencies that lack compassion, integrity and dignity for the individual's overall well-being.
    - Lacking cultural competency to the population served (Missing the margin).
    - Not enough peer lead groups/organizations.
    - Therapy.
    - Access to and more support of recovery oriented, integrated supported employment and vocational/educational opportunities.
    - More (integrated) wheelchair/disability accessible housing within the entire continuum of supported housing services.

B. Overview of Child and Youth Service System

1. ***Most important child and youth service system strengths:***
    - Comprehensive services.

- Parent Infant Early Childhood Enhancement **(**PIECE) Program has dedicated well trained (in several evidence-based practices) staff (intact team for several years) providing early intervention services to families of children under the age of 6.
- The Children Psychiatric Practice Group (PPG) has three (3) dedicated child psychiatrists that serve as the safety net for several DC core services agencies (CSAs). The PPG provides medication assessments, medication management, same day/urgent care services, and court evaluations.
- The DC Healthy Start program is designed to address the parent child dyad through the strengthening of attachment bonds and to reduce infant mortality. The program works with pre- and post-natal women residing in Wards 5, 6, 7, and 8.
- System of Care Expansion Implementation Project.
- School-based mental health services.
- Prevention and Early Intervention Services.
- Creating multiple access entrances to assess for mental health services.
- Therapy, Parent Education.
- Evidence Based services, Child and Adolescent Mobile Psychiatric Service (ChAMPS), Same Day Urgent Care.

2. ***Most important unmet service needs or critical gaps in the child and youth service system:***
   - Substance Use Disorder Treatment and Recovery Services.
   - Substance abuse treatment options for single parents that enable families to remain together during treatment, if appropriate.
   - Better coordination with other systems.
   - Coordination with workforce system and provision of employment readiness and supported employment.
   - Lack of quality outpatient therapy services for latency age youth.
   - Lack of a dedicated mental health center/agency in DC to provide public mental health and behavioral health services for children with Autism Spectrum Disorder (ASD).
   - Uneven and inconsistent provision of Individualized Education Plan (IEP) stipulated services in DC Public Schools and Public Charter Schools.
   - If the agency could provide tokens and/or fare cards families may be more able to access clinic based services.
   - Lack of child psychiatrists at the DC CSAs to provide consistent medication management and psychiatric services to children and adolescents. Lack of nursing staff, and Community Support Workers (CSWs) to support the work of the PPG.
   - Need for updated equipment to support the PIECE program's evidence-based practices and day to day operations, e.g., contemporary telephone instruments for conference calls, no intercom system to communicate with parents during coaching sessions.
   - Programmatic consideration that more latency age children are using K2 and other substances as the focus of treatment.

- Financial support for the psychoeducational groups conducted by the DC Healthy Start program so that program staff do not have to pay out of pocket for meals/incentives for clients.
- Resources to help homeless services providers navigate the behavioral health system in order to connect and support families with children identified as in need of behavioral health services.
- Family-based integrated services for families that brings together all health and human service providers in support of an integrated plan for families with children receiving behavioral health supports.
- Prevention and Early Intervention Services need the resources to serve 100% of the need.
- Lack of psychiatrists available to meet the growing demand of children mental health needs.
- CSAs have an overload of cases, which only permits the kids to receive Car Wash Services (Which means in and out services just to meet billing expectations).
- Therapy, Family Education.
- Employment, wrap around services (Psychiatrist/Psychologist/PCP, therapy, education, housing)
- More community-based alternatives (therapeutic family-like settings) for youth in crisis that cannot stay with their families (e.g., therapeutic foster care without requiring entry into foster care setting).
- Therapeutic/recovery oriented after school programs that focus on positive youth development.
- Additional focus on continuity of care for hospitalized youth.

C. <u>Other performance indicators the Behavioral Health Council would like DBH to consider in the future:</u>
    - Improved interface between the Integrated Care Application Management System (iCAMS) and the Child and Adolescent Functional Assessment Scale/ Preschool and Early Childhood Functional Assessment Scale (CAFAS/PECFAS) in order to more accurately collect data on child/adolescent impairments.
    - Addition of the evidence-based practices Parent Child Interaction Therapy (PCIT) and Child Parent Psychotherapy (CPP) to the iCAMS billing platform to reflect the utilization of these practices.
    - Number of parents receiving substance abuse treatment through family based programs.
    - Becoming innovative in allowing consumers to have virtual access to rate the services they receive.
    - The number of youth with serious emotional disturbances that are diverted from the foster care system through use of community based therapeutic settings.
    - The percentage of supported housing units that are integrated and accessible.
    - The percentage of adults engaged in full or part-time employment or vocational/education activities.
    - The percentage of youth with serious emotional disturbances engaged in structured or therapeutic activities between the hours of 3 pm and 7pm.

D. Environmental Factors:

Factor 5: *Evidence-Based Practice for Early Intervention (5%)*

The continuing emphasis of DBH on investments in early intervention, such as the TACT program, is essential to building a system of care that provides comprehensive, family-focused care starting at the early detection point. This is going in the right direction of reducing out-of-home and more intensive psychiatric interventions

Behavioral Health Council Comments for District of Columbia FY 2016 Mental Health Block Grant Report: See letter from DBH/BHC Chair below.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF BEHAVIORAL HEALTH

BEHAVIORAL HEALTH COUNCIL

November 30, 2015

I am pleased to submit comments on the District of Columbia FY 2016 Mental Health Block Grant Report on behalf of the Department of Behavioral Health Behavioral Health Council.

1. Create Department of Behavioral Health

The initiatives and activities described for the period FY 2014 and FY 2015 demonstrate substantial progress towards the integration of mental health and substance use disorder treatment and services within the Department of Behavioral Health. Ongoing staff development and training is a critical component. This is demonstrated by the course content including mental health disorders, substance use disorders, integrated training on behavioral health issues, and a number of other topics, as well as the volume of certificates and contact hours awarded, and the number of licensed attendees. Other important accomplishments include increasing the number of behavioral health services intake points, locating mental health and substance use disorder services in the same building and under a single program. The award of federal grants that focus on developing a system of care for transition age youth and young adults, and reducing underage drinking and underage marijuana use in high need communities will positively impact the youth in the District. The Department of Behavioral Health Behavioral Health Council reports to the Director of the Department, Tanya A. Royster, M.D., and will provide input as she and the staff define priorities and refine and/or develop new programs and services.

2. Health Home Planning Initiative

Although the Health Home Planning Initiative had a delay in implementation and did not meet the performance indicators outlined in the FY 2014-FY 2015 Mental Health Block Grant Application, the state plan amendment (SPA) has been approved and the project is moving forward. This is an important initiative for the District because it has the potential to integrate mental health and primary health care.

3. Transition to a Behavioral Health Planning and Advisory Council

As noted in the Report, the newly created Department of Behavioral Health Behavioral Health Council had its inaugural meeting in August 2015 and elected the officers in September 2015. The current committees that have identified members include:

- Executive Committee- Chair, Vice-Chair, Secretary
- Advocacy Committee- provides education, information, and support to efforts related to the prevention and treatment of mental health and substance use disorders.
- Block Grant Committee-works closely with the DBH Block Grant staff to develop the biennial plan and annual reports that are submitted to SAMHSA.
- Program, Data and Policy Committee- works with the DBH staff on programmatic and policy issues that affect the mental health and substance use disorder service system.

There is also an Ad Hoc By-Laws Committee.

The Department of Behavioral Health Behavioral Health Council will continue to work with the Department to address priority and other initiatives and to improve and/or expand behavioral treatment, services and supports for consumers/clients and families. This will involve ensuring input from a variety of stakeholders (e.g., consumers/clients, family members, advocates, providers and others). Our Council will also provide input on the allocation of Mental Health Block Grant funds to both Departmental programs and community-based organizations, as we seek to identify innovative ways to empower consumers/clients to move towards recovery.

Sincerely,

Senora Simpson PT, Dr. PH

Chair, Department of Behavioral Health Behavioral Health Council

Behavioral Health Council Input District of Columbia FY 2017 Mental Health Block Grant: The DBH/BHC Chair, Committee Chairs, and some of the members provided input for the Planning and Advisory Council questions in the SAMHSA FY 2017 Mental Health Block Grant Mini-Application.

2. What mechanism does the state use to plan and implement substance abuse services?

The Department of Behavioral Health (DBH)) is the Single State Agency (SSA) responsible for the development and promulgation of rules, regulations, and certification standards for prevention and treatment services related to the abuse of alcohol, tobacco, and other drugs (ATOD) in the District of Columbia. The Department is responsible for the inspection, monitoring, and certification of all District of Columbia substance use disorder treatment and recovery providers.

The DBH added Chapter 63, "Certification Standards for Substance Use Disorder Treatment and Recovery Providers," to Subtitle A (Mental Health) of Title 22 (Health) of the District of Columbia Municipal Regulations (DCMR). The purpose of this new rule is to: 1) update the substance use disorder treatment and recovery service requirements to reflect improvements in the American Society of Addiction Medicine (ASAM) practice guidelines, including the addition of clinical care coordination services and the requirement that treatment services be performed by qualified practitioners; 2) establish new levels of care that improve person-centered, individualized treatment; 3) align the certification requirements with other certified programs within the authority of the Department; and 4) incorporate the requirements of the Adult Substance Abuse Rehabilitation Services (ASARS) State Plan Amendment (SPA) that allows Medicaid reimbursement for services falling within the ASARS requirements.

The new certification standards became effective in September, 2015, and since then the Department has been working with providers to become certified pursuant to the new requirements and implement the revised ASAM standards. The Department has also been working with the providers with a Human Care Agreement with the agency to implement Medicaid billing for those services and consumers for which Medicaid reimbursement can be used. While services have been ongoing throughout this entire process, DBH is anticipating that in the near future it will be able to analyze utilization and outcomes under the new standards and determine what, if any, adjustments need to be made.

The DBH Substance Use Disorders Office utilizes a data driven approach to support the development of measurable service and program goals to determine the level of successful goal attainment. The tools and processes used include the implementation of a State Needs Assessment conducted by an external consultant to identify gaps, analyze and improve service delivery.

Internally, the DBH Office of Accountability develops a Quality Improvement Plan through ongoing quality assurance (QA) and quality improvement (QI) work groups. The DBH has instituted a number of internal and external workgroups that informs the continuous quality improvement (CQI) process and helps to promote a total quality management (TQM) environment. This process allows DBH to thrive in changing the healthcare environment and provides comprehensive community services throughout the provider network. The DBH has a number of tools that are used in the CQI process. Information Technology (IT) conducts

both claims audits and quality reviews to produce a Provider Scorecard which rates provider's on a scale of 1 – 5 stars (5 being the highest score). The DBH also conducts annual Community Service Reviews (CSRs) which are in depth studies of a sample of clients that allows the agency to determine the overall quality of the service system (versus an individual provider). Due to the recent changes to the substance use disorder (SUD) service system the Provider Scorecard and the CSR for the SUD services has just been completed and is being piloted in fiscal year 2017.

The DBH has engaged other government partners in the CQI process to improve access and services for shared clients. A component of the CQI process is the development of a comprehensive plan to monitor the delivery of all services that the provider network delivers. This plan will identify target areas where resource allocation is necessary to align the quality of service with core strategic objectives and maximize the probability of desired outcomes.

The DBH customers consist of individuals seeking treatment or recovery services; providers that look to the State Substance Abuse Authority for oversight, guidance and support; and community partners that also serve individuals seeking services. In an effort to learn more about these stakeholders and become more customer focused, DBH has begun to address the needs of customers by instituting a process for client satisfaction surveys, provider meetings that illicit structured feedback and creating meaningful partnerships with community agencies.

The Substance Use Disorders Office has a Recovery Advisory Council (RAC) comprised of stakeholders and consumers that advise on long-term planning for a recovery-oriented system of care. Additionally, this Office is planning to launch a Recovery Coach Training Course in fiscal Year 2017.

Planning for SUD services is also guided by the priorities in the SAMHSA Substance Abuse Block Grant (SABG) and the Mayoral priorities for the city. Each year the agency completes a Performance Plan that outlines the agency's objectives, Key Performance Indicators, and Strategic Initiatives for the year. The Strategic Initiatives are designed to continually improve the level of services while complying with the legal and regulatory framework under which the service system is designed.

3. Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?

The DBH/BHC 1-year anniversary was August 19, 2016. The focus of the first year included: 1) organizational development including activating committees; 2) District training on ethics and the Open Meetings Act; 3) SAMHSA State Technical Assistance Project 2015-2016 participation in the Advocacy Teams Group (monthly conference calls); and 4) one and a half day on site Individual State Targeted Technical Assistance on the DBH/BHC data needs and types of data to support the Council activities.

The newly formed DBH/BHC has adequate and active members who represent both mental health and substance use disorder issues. More importantly, they provide insight and concerns related to co-occurring disorder issues. The DBH/BHC members are especially interested in the need to provide one stop attention for consumers/clients and their families.

During its second year, the DBH/BHC will focus on the integration of substance abuse prevention and treatment and co-occurring disorder issues, concerns, and activities. During Year 1 there were some preliminary discussions about these issues. For example, the Advocacy Committee suggested adding the DBH Ombudsman and First Stop Recovery to the agenda for future meetings. The Program, Data and Policy Committee plans to review data and data analyses related to DBH programs and the provider network (mental health rehabilitation services (MHRS) and substance use disorder services).

Other strategies were derived from the DBH/BHC Data Needs Survey and the Data Needs Technical Assistance meetings. The Council suggested including presentations from the DBH substance use disorder staff on prevention, treatment, and recovery issues at the DBH/BHC meetings. A presentation on the components of the SAMHSA Substance Abuse Block Grant and how these issues are addressed was also suggested.

The DBH Substance Use Disorders Office has a Recovery Advisory Council (RAC). The DBH/BHC will explore with the substance abuse staff and RAC initiatives and activities for future collaboration.

4. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?

Yes, the membership is representative of the service area populations in the District of Columbia. The DBH/BHC membership was very carefully selected to ensure the maximum adherence to these requirements. The Council includes individuals with lived experience (mental health and substance use disorders), family members (adults and children), state employees, providers, others (not state employees or providers), and the SAMHSA required District agencies as well as others. The DBH/BHC also includes individuals from diverse ethnic and cultural backgrounds.

The DBH/BHC is always seeking additional members and/or participants' points of view. A call for volunteers is an ongoing strategy. There were three (3) vacancies: 1) an Individual in Recovery (to include adults with SMI who are receiving or have received mental health services), and 2) two (2) Other positions (not state employee or providers). The DBH/BHC plans to recruit an Individual in Recovery and has used one (1) of the Other category positions to recruit an additional Parent of a child with SED. This individual is also a Certified Peer Specialist. The remaining Other position will be used to try to recruit a transition age youth.

5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders, and how it has advocated for individuals with SMI or SED.

In the District of Columbia the Department of Behavioral Health/Behavioral Health Council reports to the Department's Director. The DBH/BHC adheres to the federal statute mandating recipients of Block Grant funds to: 1) review the Mental Health Block Grant Plan and make recommendations; 2) serve as advocates for adults with a serious mental illness, children with a serious emotional disturbance, and other individuals with mental illnesses or

emotional problems; and 3) monitor, review, and evaluate at least once each year the allocation and adequacy of mental health services within the District.

Behavioral Health Council Activities: During FY 2016, the first year of the DBH/BHC, the primary focus for the larger body and the committees was to create a process by which it could organize, obtain information, engage in planning, and implement strategies to carry out the mission. The DBH/BHC elected officers and the Council members volunteered to serve as a committee chair or a co-chair.

Information Requests: The DBH/BHC requests information from the Department and other resources as one of the ways it gathers information and data. For example, one of the requests to the Department was to provide information about previous needs assessments and related reports. In response to this request several reports were identified and provided to the Behavioral Health Council. They included the following documents:

- The RAND Corporation DC Behavioral Health Needs Assessment - Guide to the Behavioral Health System in the District of Columbia (August 2010)
- The RAND Report Behavioral Health in the District of Columbia: Assessing Need and Evaluating the Public System of Care (2010)
- Documents on the DBH website:
  - The Children's Performance Plan Report (2009-2013)
  - Children's System of Care Plan: A Comprehensive 3-5 Year Plan for Redesign
  - Behavioral Health for Children, Youth and Family Services in the District of Columbia Report: A Review of Prevalence, Service Utilization, Barriers and Recommendations (May 2014)

Ethics and Open Meetings Act Training: The DBH/BHC March 2016 meeting was devoted to Training on Ethics and the Open Meetings Act conducted by the District of Columbia Office of Open Government, Board of Ethics and Government Accountability (BEGA). Darrin P. Sobin, Director of Government Ethics presented information on the Board of Ethics and Government Accountability Establishment and Comprehensive Ethics Reform Amendment Act of 2011 ("Ethics Act"), effective April 27, 2012. Traci L. Hughes, Esquire, Director of Office of Open Government presented information on the Open Meetings Act requirements.

Data Needs: As the DBH/BHC committees pursued their interest areas, they began to inquire more about the Department's services and available data. This led to a request from the SAMHSA State Technical Assistance Project 2015-2016 for planning councils for Individual State Targeted Technical Assistance to help address data needs issues.

***Data Needs* Survey:** The first step was developing the DBH/BHC Data Needs Survey that was disseminated to the members. The survey asked the respondents to identify the populations of interest that included: 1) children and youth with serious emotional disturbances (SED); 2) families of children and youth with SED; 3) transition age youth/young adults with serious mental illnesses (SMI); 4) adults with SMI; and 5) older adults with SMI. They were asked to provide information about the data questions related to

the population selected and how it was related to the mission of their Committee and/or the DBH/BHC.

The survey also asked the respondents to identify the services of interest that included services for: 1) adolescents with substance abuse and/or mental health problems; 2) children and youth who are at risk for mental, emotional, and behavioral disorders, including but not limited to addiction, conduct disorder, and depression; 3) women who are pregnant and have a substance use and/or mental disorder; 4) parents with substance use and/or mental disorders who have dependent children; and 5) military personnel (active, guard, reserve, and veteran) and their families. They were also asked to provide information about the data questions related to services they selected and how it was related to the mission of their Committee and/or the DBH/BHC.

The survey asked the respondents to indicate their level of interest in data related to: 1) availability and identification of relevant/useful data sources/reports; 2) data interpretation and analysis; 3) evidence-based decision making; and 4) how to present and disseminate results. They could also provide other data related information.

The data was analyzed by the DBH Applied Research and Evaluation Unit (ARE) within the Office of Organizational Development. With regard to the populations of interest, older adults with SMI received the highest level of interest followed by adults with SMI. With regard to services of interest, both services for children and youth at risk for mental, emotional and behavioral disorders and services for parents with substance use and/or mental disorders with dependent children were rated the highest.

Data Needs Technical Assistance Meetings: The next step following the completion of the data analysis was planning the one (1) and a half day on-site visit Data Needs Technical Assistance meetings. The Pre-Data Needs Technical Assistance meeting was held on July 28, 2016 and was designed to bring together the Committee Chairs and interested members to engage in an informal discussion about data needs. This meeting also included the Technical Assistance consultant and staff in the DBH ARE. The topics included: 1) evidence based decision-making; 2) reviewing the DBH/BHC data needs surveys, 3) exploring data sources, 4) selecting evidence based interventions; and 5) next steps.

The Data Needs Technical Assistance meeting was held on July 29, 2016. It was designed to engage the DBH/BHC, DBH substance used disorder staff, and other interested persons in discussions that include: data planning, data presentations, data needs, data resources, and preliminary thoughts about developing a data plan. The SAMHSA block grants data discussed included: 1) National Outcome Measures (NOMS); 2) Uniform Reporting System (URS); and 3) Mental Health Statistics Improvement Program Survey (MHSIP) and Youth Services Survey for Families **(**YSS-F**)**. The DBH data included the: 1) MEASURES Report (mental health and substance use disorder data); 2) Community Services Review (overall quality of the service system); and 3) Provider Scorecard (rates providers certified by DBH to deliver mental health treatment and supports). The results of the Data Needs Survey Summary was disseminated. There was an overview about the next steps for developing a Draft Data Plan.

The Data Needs Technical Assistance Consultant integrated the discussions and presentations during the day and a half on site meetings into a draft strategy for *Creating and Implementing*

a Data Collection Plan. This information will be reviewed and discussed by the DBH/BHC and follow-up action taken.

Behavioral Health Council Committees: The DBH/BHC relies on the input of very active committees. Each committee has been charged with using data to inform its individual work as well as the larger body including providing input to the State Plan. It also relies on DBH staff reports, especially the performance of the provider network and other contractors, and consumer satisfaction survey reports.

The DBH/BHC Committees include the: 1) Advocacy Committee, 2) Program, Data and Policy Committee, 3) Block Grant Committee, and 4) Ad Hoc By-Laws Committee.

Advocacy Committee Report: This Committee provides education, information, and support to efforts related to the prevention and treatment of mental health and substance use disorders. The Advocacy Committee identified three (3) members to participate in the SAMHSA State Technical Assistance Project 2015-2016 Advocacy Teams Group. This group advocates for the work of the planning and advisory councils as an important influence in mental and behavioral health service system planning.

The monthly Advocacy Teams Group calls focused on several issues. They include: 1) overview of advocacy definitions along with a review of successful campaigns; 2) the role of internal advocacy for planning and advisory councils; 3) including underserved and emerging groups in advocacy efforts; and 4) utilizing data for advocacy (fiscal and program).

The Chair of the Advocacy Committee was invited to become a member of the DBH Ombudsman Advisory Council as a way to foster linkages between the two (2) Councils. The DBH Ombudsman's office ensures District residents have a clear pathway to access quality behavioral health coverage and services. The Advisory Council will work with consumers, consumer groups, community organizations, government agencies, and individuals, to improve access to and the quality of services for children, youth, families and residents of the District of Columbia.

Block Grant Committee Report: This Committee works closely with the DBH Block Grant staff to develop the biennial plan and annual reports that is submitted to SAMHSA. The Block Grant Committee participated in the FY16-FY17 Mental Health Block Grant application process to request projects for funding consideration. The Committee selected SAMHSA topics that address the services and supports needs of: 1) persons with mental health diagnosis and substance use issues who have experienced trauma; 2) peer run organizations and/or the establishment of peer organizations that support the behavioral health system of care; 3) persons diagnosed with HIV/AIDS and a mental health and/or substance use disorder; 4) children and youth who are at risk for mental, emotional, and behavioral disorders, including but not limited to, addiction, conduct disorder, and depression; 5) women who are pregnant and have a substance use issue and/or a mental disorder; 6) older adults living with substance use issues and/or mental health disorders; and 7) integration of primary health, mental health and substance use disorders to address the service and support needs of children and youth with serious emotional disturbances (SED) or adults with serious mental illnesses (SMI).

The Block Grant Committee recommended that an independent reviewer that DBH would procure would review all applications. This decision was made because the Committee felt this option reduces the risk of conflict of interest for the Committee members and the Council. The Committee also recommended that a minimum of 10 awards be made up to $300,000.00.

The Block Grant Committee received the notice of funding availability (NOFA) and request for applications (RFA). The Committee Co-Chairs also attended the Pre-Application Conference and received the questions and answers.

The DBH Director has final approval for the recommendations from the external review process. The Director's decisions will be shared with the Block Grant Committee and the DBH/BHC.

Program, Data and Policy Committee Report: This Committee works with the DBH staff on programmatic and policy issues that affect the mental health and substance use disorder service system. Some of the Committee members attended a Policy Writing Workshop at DBH. The workshop was divided into three (3) parts. Lesson 1 focused on: 1) the purpose of policies and procedures and their importance; 2) their relevance to the organization's vision and mission; 3) the things that influence them; and 4) the criteria that makes them effective. Lesson 2 addressed developing policies and procedures including drafting them and policy elements. Lesson 3 provided suggestions for policies and procedures including keeping them simple, common style tips, keeping them general and helpful, and drafting the policy. The Committee is working with the DBH Policy Division to explore ways that can work on policies.

The Committee also began to focus on data that could be useful in carrying out its mission. They reviewed information about the Provider Scorecard on the DBH website, which addresses issues related to the mental health rehabilitation services (MHRS) providers. The Committee will also review and discuss the DBH Mental Health and Substance Use Report on Expenditures and Services (MHEASURES Report).

Ad Hoc By-Laws Committee: This Committee's task is to review the DBH/BHC By-Laws and make recommended changes that will be submitted to the BHC for approval. This Committee recommended the following changes to the By-Laws:

Terms of Appointment – The DBH/BHC members will be appointed for a 3-year term, and may be reappointed for one additional 3-year term or until replacement.

Attendance at Meetings – The DBH/BHC members may attend meetings telephonically or through other electronic means; if unable to attend in person but may not exceed three (3) by any other means. There are six (6) regularly scheduled council meetings. After the second absence, of any type, in any consecutive 12-month period, a letter will be sent to the Council members inquiring about their status.

Quorum –A quorum shall consist of a minimum of twenty-five percent (25%) of active, participating, appointed voting membership of the DBH/BHC. At meetings where a quorum

is not present, the only actions that may legally be taken are to set a time for adjournment, adjourn, recess, take measures to obtain a quorum, and to determine the time for the next meeting.

DBH Behavioral Health Council and Staff Participation in SAMHSA National Block Grant Conference: The Conference was held in Arlington, VA August 9-11, 2016. The Department of Behavioral representatives that attended the Conference included the Mental Health Block Grant Planner, Director of Child and Youth Services Division, and Substance Use Disorder staff representing Treatment and Prevention. The Chair of the Behavioral Health Council also attended. The Conference theme was *Building and Sustaining State Behavioral Heathcare Systems.* The format included plenary sessions and concurrent panel sessions. The sessions were divided into: 1) clinical treatment track, 2) financial track; 3) workforce development track; 4) technology/data track; 5) process and integrated systems track; and 6) prevention track.

***Please provide a description of how the application was made available to the public for comment.

Public Comment

The D.C. Department of Behavioral Health posts all Mental Health Block Grant Applications on its website for review and comment. There is no end date for the review period. Any comments received are reviewed by the Department and a response provided; if warranted revisions are made and SAMHSA informed via a revision request.

Behavioral Health Advisory Council Members

Start Year: 2017 End Year: 2018

Name	Type of Membership	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Benita Blaine	Parents of children with SED		DC,	
Doris Carter	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		915 Allison Street, NW #201Washington DC, 20011 PH: 202-832-8336	DCarter@calvaryhealthcare.org
Yuliana Del Arroyo	State Employees	Office of the State Superintendent of Education	810 First Street NE, 9th FloorWashington DC, 20002 PH: 202-741-0478	Yuliana.delarroyo@dc.gov
Nicole Denny	State Employees		2435 Alabama Avenue, SEWashington DC, 20020 PH: 202-671-6140	Nicole.denny@dc.gov
Luis Diaz	State Employees	Criminal Justice Coordinating Council	441 Fourth St NWWashington DC, 20001	luis,diaz@dc.gov
Cheryl Doby-Copeland	State Employees		DC,	
Donna Flenory	Parents of children with SED		510 Division Avenue, NEWashington DC, 20019 PH: 202-497-3097	dlflenory@gmail.com
Mimi Gardner	Providers		DC,	
Julie Kozminski	Providers		1220 12th Street, SE, Suite 120Washington DC, 20003 PH: 202-715-7966	jkozminski@unityhealthcare.org
Tammi Lambert	Others (Not State employees or providers)		905 6th Street, SW, Apt. 708BWashington DC, 20024 PH: 202-724-5454	Lambert.tammi@gmail.com
Evan Langholt	Providers		2100 New York Avenue, NEWashington DC, 20002 PH: 202-269-6333	evan_langholt@uss.salvationarmy.org
Jennifer Lav	Others (Not State employees or providers)		220 I Street, NE, Suite 130Washington DC, 20002	jlav@uls-dc.org

			PH: 202-547-0198	
Diane Lewis	State Employees	District of Columbia Health Benefit Exchange Authority	1225 I Street, NW 4TH FLOORWashington DC, 20005 PH: 202-966-7516	dlewis@acg-cos.com
Marie Morilus-Black	State Employees	Child and Family Services Agency	200 I Street, SEWashington DC, 20003 PH: 202-442-6002	marie.morilus-black@dc.gov
Maria Newman	Family Members of Individuals in Recovery (to include family members of adults with SMI)		1363 Spring Road NWWashington DC, 20010 PH: 202-865-3796	m_newman@howard.edu
Lynne Person	Others (Not State employees or providers)		601 E Street, NW T3-314Washington DC, 20049 PH: 202-434-2140	lperson@aarp.org
Andrew Reese	State Employees	Department on Disability Services	1125 15th Street, NW, 4th FloorWashington DC, 20005 PH: 202-442-8606	andrew.reese@dc.gov
Timothy Robinson	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1511 E Street, SEWashington DC, 20003 PH: 202-569-0151	Timrobinsonskate64@gmail.com
Evelyn Sands	Parents of children with SED		4030 Livingston Road, SE #301Washington DC, 20032 PH: 202-271-6032	esands231@gmail.com
Claudia Schlosberg	State Employees	Department of Health Care Finance	441 Fourth Street, NW 900 SouthWashington DC, 20001 PH: 202-442-9075	Claudia.schlosberg@dc.gov
Senora Simpson	Family Members of Individuals in Recovery (to include family members of adults with SMI)		323 Quackenbos, NEWashington DC, 20001 PH: 202-529-2134	Ssmimp2100@aol.com
Effie Smith	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Consumer Action Network	1300 L Street, NW, Suite 1000Washington DC, 20005 PH: 202-842-0001	esmith@can-dc.org
Sakina Thompson	State Employees	Department of Human Services	64 New York Avenue, NE 6th FloorWashington DC, 20002 PH: 202-671-4451	Sakina.thompson@dc.gov
Adrienne Todman	State Employees	District of Columbia Housing Authority	1133 North Capitol Street, NEWashington DC, 20002 PH: 202-535-1513	ATodman@dchousing.org
			500 K Street,	

Sara Tribe Clark	State Employees	District of Columbia Office on Aging	NEWashington DC, 20002 PH: 202-535-1367	Sara.tribe@dc.gov
Tamara Weissman	Providers		1104 Allison Street NWWashington DC, 20011 PH: 202-722-1815	tweissman@gafsc-dc.org
Miya Wiseman	Family Members of Individuals in Recovery (to include family members of adults with SMI)		3105 18th Street, NEWashington DC, 20018 PH: 202-270-6173	Miya714@yahoo.com
James Wotring	State Employees	DC Department of Behavioral Health	64 New York Ave. NEWashington DC, 20002	

Footnotes:

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year: 2017 End Year: 2018

Type of Membership	Number	Percentage
Total Membership	28	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	3	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	3	
Parents of children with SED*	3	
Vacancies (Individuals and Family Members)	0	
Others (Not State employees or providers)	3	
Total Individuals in Recovery, Family Members & Others	12	42.86%
State Employees	12	
Providers	4	
Federally Recognized Tribe Representatives	0	
Vacancies	0	
Total State Employees & Providers	16	57.14%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Persons in recovery from or providing treatment for or advocating for substance abuse services	0	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

Footnotes: