District of Columbia

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

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

OMB - Approved 06/12/2015 - Expires 06/30/2018
(generated on 06/01/2016 2.07.04 PM)

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 2016

End Year 2017

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

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Email Address tanya.royster@dc.gov

III. Expenditure Period

State Expenditure Period

From

To

IV. Date Submitted

Submission Date 9/30/2015 2:33:52 PM

Revision Date 6/1/2016 2:06:08 PM

V. Contact Person Responsible for Application Submission

First Name Javon

Last Name Oliver

Telephone 202-821-3364

Fax

Email Address javon.oliver@dc.gov

Footnotes:

State Information

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

Fiscal Year 2016

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:

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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 Steps

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

Narrative Question:

Provide an overview of the state's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health 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 SSA, the SMHA, and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health 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 gender minorities, as well as American Indian/Alaskan Native populations in the states.

Footnotes:

DISTRICT OF COLUMBIA

FY 2016-FY 2017 MENTAL HEALTH BLOCK

GRANT APPLICATION BEHAVIORAL HEALTH ASSESSMENT AND PLAN

Table of Contents

Executive Summary

The Substance Abuse and Mental Health Services Administration (SAMHSA) oversees two (2) major block grants: 1) the Substance Abuse Prevention and Treatment Block Grant (SABG), and 2) the Community Mental Health Services Block Grant (MHBG). This document is the District of Columbia FY 2016-FY 2017 Mental Health Block Grant Application. The District's FY 2016-FY 2017 SABG Application will be submitted under separate cover in accordance with the submission date.

A major component of the MHBG Application is the Behavioral Health Assessment and Plan. It provides information about the: 1) the District of Columbia population characteristics, health status, and homelessness; 2) D.C. Department of Behavioral Health (DBH) including primary organizational components, adult and child and youth service system initiatives, services and supports; 3) adult and child DBH and sub-grantee projects funded by the MHBG; 4) behavioral health data; 5) planning steps (including assessment of strengths of the system in serving various populations, unmet and/or critical gaps in the service system, priority planning initiatives and associated goals, objectives, performance indicators and strategies); 6) expenditure data (District, DBH, and MHBG); 7) key environmental factors and technical plan; 8) behavioral health planning and advisory council input and activities; and public awareness of MHBG application and opportunity to comment.

I. Overview of the District of Columbia

The District of Columbia is the capital of the United States. Its land area is 61.05 square miles. The U.S. Constitution allows for the creation of a special district to serve as the permanent national capital. The District is not a part of any U.S. state and is governed by an elected Mayor and a 13-member elected Council. The District functions as a state government and a local government.

A. Population: The U.S. Census Bureau 2014 estimate for the District of Columbia population is 658,893. The gender, age, and race/ethnicity data source is the U.S. Census Bureau Population Estimates 2013. The education and household data source is the U.S. Census Bureau, American Community Survey (ACS) 2009-2013.

- ***Gender:*** There are 340,199 females representing 52.6% of the population, and 306,250 males representing 47.4% of the population

- ***Age:*** The majority of the residents are age 25-64 (380,571) followed by those 18-24 (80,982).

Age	Number of People	Percent of Population
Under age 5	40,967	6.3%
5-12	45,134	7.0%
13-17	25,373	3.9%
18-24	80,982	12.5%
25-64	380,571	58.9%
65 and over	73,422	11.4%

- ***Race/Ethnicity:*** The majority of the residents are African American (319,676) followed by White alone (280,509).

Race/Ethnicity	Number of People	Percent of Population
African American or Black	319,676	49.5%
White alone	280,509	43.4%
White alone, not Hispanic or Latino	231,281	39.8%
Hispanic or Latino	65,560	10.1%
Asian alone	25,047	3.9%
Two or more races	16,635	2.6%
American Indian & Alaska Native alone	3,639	0.6%
Native Hawaiian & Other Pacific Islander alone	943	0.1%

- ***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). The data is presented in the table that follows.

Educational Level	Number of People	Percent of Population
High School Graduate (includes equivalency)	80,898	18.8%
Bachelor's Degree	97,680	22.7%
Other Professional Degrees	127,801	29.7%

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

Household Characteristics	Number/Rate/Median
Housing Units	298,327
Homeownership Rate	42.1%
Housing Units in Multi-Unit Structures	61.2%
Median Value Home Owner Occupied Units	$445,200
Median Household Income	$65,830

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

Family Characteristics	Percent of Population
Female Single Parent Household	37.3%
Married No Children	34.4%
Married With Children	19.6%
Male Single Parent Household	8.7%

B. Health Profile: The District Department of Health developed and disseminated the first edition of the *District of Columbia Community Health Needs Assessment* (February 28, 2014). It is a comprehensive analysis and review of the health and quality of life of District residents. The tables that follow provide data for key health indicators for the District and the United States (2010 reporting period).

- ***Mortality and Life Expectancy*** (asterisk notes the District is higher on health indicator)

Health Indicator	District of Columbia	United States
Life Expectancy (at birth, age in years)	77.7	78.7
Leading Causes of Death (age adjusted death rate per 100,000 population):		
Heart Disease	239.7*	178.5
Cancer	193.0*	172.5
Accidents	36.9	37.1
Cerebrovascular Disease	35.5	39.0
Chronic Lower Respiratory Disease	27.0	42.1
Diabetes	26.7*	20.8
HIV Disease	21.4*	2.6
Alzheimer's Disease	20.3	25.0
Homicide/Assault	16.9*	5.3
Septicemia	16.7*	10.6

- ***Maternal and Child Health Outcomes*** (asterisk notes the District is higher on health indicator)

Health Indicator	District of Columbia	United States
Infant Mortality (per 1,000 births)	8.0*	6.1
Low Birth Rate (percent of births)	10.2*	8.2
Pre-term Birth (percent of births)	10.3	12.0
Teen Birth Rate (per 1,000 women ages 15-19)	45.4*	34.2
Fertility Rate (births per 1,000 women ages 15-44)	56.4	64.1

- ***Chronic Health Indicators*** (asterisk notes the District is higher on health indicator)

Health Indicator	District of Columbia	United States
Overweight and Obesity (BMI):		
Neither Overweight or Obese (percent adults 18 and older)	43.7*	35.3
Overweight (BMI 25.0-29.9, percent adults 18 and older)	33.8	36.2
Obese (BMI 30.0-99.8, percent adults 18 and older)	22.4	27.6
Cardiovascular Diseases:		
Heart Attack or Myocardial Infarction (percent adults 18 and older)	2.8	4.1
Angina or Coronary Heart Disease (percent adults 18 and older)	2.6	4.1
Stroke (percent adults 18 and older)	3.4*	2.6
Diabetes:		
Diagnosed with Diabetes (percent adults 18 and older)	8.3	8.7
Asthma:		
Current Asthma (percent adults 18 and older)	10.4*	9.1
Lifetime Asthma (percent adults 18 and older)	16.0*	13.8
Current Asthma (percent children 17 and under)	18.0*	8.4
Lifetime Asthma (percent children 17 and under)	22.4*	12.4

C. Health Disparities: Race/ethnic health disparities are presented below.

- Non-Hispanic black infants account for a disproportionate percentage of all infant deaths.
- Hispanic females were expected to live the longest in the District (88.9 years), followed closely by Hispanic males (88.4 years).
- Hispanics newly diagnosed with HIV were more likely to be younger than other racial groups.

- Blacks/African Americans have the highest obesity rates, and are least likely to exercise or consume the recommended serving of fruits and vegetables.
- The crude death rate due to diabetes for Blacks/African Americans was seven (7) times the rate for Whites in 2010.
- Blacks/African Americans were over three (3) times more likely to die from cerebrovascular diseases compared to their white counterparts.

D. Homelessness: The Community Partnership for the Prevention of Homelessness (TCP) conducts the Point in Time (PIT) census and survey of persons who are homeless on behalf of the District. This single-day count was conducted on January 28, 2015. There were: 1) 1,593 unaccompanied individuals and 66 persons in families who met the federal definition of "chronic homelessness" (living with disabilities and lengthy or repeated episodes of homelessness), and 2) 7,298 persons experiencing homelessness were counted including: 544 unsheltered (living on the street or places not meant for habitation) and unaccompanied; 5,085 in emergency shelters (2,612 unaccompanied and 2,473 people in 768 families); and 1,669 in transitional housing (665 unaccompanied and 1,004 people in 363 families).

- ***PIT Count by Category:***

Category	2014	2015	Percent Change
Total Number Counted	7,748	7,298	-5.8%
Total Number of Individuals	3,953	3,821	-3.3%
Total Number of Families	1,231	1,131	-8.1%
Total Persons in Families	3,795	3,477	-8.4%
Total Adults in Families	1,559	1,428	-8.4%
Total Children in Families	2,236	2,049	-8.4%

The decreases are largely due to the District's continued investment in permanent housing solutions for individuals and families. While the continuum of care continues to see more new individuals and families enter the system, Permanent Supportive Housing and Rapid Rehousing resources have helped increase the rate of exits from homelessness, especially among persons who are chronically homeless. There were 4,415 individuals and 6,129 people in 2,016 families residing in Permanent Supportive Housing, Rapid Rehousing, or other permanent housing for persons who had previously experienced homelessness.

- ***Other Characteristics:***

Characteristic	Age/Number/Percent
Median age unaccompanied homeless persons	Age 50
Median age among adults in homeless families	Age 25
Unaccompanied minors in shelters, transitional housing	7
Served in United States Armed Forces	10%
No income unaccompanied homeless adults	66%
No income adults in homeless families	14%
Adult homeless history of substance use or mental illness	1 in 5
Adult homeless with substance use and mental illness	9%
Adult homeless with chronic health problem	8%
Adult homeless with physical disability	13%

Adult homeless history of domestic violence	15%
Adult homeless domestic violence caused homelessness	6%

II. Overview of the District of Columbia Department of Behavioral Health

The mission of the Department of Behavioral Health (DBH) is to support prevention, treatment, resiliency, and recovery for District residents with mental health and substance use disorders through the delivery of high quality, integrated services. DBH serves as the District of Columbia State Mental Health Authority and the Single State Agency for substance abuse. The primary components of the DBH organizational structure is described below.

A. Behavioral Health Authority (BHA): The BHA supports the overall administrative mission of DBH and encompasses the functions necessary to support the entire system. It is responsible for: 1) establishing priorities and strategic initiatives; 2) system planning and policy development; 3) planning and developing mental health and substance use disorder services; 3) ensuring access to services; 4) monitoring the service system; 5) regulating the providers within the District's public behavioral health system including certifying providers of mental health rehabilitation services, substance abuse treatment centers, and licensing mental health community residential facilities; 6) providing grant or contract funding; and 7) coordinating fiscal services; accountability functions; and information systems.

B. Office of Programs and Policy (OPP): The OPP is responsible for the design, delivery, evaluation and quality improvement of behavioral health services and support for children, youth, families, adults, and special populations to maximize their ability to lead productive lives. This includes a variety of services and supports: 1) early childhood and school mental health programs; 2) care coordination; 3) same-day or walk-in services; 4) multicultural outpatient services; 5) physicians practice group; 6) outpatient competency restoration; 7) outpatient forensics; 8) crisis emergency services; 9) homeless outreach; 10) assertive community treatment; 11) supported housing; 12) supported employment; 13) services for individuals who are deaf and for persons who are developmentally disabled with a psychiatric illness; 14) a training institute, community services reviews, applied research and evaluation; two (2) government operated outpatient clinics; 15) development and implementation of substance use disorder treatment services, prevention services, and recovery support services; and 16) the private provider network.

C. Care Coordination: The Access Helpline (AHL) is the DBH call center. It is the major point of entry into the behavioral healthcare system. As of June 2015, there were 79,594 incoming and outbound calls. AHL activities include: 1) enrollment for Mental Health Rehabilitation Services (MHRS); 2) authorization for specialty services including Assertive Community Treatment, Community-based Intervention, Intensive Day Treatment, Rehabilitation Day Services and Crisis Stabilization (crisis beds); 3) authorization and review of .involuntary hospitalization admissions; 4) crisis response and deployment of emergency response teams for adults (Mobile Crisis Services) and child/youth (Child and Adolescent Mobile Psychiatric Services); 5) discharge planning and disenrollment from MHRS; 6) coordination of services; and 7) 24-hour access to suicide prevention and intervention services. As of June 2015, there were 45,981 Crisis Line inbound calls, 3,265 DBH Suicide Lifeline calls, and 352 calls to the

Washington Metropolitan Area Transit Authority Lifeline (through AHL) for citizens identified within Metro stations who are in need of support.

D. Provider Relations: Provides support that enhances the success and effectiveness of the DBH provider network development. This includes both mental health and substance use disorder providers. The services include technical assistance for adult and child providers related to: 1) front desk operations- intake processes, billing and claims operations, coordination of benefits, HIPAA compliance, utilization review and medical records and development of administrative and clinical forms; 2) liaison between providers, DBH and other government agencies including coordinating services, providing information, coordinating meetings between providers and other agencies; 3) primary center for distribution of information to providers; 4) central point for troubleshooting provider problems, issues and concerns or responding to stakeholder issues related to providers; 5) coordinate monthly and semi-annual meetings with individual providers and key DBH staff; and 6) manages provider closures in collaboration with other DBH divisions, providers, stakeholders and third party payers including transition of consumers and closeout payment.

E. Office of Accountability: Provides three (3) distinct functions: 1) quality improvement audit- includes oversight of MHRS providers to ensure they meet or exceed the service delivery and documentation standards, substance abuse treatment and recovery services, Mental Health Community Residence Facilities (MHCRF) and comply with applicable District and federal laws and regulations, monitor the provider network, investigate complaints and unusual incidents\, and make policy recommendations; 2) certification/licensure-certifies DBH provider agencies, licenses of all MHCRFs, additionally these units monitor provider compliance with DBH regulations and local and federal laws, generates and enforces corrective action plans when necessary, monitors facilities on a regular basis, issuing notices of infraction when necessary; and 3) investigations- conducts major investigations of critical incidents, presents a disposition of the matter, and develops the final investigative report that is submitted to the DBH Director, General Counsel and other appropriate parties, to ensure that the needs and treatment goals of individuals in care are identified and addressed.

F. Office of Strategic Planning, Policy and Evaluation: Responsible for coordination and/or development of DBH, District and federal planning initiatives. The functions include: 1) coordinate, in collaboration with program staff, the development of draft regulations, stakeholder input process and publication and dissemination of regulations to support new programs, initiatives and functions; 2) draft DBH policies based upon input received from program and executive staff including identification of need, coordination with program area, review of other policies/regulations/laws, solicitation of comments from staff and stakeholders, finalize, publish and disseminate; 3) management of the DBH grants portfolio including the Substance Abuse and Mental Health Services Administration Mental Health Block Grant; 4) District agency performance planning and management including the development of the DBH performance plan, key performance indicators and Performance Accountability Report; and 5) inter-agency coordination.

G. Organizational Development: Consists of the Applied Research and Evaluation (ARE) Unit and the Community Services Review (CSR) Unit.

- ***ARE:*** Creates data reports for mental health and substance use disorder services and disseminates findings to internal stakeholders. This unit helps create data tracking systems, conducts research studies and program evaluations, and makes recommendations for practice improvement activities. It is responsible for collecting consumer satisfaction data and reporting the findings. ARE produces a semi-annual data report on utilization and expenditures, the *Mental Health Expenditures and Service Utilization Report* (MHEASURE). ARE also conducts analysis on Crisis Intervention Officer (CIO) data.
- ***CSR:*** Conducts case-based qualitative reviews for use in system performance monitoring. It provides technical assistance to the DBH provider network regarding CSR findings. This unit conducts reviews on child mental health consumers and services (in collaboration with the Child and Family Services Agency), adult mental health consumers and services, and is in the process of creating a tool to assess substance use consumers and services.

H. Training Institute: Coordinates and supports the workforce needs of DBH and the community behavioral health providers. It collaborates with other District agencies, learning institutions and community stakeholders to facilitate educational opportunities designed to build a strong behavioral health community. Current interagency partnerships include***:*** 1) ***Metropolitan Police Department- Crisis Intervention Officer (CIO)*** training and program support (40-hour CIO training 5 times annually and 8-hour CIO Refresher training twice annually) and trains all incoming police recruit classes in behavioral health concepts, resources and crisis response; 2) ***Office of Police Complaints-*** developing internal safety policies and training to prepare employees for potential crises that may erupt during the complaint process; 3) ***Department on Disability Services-*** in FY 2015 launched collaborative training to build capacity among behavioral health clinicians to provide services to individuals dually diagnosed with mental illness/substance use disorder and intellectual disabilities; 4) ***District of Columbia Public Schools***- launched e-learning course series in FY 2015 to train all public school, public charter school and child development center staff in the screening and referral of youth with emotional and mental health issues; and 5) ***Person-Centered Care-*** an ongoing initiative to transform the assessment and treatment planning process to improve consumer outcomes throughout the behavioral health system. As of June 2015, more than 4,500 classroom attendees were trained in behavioral health concepts, and over 7,500 continuing education contact hours were awarded to over 1,000 licensed attendees.

I. Office of Disaster Behavioral Health Services (ODBHS): Leads emergency preparedness efforts with the guidance of the ***Emergency Preparedness Coordinating Committee.*** ODBHS develops and implements a plan that ensures DBH is prepared to quickly mobilize and provide behavioral health services in the event of a disaster or emergency. To ensure continuity of consumer care, DBH certified providers and certified community residential facility operators must have internal policies and procedures to prepare for and respond to emergencies, and a written plan to ensure that essential operations continue in the event of an emergency or threat of an emergency. ***Behavioral Health Response Teams*** provide rapid and effective disaster behavioral health crisis counseling and stress management. They are DBH staff clinicians trained and experienced in providing disaster and emergency behavioral

health assessments, interventions, and referrals for long-term treatment offered in a variety of settings. DBH ***Disaster Behavioral Health Emergency Response Team Certification Program*** provides the critical knowledge areas that allow the responders to work with the public health, law enforcement, and emergency management systems to address the behavioral health consequences during wide spread community incidents. In 2014, ODBHS responded to and received an award for group achievement from the Secretary of the Navy for their role in support to survivors of the Navy Yard Shooting. As of June 2015, 73 people were trained in disaster behavioral health response and there were 90 response team members.

J. Office of Consumer and Family Affairs: Works to ensure the rights of people with behavioral health issues are protected including: 1) encourages and facilitates consumer and family input in all aspects of an individual's treatment and plan for recovery; 2) ensures providers post a consumer rights statement and receives and responds to all grievances; 3) provides grievance training for DBH providers; and 4) works with the Office of Disability Rights to sponsor the annual ***Olmstead Conference*** to promote community integration of individuals with disabilities. A 6-week ***Peer Certification Program*** is offered twice a year to train individuals with lived experience to assist others receiving behavioral health services move towards and sustain their recovery. Some peer support staff work within the public behavioral health system. The services provided by the certified peer specialists are Medicaid reimbursable. As of June 2015, 100 individuals with lived experience have been certified through this program. ***A Child-Youth-Family Specialty*** Track has also been developed. As of June 2015 12 family members have been certified. The office will also oversee a peer focused activity center, ***Our Door***, scheduled to open during the first quarter of FY 2016. The purpose of the community peer operated activity center is to: 1) assist people with psychiatric illness who may also have co-occurring substance use disorder and medical conditions, regain control over their lives and their own recovery process; 2) achieve this goal in an environment that is conducive to support for self-directed recovery, advocacy, education, and information and referral services based on consumer experience, knowledge and input; and 3) provide activities that include: recreational and social, educational, Peer Support and Peer Advocacy groups, health education and linkages to medical care including participating in health fairs, community resource identification, assistance with benefits and entitlement applications; improvement of social interpersonal skills and life skills validation (e.g., Wellness Recovery Action Plan (WRAP) classes); and education on consumer rights.

K. Saint Elizabeths Hospital (SEH): The SEH provides psychiatric, medical, and psychosocial inpatient psychiatric 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. In addition, this program manages logistics, housekeeping, building maintenance, and nutritional services at SEH, to ensure the provision of a clean, safe and healthy hospital environment for individuals in care, their families, and staff. The Hospital also ensures staff credentialing and licensing privileges, and provides medication and medical support services to eligible inpatients in order to effectively treat mental illness and enhance recovery. The Hospital is licensed by the District's Department of Health as well as the U.S. Department of Health and Human Services (DHHS) Centers for Medicare and Medicaid Services.

III. Overview of Adult Service System

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. DBH contracts 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 services; 7) intensive day treatment, and 8) assertive community treatment (ACT). As of June 2015, there were 37 total MHRS providers that included 25 core service agencies, and 14 adult and child serving agencies.

Also, as of June 30, 2015 there were 15,847 adults age 18 and above, of which 15,707 were seriously mentally ill. Some of the adult system of care behavioral health program initiatives, treatment services and supports are described below.

A. Integrated Care: Seeks to reduce the inpatient census and admissions to Saint Elizabeths Hospital by: 1) identifying consumers who need a comprehensive array of services that include mental health, non-mental health, and informal support services to integrate to their fullest ability in their communities and families; 2) coordinates, manages, and evaluates the care for these consumers to improve their quality of life and tenure in a community setting; and 3) provides care management services to individuals with complex mental health needs as well as those discharged from a psychiatric inpatient stay in a community hospital.

B. Health Homes: This initiative is a joint effort by the Department of Behavioral Health and the Department of Health Care Finance. 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 eligibility requirements are: 1) age 18 or above; 2) Medicaid eligible and enrolled; 3) have a serious mental illness; and 4) may or may not have a co-existing chronic physical condition. During FY 2015 the State Plan Amendment (SPA) was submitted to the Centers for Medicare and Medicaid Services (CMS) for approval. It is anticipated that the Health Homes initiative will be implemented in January 2016.

C. Crisis Stabilization Beds: DBH contracts with two (2) community providers for 15 crisis stabilization beds. There are eight (8) beds at Jordan House and seven (7) beds at Crossing Place. As of June 2015, the average quarterly crisis stabilization bed utilization rate was 88.90%.

D. Crisis Emergency Services: The Comprehensive Psychiatric Emergency Program (CPEP) is a 24-hour specialty psychiatric unit responsible for assessing and treating individuals with acute and chronic mental illness in or pending psychiatric crisis. It has three (3) components: 1) Psychiatric Emergency Services, 2) Mobile Crisis Services, and 3) Homeless Outreach Program.

- ***Psychiatric Emergency Services (PES)***: Medical treatment is available for common medical problems and limited medical testing is conducted. CPEP accepts voluntary patients who come on their own or accompanied by family, friends or healthcare

professionals; and involuntary patients from community settings who are referred by law enforcement, physicians, psychologists or officer-agents. Each patient receives a nursing assessment and a psychiatric evaluation; depending on the clinical presentation, most have a psychosocial assessment and a medical screening. Once a psychiatric evaluation is completed, the patient may be discharged immediately, kept at CPEP for stabilization (up to 72 hours in the Extended Observation Bed unit) or referred for psychiatric hospitalization. As of June 2015, 1,935 unduplicated individuals out of 2,769 visited PES.

- ***Mobile Crisis Services (MCS):*** Provides services to adults experiencing a psychiatric crisis in the community including at home, office or any public area. The team acts quickly as a first responder to adults who are unable or unwilling to travel to receive mental health services and may provide in-field psychiatric assessment, bilingual clinical consultation, medication management, linkages to ongoing services, and follow-up services to assure stability. The team also responds to critical incidents including tragedies and disasters throughout the District. As of June 2015, 861 unduplicated individuals out of 968 received a team visit.
- ***Homeless Outreach Program (HOP):*** Operates as part of the MCS program. Its primary purpose is to provide a variety of mental health outreach services and supports to adults and families who are homeless. These services include: mental health assessments, crisis intervention, care coordination between mental health agencies, and referrals to other services. As of June 2015, 472 unduplicated persons received engagement services out of 1,541. The HOP also provides consultation and training to the provider network working most closely with this population.
- ***Technical Assistance through SAMHSA-*** In May 2015, DBH developed a technical assistance request through the SAMHSA TA Tracker to evaluate and develop strategies to enhance the quality of service delivery and therapeutic efficiency of CPEP's three (3) complementary programs (PES, MCS, and HOP). Other goals included: 1) a review of the literature and/or examples of other state/jurisdiction operation of urban emergency psychiatric services, including the use of evidence-based practices, outcomes and limitations; and 2) development of strategies and roadmap for CPEP to incorporate relevant evidence-based practices and tools into psychiatric care delivery, thereby improving quality and enhancing staff development. The TA request was approved in June 2015. Mark Engelhardt, an expert in both crisis services and homelessness, was the assigned consultant. There was an exchange of documents, a planning conference call, and a 2-day site visit August 6-7, 2015. The consultant report was received at the end of August and was very positive with some short-term follow-up actions.

E. Mental Health Services Division (MHSD): Manages the DBH operated mental health services for adults to ensure accessibility and effectiveness of services and cost efficient use of resources. It provides specialized mental health services that are not otherwise readily available within the community provider network. The MHSD programs are described below.

- ***Same Day Urgent Care Clinic Services-*** Provides same day service for walk-in adult mental health consumers who need immediate assessment or medication. Interventions include triage, assessment, supportive counseling, crisis intervention, medication services

and linkage to ongoing services. As of June 2015, the average quarterly unduplicated number of adult intakes at the Same Day Urgent Care Clinic was 1,265.

- ***Physicians Practice Group***- Provides psychiatric services to individuals seen for Urgent Care service and mental health consumers who need medication management only. It also provides psychiatric services to support the DBH private provider network with psychiatrists on-site at provider agencies.
- ***Pharmacy Services***- Provides prescribed medication for mental health consumers who are uninsured or underinsured. As of June 2015, 11,850 prescriptions were filled for 2,008 unduplicated consumers.
- ***Multicultural Services***- Provides culturally and linguistically appropriate mental health services for the diverse, racial and cultural communities in the District. As of June 2015, 210 consumers received services from this program.
- ***Deaf /Hard of Hearing Services***- Provides mental health services for mental health consumers who are deaf and/or hard of hearing. As of June 2015, 36 consumers received services from this program.
- ***Intellectual/Developmental Disability Services***- Provides mental health services for mental health consumers who are also intellectually/developmentally disabled. As of June 2015, 163 consumers received services from this program.

F. Assessment and Referral Center (The ARC): Adults access substance use disorder treatment services through the DBH ARC. The client participates in a comprehensive assessment and evaluation to determine the appropriate level of treatment and maintenance of care. The DBH Addiction Prevention and Recovery Administration contracts with approximately 30 providers for a continuum of substance use treatment services that include: detoxification, residential, intensive outpatient, and outpatient.

G. Intake Points for Behavioral Health Services: There are four (4) primary intake points for behavioral health services that include: 1) DBH operated programs- The ARC, Comprehensive Psychiatric Emergency Program (CPEP), and Saint Elizabeths Hospital (SEH); 2) DBH contracted program- Court Urgent Care Clinic; 3) Acute psychiatric hospitals- Providence Hospital-Seton House, Psychiatric Institute of Washington, and Washington Hospital Center; and 4) substance use disorder contractors- Community Connections and Family and Medical Counseling Services, Inc.

H. D.C. Prevention Centers: DBH funds four (4) DC 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) distal or behavioral outcomes.

I. Adult Substance Abuse Rehabilitative Services (ASARS): This initiative began in FY 2013 through a partnership with the Department of Health Care Finance to amend the ASARS State Plan Amendment (SPA) and develop regulations that will allow implementation of Medicaid services and billing. The work continued through FY 2015 as there were delays due to revision of the rules and transitioning to the iCAMS data processing system. It is anticipated that the implementation will begin in FY 2016.

J. Forensic Outpatient Services: This service: 1) provides court ordered outpatient competency restoration and evaluations for pre-trial defendants at the adult clinic; 2) provides court ordered evaluations at the D.C. Superior Court for both pre-trial and post-trial defendants; 3) provides 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) provides 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. Also, works to maintain the connection if an individual is incarcerated.
- ***Court Urgent Care Clinic Services (D.C. Superior Court*)-** Serves individuals in the criminal justice system who are in 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. A 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 ACT services for the Options and D.C. Linkage Plus programs. The data through June 2015 include: 1) 638 total referrals seen; 2) 536 total patient referrals; 3) 139 total discharges; and 4) 142 unique individuals seen.
- ***Re-entry Program Services*-** These services include: 1) the Options Program operated by Community Connections provides services to individuals with pre-trial supervision requirements or those being released from the D.C. Jail or prison; 2) the Mental Health Specialists located at the D.C. Jail screens and links individuals requiring mental health services or co-occurring substance use disorder programs, and coordinates release planning activities for those already linked to DBH; 3) the D.C. Linkage Plus Program operated by the Green Door serves individuals with misdemeanor and felony charges previously unlinked to mental health services, referrals generally occur within 90 days of release and individuals are seen within 48 hours of referral (made through DBH Jail and Re-entry Coordinators); and 4) the Liaison Coordinator, co-located with the Department

of Employment Services with the Court Services and Offender Supervision Agency (CSOSA), screens and links individuals to services.

K. D.C. Jail-Women's Facility: DBH received funds from the Justice Grants Administration (JGA), the State Administering Agency (SAA) that secures and manages federal grant funds related to juvenile and criminal justice for the District. These funds allowed a DBH Re-entry Coordinator to be placed at the D.C. Jail Women's Facility to facilitate women with mental health and/or substance use disorder issues being linked prior to discharge with the appropriate service provider. Women may be newly linked or re-linked to mental health services. As of June 2015, the average quarterly number of women provided services was 76.

L. Assertive Community Treatment Services: DBH implements this evidence-based intensive, integrated, rehabilitative, treatment and community-based service provided by an interdisciplinary team to adults with serious and persistent mental illness. DBH ACT teams include a Team Leader, psychiatrist, registered nurse, social worker, certified addictions counselor, peer support specialist, supported employment specialist, and recovery specialist. The services provided include: 1) mental health-related medication prescription, 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 disorder; 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. There are seven (7) ACT providers that have 21 teams. The Dartmouth Assertive Community Treatment 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 (TIP) and ACT teams, known as TACT, that target transition age youth (18-29). As of July 2015, 1,750 consumers were being served by ACT teams.

M. Supported Employment Services: DBH provides an evidence-based Supported Employment Program designed for adult consumers (age 18 and older) with serious mental illness 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 there consumer receives supports in a competitive employment setting and earns at least minimum wage. The services provided to consumers participating in a DBH Supported Employment Program are: intake, assessment, benefits counseling, treatment team coordination, job development, job coaching, follow-along supports, and job club for those on an agency internal waiting list (optional). DBH currently has 10 certified Supported Employment providers with a total of 40 Employment Specialists, each carrying a maximum caseload of 20 clients. The maximum DBH capacity is 800. DBH uses a 14-point fidelity scale to annually review and rate the quality of supported employment services. As of June 2015, 1,113 consumers received supported employment services, 370 were employed, and the average hourly salary was approximately $11.15. The jobs included dishwasher, housekeeper, mover, welder, receptionist, pressman, self-employed driver, optician, medical assistant, and research assistant.

N. Supported Housing Services: DBH has an array of supportive housing options for persons with serious mental illness.

- ***Supported Rehabilitative Residence-*** Provides 24-hour supervision for consumers with severe and persistent mental illness who need an intense level of support to live in the community. The services 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 ensure that residents take their medications 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. The FY 2015 capacity is 208.
- ***Supported Residence-*** This service is for individuals who need less intense support to live in the community. Specific services include: on-site supervision when residents are in the facility; medication monitoring and 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. In addition, DBH provides services and supports to assist individuals to transition to living on their own. The FY 2015 capacity is 453.
- ***Supported Independent Living Program-*** Provides an independent home setting with services and supports to assist consumers in transitioning to living on their own. Community support workers conduct weekly home visits and monitoring to ensure that the individual is able to maintain community tenure and move to independent living. DBH manages locally funded programs that offer rental assistance to individuals enrolled in mental health services who live independently. The FY 2015 capacity is 366.
- ***Home First II Housing Subsidy Program-*** Provides housing subsidies for individuals and families who live in an apartment or home of their choice and sign their own leases. Consumers pay 30% of their household income toward their rent and the Home First Program subsidizes the balance of the rental amount. This program is administered by DBH and supported with locally-appropriated funds. The FY 2015 capacity is 1,105.
- ***D.C. Local Rent Supplement Program-*** Designed to increase the number of permanent affordable housing units and provide housing assistance to extremely low-income households, including individuals who are homeless or need supportive services, such as elderly individuals or those with disabilities. It follows the rules and regulations of the federal housing choice voucher program, is administered by the D.C. Housing Authority, and is supported through local funds. The FY 2015 capacity is 60.

O. Federal Voucher Programs: The FY 2015 capacity for federal vouchers is 586. They include the following programs:

- ***Shelter Plus Care-*** Provides 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. A primary requirement is that each dollar of rental assistance must be matched with an equal or greater dollar value of supportive services.

- ***Housing Choice Voucher Program-*** Formerly Section 8, this federal low income assistance program is administered through the D.C. Housing Authority (DCHA) and via a memorandum of agreement DBH has a set-aside of vouchers for individuals with serious mental illness.
- ***Mainstream Housing For People With Disabilities-*** The U.S. Department of Housing and Urban Development Mainstream Program provides federal vouchers for individuals with disabilities and is administered through DCHA.
- ***Partnerships for Affordable Housing-*** This project-based voucher program provides housing for low-income disabled or elderly families and is administered by DCHA.

P. Homeless Services Initiatives: As previously noted, the Homeless Outreach Program (HOP) is part of Mobile Crisis Services (MCS) within the Comprehensive Psychiatric Emergency Program (CPEP). The HOP staff conducts targeted 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.

- ***Case Finding-*** The resources for case finding include: 1) street and shelter outreach; 2) adult and family shelters; 3) District agencies and hospitals; 4) general public, consumers and family members; and 5)) Metropolitan Police Department and other policing agencies (District Protective Services, Metro, Amtrak, Capitol Hill, U.S. Park, Homeland Security, FBI, Secret Service).
- ***General Services-*** The HOP provides a variety of services to homeless adults, emancipated minors and adult heads of families throughout the District. They include: 1) engagement; 2) refer, link, re-link to community support services including the DBH provider network; 3) wellness checks; 4) crisis emergency services (assessment, referral for voluntary FD-12, outpatient mental health treatment); 5) ACT referrals; 6) substance use treatment referrals and transportation; 7) medical referrals and transportation; 8) encampment outreach and evaluations; 9) referral to DBH, Department of Human Services and other housing resources; and 10) cold weather outreach (hypothermia) and safety checks.
- ***Veteran Services-*** The HOP efforts focus on linking veterans to services such as the 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.
- ***SSI/SSDI Outreach Access Recovery (SOAR)-*** The HOP staff are trained in SOAR. The new staff are also enrolled as part of the new employee orientation and training. Consumers who are eligible and amenable to receive benefits are targeted for quick assessment and enrolled in programs.
- ***Interagency Council for the Homeless (ICH)-*** DBH is member of this body of government agencies, public partners, homeless advocates, consumers, and former consumers of homeless services) that convenes to address challenges and plan for solutions to improve access to homeless services and end homelessness. DBH participates in numerous ICH committees including the Executive Committee, Strategic Planning, Housing Solutions, Operations and Logistics, and the Winter Planning Process.

- ***Project for Assistance in Transition from Homelessness (PATH) Grant-*** These funds are used to support the DBH Homeless Outreach Program and the Housing Subsidy Program.
- ***"Cooperative Agreement to Benefit Homeless Individuals – States" (the CABHI grant)-*** The District/DBH was awarded a 3-year grant for $3 million per year to assist individuals who are homeless with mental health and/or substance use disorders obtain housing. The commitment is to house 300 people per year. The funds will be used to: 1) provide care coordination at DBH with outreach through homeless services providers, and 2) the homeless outreach providers will also provide SSI/SSDI Outreach, Access, and Recovery (SOAR) assistance and peer support.

Q. Older Adult Initiatives: As of June 30, 2015, there were 6,815 older adults age 50 and above of which 6,805 were seriously mentally ill. The initiatives that are described include: 1) a District planning grant, 2) DBH focused service reviews, and 3) technical assistance through SAMHSA contracted services.

- ***Long-Term Support Services/No Wrong Door (LTSS/NWD) grant-*** The District has a planning grant and is applying for an implementation grant for a LTSS/NWD system of care within the District. The planning has required significant cooperation and communication between the different health and human services agencies with particular emphasis on the work of the Aging and Disability Resource Center (ADRC) housed within the D.C. Office on Aging. DBH is an integral part of this work group and is sharing its Person-Centered Planning development; web-based information portal; and care coordination efforts for individuals in need of long-term supportive services. While this service is for all elderly and disabled in need, the majority of the population that it will benefit will be the elderly.
- ***Adult Reviews-*** The Community Services Review (CSR) Unit initiated a targeted review of older adults receiving day rehabilitative treatment that began in July 2015. This population was chosen by DBH Adult Services staff to further explore the previous Applied Research and Evaluation (ARE) Unit data analysis findings that indicated older adults are the costliest users of day services. The CSR Unit focused review outcomes may:1) provide answers about the day services utilization cost relationship for older adults; 2) uncover service needs for this demographic that are not obvious; and 3) inform behavioral health service planning for this population. Preliminary activities included reviewing the literature about older adults with psychiatric illness and day service utilization in order to generate focused questions to supplement the Quality Service Review for an Adult Participant: Field Use Version 1. While 87 consumers were identified only eight (8) met the sampling criteria. The review process involves obtaining their written consent and scheduling interviews with all members of their treatment team and key natural supports. Following the development of narrative reports and data analysis, it is anticipated that a report will be disseminated at the end of September 2015.
- ***Older Adult Services and Community Transition-*** Stephen J. Bartels, MD, MS, a geriatric psychiatrist, Director of the Dartmouth Centers for Health and Aging, and a nationally recognized expert, facilitated a half day meeting on August 24, 2012. The participants included the Department Director and program staff, the mental health advisory councils, long-term care advocates, and other District agencies. The discussion addressed the needs, strengths, challenges and opportunities for effective intervention

with older adults in general, and a specific focus on service transition issues involving nursing homes. Dr. Bartels' research and model on core principles for skills teaching has been successful in diverting individuals from nursing home care.

- ***Olmstead Presentation-***The Department requested that Dr. Bartels conduct a presentation and co-facilitate the discussion with the District inter-agency committee charged with developing a plan to address the issues raised in the *Thorpe vs. The District of Columbia* Olmstead Case. The plan focuses on supports and services necessary for persons who are disabled living in nursing home facilities to transition to integrated, community-based settings. This half-day meeting was held October 18, 2012.
- ***Older Adult Day Services Program-*** In March 2013, the Department continued the technical assistance relationship with Dr. Bartels to explore developing an Older Adult Day Services Program. Two (2) models were discussed: 1) an outreach model, and 2) a skills training model. Dr. Bartels assisted the Department staff with scheduling a site visit to a program that was implementing aspects of the models discussed. On June 13, 2013 the Department Senior Deputy Director and the Adult Services Director visited the Boston VINFEN Corporation, lead organization for the Center for Medicare and Medicaid Innovation (CMMI) grant. They were able to discuss with leadership and management various aspects of program operations and implementation. The next step involved a review of the overall Departmental Day Treatment Service programs. The on-site technical consultation with Dr. Bartels occurred August 22-23, 2013. The first day involved site visits to the day treatment facilities. On the second day, Dr. Bartels facilitated a meeting with providers to discuss: 1) positive aspects of program service delivery; 2) areas for improvement in program service delivery; and 3) curricula and/or other things that might be helpful for the programs. The day ended with a meeting with the Department Director. The summary of findings included specific observations about each program and a general finding that "*given the short amount of time that these programs have been implemented, the programs have all achieved remarkable (though varied) progress and would benefit from working together to share successes, challenges, and "lessons learned". Such a group effort would also be beneficial in working with the Department to collaborate in defining clear goals and benchmarks consistent with age-appropriate, high quality integrated rehabilitative services targeting older adults with serious mental illness."*

R. Mental Health Statistics Improvement Program (MHSIP) Survey: The MHSIP adult consumer survey measures concerns that are important to consumers of publicly funded mental health services. The DBH FY 2015 MHSIP survey is in the data collection phase that is expected to be completed by the end of September 2015. The data reported is for the DBH FY 2014 MHSIP survey. The adult sample size was 445. The findings are reported across the seven (7) domains.

- ***Access to Care-*** 78% of respondents reported positively to this domain.
- ***Participation in Treatment Planning-*** 80% of respondents reported participation in this domain.
- ***Quality and Appropriateness-*** 86% of respondents reported positively to this domain.
- ***Social Connectedness-*** 71% of respondents reported positively to this domain.
- ***Functioning-*** 73% of respondents reported positively to this domain.
- ***Outcomes-*** 69% of respondents reported positively to this domain.

- ***General Satisfaction with Services***- 82% of respondents reported positively to this domain.

S. Adult Mental Health First Aid (MHFA): Adult MHFA is a public education program that introduces participants to risk factors and warning signs of mental health problems, builds understanding of their impact, and overviews common treatments. It allows early detection and intervention by teaching participants about the signs and symptoms of specific illnesses like anxiety, depression, schizophrenia, bipolar disorder, eating disorders, and addictions. As of June 2015, DBH and community certified MHFA trainers conducted 18 courses training 384 individuals. The trainee affiliations included: colleges and universities, health centers, DBH staff and providers, other behavioral health agencies, certified Peer Specialists, community organizations, U.S. Army, and U.S. Department of Interior staff.

T. Adult System of Care Mental Health Block Grant (MHBG) Funded Projects: Several MHBG projects were implemented during FY 2015 that focus on adult populations.

- ***Peer Support Services***- There are two (2) projects in this category. 1. Open Arms Housing, Inc. *Integration and Expansion of Peer Support Services (PSS) Project* goal is to fully integrate PSS at both the Dunbar and Owen House facilities to include on site outreach and engagement, orientation to building and apartment, unit assistance in obtaining rental subsidy, help with activities of daily living, supportive counseling, crisis intervention, and linkage to off-site services, such as mental health treatment, alcohol and drug abuse counseling, and assertive treatment teams. The project targets 20 adult single women on the District's homeless vulnerability list (living on the streets, referred to by the shelters, soup kitchens, day centers, or self-referred). 2. PRS, Inc. *Peer Support Training in Whole Heath Action Management (WHAM) Project* supports hiring a part-time peer Recovery Support Specialist (RSS) including their participation in the WHAM training program, and offering this program at the DC Recovery Academy. Target group includes 48 young adults age 18-25 or older, diagnosed with co-occurring mental illness/substance use disorder, who are unemployed, homeless, involved with the criminal justice system, and/or identify as LGBTQ.
- ***Housing Special Populations***- DBH *Supportive Housing for Special Populations Project* provides "bridge" rental subsidies to consumers transitioning from higher levels of care into independent living. The target group involves approximately 17 adults with serious mental illness who are: formerly homeless or at risk of homelessness, pending discharge from Saint Elizabeths Hospital, residing in community residential facilities (CRFs), single-room occupancy (SROs) properties, and/or being released from jail/prison.
- ***Housing Women Who Are Homeless***- The Institute of Urban Living - *Hyacinth's Place Project* services include: intensive case management, mental health treatment, job readiness and vocational counseling, substance abuse education/recovery, and medication education. It includes 135 women, 15 residents at Hyacinth's Place plus three (3) cohorts of 40 women each from the waiting list.
- ***Housing Adults Who Are Homeless***- Miriam's Kitchen *Mission Possible: Housing the Chronically Homeless Project* serves 4,500 homeless adults overall, a sub-set of 1,250 will receive intensive 1:1 case management services and ultimately 50 chronically homeless adults will be placed in Permanent Supportive Housing.

- ***Week End Socialization Program-*** The *FamilyLinks Outreach Center, Inc. Project* focuses on persons who, because of the challenges presented by their mental illness, are not able and/or not yet ready for regular, salaried employment. The program emphasizes self-care and health, as well as recreation and self-development. It serves 30-35 adults and while the ages vary most are between the ages of 45 and 85.
- ***Trauma and Recovery Initiative-*** The Women's Collective (TWC) *Trauma Recovery and Empowerment Model (TREM) @ TWC Project* involves implementing this model with 20 urban, low-income African American women ages 18 and above, living with HIV/AIDS, psychological and trauma symptoms, and co-occurring substance use disorder.
- ***Creative Expression-*** The Spoken Word *Lens and Pens Creative Expression Project* provides weekly creative writing and photography workshops for 20-25 seriously mentally ill male and female adults in care at Saint Elizabeths Hospital with a focus on the maximum security population.
- ***Primary Health and Behavioral Health Initiatives-*** There are three (3) projects in this category. 1. So Others Might Eat (SOME) *Warm Handover: An Approach to Integrated Health Care Project* that involves providing 70 adults in the SOME Medical Clinic with as many real-time linkages between providers and clients as possible. The goals include: use brief tools to quickly assess mental health conditions or substance use disorders; use Motivational Interviewing to motivate clients to consider taking steps towards positive changes; and link as many clients as possible to needed services they would not otherwise access. 2. Volunteers of America Chesapeake, Inc. *Improving Healthcare for Consumers with Co-occurring Medical, Substance and Mental Health Disorders Program* provides services for 50 adults with mental illness and substance use disorders (including cigarettes) who have been diagnosed with and/or at risk for a somatic/physical illness. 3. The MedStar Health Research Institute *Embedding Psychiatry into Primary Care: Improving the Quality of Behavioral Health Services through an Integrated Care Delivery Model* goal is to improve services by using a co-location model (mental health specialist in the primary care setting). It targets 25 adults age 18 and older who are new patients or coming for a follow-up visit at the MedStar Washington Hospital Center Internal Medicine Ambulatory Care Clinic.
- ***Veteran Initiatives-*** There are three (3) projects in this category. 1. The University of the District of Columbia Foundation *Supporting our Service Members- SOS Project* places emphasis on opportunities for veterans to receive linkages to care related to education and mental health support (and related issues) to address the gaps facing student military personnel. 2. The Work First Foundation *Back to Work Boot Camp Project* goal is to provide 30 individuals who identify as Veterans, Active Duty, National Guard, Reserves, or spouses and/or children, comprehensive case management, employment readiness and placement, and retention services that lead to the self-sufficiency and stability. 3. The Wendt Center for Loss and Healing *Mental Health Services for Veterans, Active Duty Military and Families Project* goal is to help them access effective, culturally sensitive mental health services to overcome obstacles to healthy functioning. The target is 75 veterans, active duty members of the military and their family members over two (2) years. Most participants have been exposed to trauma and are experiencing major depressive disorder, PTSD, and possible co-occurring substance use. Additionally, through the Wendt Center media and outreach component, the project serves the broader

military community in the District through raised public awareness of mental health issues and services.

IV. Overview of Child and Youth Service System

The primary goal for the child and youth service system is to ensure that all children/youth and their families have access to a coordinated system of care that is easy to navigate, community-based, family-driven, youth-guided, and able to meet their multiple and changing needs. The Child and Youth Services Division (CYSD) is responsible for developing a comprehensive system of care for children, adolescents, transition aged youth and their families, that promotes prevention, early intervention, and treatment.

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 June 30, 2015, there were 3,879 children/youth ages 0-17 in the child system of care, of which 3,257 had serious emotional disturbances. The description that follows includes a variety of services and program initiatives including behavioral health prevention, early intervention, treatment services and supports for children, youth, transition age youth, young adults and families.

A. Parent Infant Early Childhood Enhancement Program (PIECE): Provides mental health services to children ages 3-7.6 and their families who present with challenging social-emotional behaviors that are disruptive at home, school and the community. This program seeks to provide comprehensive services to children and families that focus on supporting cognition, language, motor skills, adaptive skills and social emotional functioning. It utilizes a number of treatment modalities as well as evidence based practices (Parent Child Interaction Therapy and Child Parent Psychotherapy). As of June 2015, the total number of cases served was 117 and the total number of new cases was 71.

B. Healthy Start Project: A collaboration between the Department of Health and DBH to address the medical and mental health challenges of women who reside in wards 5, 6, 7, and 8, are of childbearing age, and have children from birth to age 2. The focus is to ensure that these women who reside in low income areas have access to comprehensive medical and psychiatric care. The mission for the Healthy Start Project is to reduce infant mortality in the District by improving the emotional, mental and physical health of pre- and postnatal women. As of June 2015, there were 63 active cases (Ward 5=1, Ward 6=1, Ward 7=19, Ward 8=42).

C. Early Childhood Mental Health Consultation Program – Healthy Futures: Mental health professionals provide center-based and child and family-centered consultation services to the staff and family members at 26 Child Development Centers (CDCs). Services are provided to improve social-emotional competence among young children and increase the knowledge of children's mental health issues among staff and family members. DBH clinicians also

conduct individual child and classroom observation, screen for the early identification of social-emotional concerns and refer and link children and their families to community resources and mental health services when required. Year 5 outcome data will not be completed until after September 30, 2015. The previous 4-year data indicate: 1) services were provided to approximately 5,200 young children (about1,300 annually); 2) the expulsion rate for the first 3 years of the evaluation was half the national average of 6.7 children per 1,000; and 3) Year 4 was a landmark year with no expulsions in any of the child development centers receiving Early Childhood Mental Health Consultation services.

D. Primary Project: A component of the School Mental Health Program that is an evidence-based, early intervention/prevention program for identified children in Pre-kindergarten (age 4) through 3rd grade who have mild problems with social-emotional adjustment in the classroom. Primary Project services are provided to children attending child development centers, and D.C. public and charter schools that receive on-site services from a DBH School Mental Health Program or Healthy Futures clinician. The program has two (2) major components: 1) screening for identification of level of need for service, early intervention/prevention or more intensive service (counseling/therapy); and, 2) intervention for children identified as having mild adjustment problems in the classroom. The "intervention" is a 1:1, non-directive play session provided at school by a trained paraprofessional (Child Associate) under the supervision of a Primary Project Program Manager. As of June 2015, the program data indicate that: 1) 45 sites had Primary Project *Agreements to Proceed,* 28 D.C. public and public charter schools, and 17 child development centers; 2) 4,775 children were screened using the Teacher-Child Rating Scale; 3) 2,456 children screened positive for needing more intensive mental health intervention; 4) 1,067 children screened positive for early intervention/ prevention services (Primary Project); 5) 441 children received Primary Project services; and 6) 292 end-of-year conferences were held with parents/guardians of participating children.

E. 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. As of June 2015, the SMHP operated in 63 schools, 44 D.C. public schools and 19 public charter schools. In FY 2015, DBH began implementation of the Child and Adolescent Functional Assessment Scale (CAFAS) and the Preschool and Early Childhood Functional Assessment Scale (PECFAS). There is no available FY 2015 data for the SMHP at this time. However, data for the FY 2013-FY 2014 school year using the Ohio Scales Problem Severity Score indicate that students, their parents, and clinicians reported a statistically significant reduction of behavioral and emotional symptoms after treatment. Also, the average youth, parent and worker self-report of the child's problems shifted from the clinical range to the non-clinical range after treatment. Scores on the Functioning Index indicate that youth, parents and clinicians all felt that everyday level of functioning significantly improved after treatment. The average worker report of functioning shifted from the clinical to non-clinical range.

F. Children Psychiatric Practice Group (PPG): Provides psychiatric services and consultation for children and adolescents between the ages of 4-21, who have emotional/ behavioral and mental health challenges. The PPG serves as a psychiatric safety net for the DBH child serving core service agencies (CSAs). The services are available to children, youth and their families who are residents of the District, receive services within the DBH provider network, are linked to a child serving agency (Child and Family Services Agency, Department of Youth Rehabilitation Services, D.C. Public Schools), and/or court involved. As of June 2015, 334 unduplicated children/youth were served.

G. Same Day Urgent Care Clinic Services: Provides same day walk-in services for child/youth mental health consumers who need immediate assessment or medication. As of June 2015, the average quarterly unduplicated number of child/youth intakes at the Same Day Urgent Care Clinic was 53.

H. Children and Adolescent Mobile Psychiatric Service (ChAMPS): FY 2015 is year 7 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, 7days a week for children and youth ages 6 to 18, except for youth who are committed to the Child and Family Services Agency (CFSA) who are 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. As of June 2015, the quarterly average number of children/youth served was 225. The unduplicated number served during this period was 726.

I. Child and Youth Clinical Practice Unit: This unit conducts early mental health screenings for children entering the child welfare system. It is also responsible for identifying and expanding the availability of evidence-based practices (EBPs) for youth and their families. The current EBPs 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 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 and 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 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.

- ***Multi-Systemic Therapy for Youth with Problem Sexual Behavior-*** For ages 10-17 and is an intensive family and community based program that addresses factors that influence problem sexual behavior, focusing on the offender's home/family, school, neighborhood and peers.
- ***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.
- ***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 successful achievement of their goals.
- ***Multi-Systemic Therapy for Emerging Adults-*** DBH is seeking a provider for this service for ages 17-21 with serious mental health conditions and justice involvement, that decreases offending and increases positive transition age role functioning and reduces symptoms.

J. Clinical Practice and Support Unit: This unit is responsible for the Assessment Center that provides mental health consultation and support as well as conducts forensic mental health assessments and evaluations for court involved children and youth in the juvenile justice and child welfare systems, and domestic relations cases being heard in the Family Court Division. The unit also provides oversight for the two (2) Care Management Entities (CMEs) that deliver wraparound services aimed at diverting youth from psychiatric residential treatment facilities. In addition the unit provides technical assistance and coaching to certified providers within the network on best practice delivery models and how to integrate the Community Service Reviews (CSR) indicators into supervision. In FY 2015, the Juvenile Adjudicatory Competency Program was established to conduct competency evaluations for youth engaged in the juvenile justice system and provide restoration services.

K. Residential Treatment Center Reinvestment Program (RTCRP): Provides clinical monitoring and oversight for children and youth receiving services in psychiatric residential treatment facilities (PRTFs) and children returning to the community from a PRTF. Program monitoring activities include scheduled on-site visits, monthly treatment planning meeting attendance and participation, discharge planning, and post discharge community monitoring. As of June 30, 2015, the RTCRP had completed site visits to the following facilities: Devereux Florida, Gulf Coast Treatment Center, Millcreek, Youth Villages, Coastal Harbor Treatment Center, Liberty Point, the National Deaf Academy, and Devereux Georgia. The RTCRP monitored 87 youth post-discharge to the District, and attended 360 of 365 (99%) treatment team meetings. The RTCRP also attended 74 discharge planning meetings.

L. Juvenile Behavioral Diversion Program (JBDP): This program operated within the D.C. Superior Court Juvenile Division began in January 2011. This voluntary program links and engages juveniles in appropriate community-based mental health services and supports. Court-involved juvenile status offenders are given the option of participating in mental health services rather than being prosecuted. The goal is to reduce behavioral symptoms that may contribute to juveniles' involvement with the criminal justice system and to improve their functioning in the home, school, and community. This program is intended for children and

youth who are often served within multiple systems who are at risk of re-offending without linkage to mental health services and other important supports. Participants are enrolled from six (6) months to a year and are required to attend regular court monitoring meetings and participate in mental health services. The capacity for JBDP has been 60 since its inception and based upon a request from the Court, it was expanded to 75 in 2015.

M. DBH Child and Youth Services Ombudsman Program: This program was created in FY 2015 with full implementation beginning during FY 2016. The core processes and functions include: 1) educate District residents about behavioral health coverage within the health benefits plan, managed care plan and other behavioral health services options; 2) assist consumers 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 will: 1) conduct intake; 2) track inquires and complaints to determine trends and patterns within the current system of care; 3) track and trend information that is collected to report on system gaps related to service delivery; and 4) review current policies to determine potential gaps and make clear system recommendations for changes.

N. System of Care Expansion Implementation Project (DC Gateway Project): This 4-year Substance Abuse and Mental Health Services Administration (SAMHSA) grant focuses on the development and strengthening of the infrastructure and services to children, youth and their families with mental health concerns across the District and across child serving systems. It began in October 2012 following the development of a Strategic Plan supported by a SAMHSA System of Care (SOC) Planning grant and has now completed three (3) quarters of Year 3 implementation. The goals are addressed through five (5) focus areas and each integrates social marketing. They include: 1) improved access to mental health services; 2) parent and youth peer support; 3) functional assessment utilizing the Child and Adolescent Functional Assessment Scale (CAFAS) and the Preschool and Early Childhood Functional Assessment Scale (PECFAS); 4) integration of behavioral health and primary care; and 5) reinvestment strategies to promote sustainability. A description of some of the initiatives follows.

- ***DC Mental Health Access Project (DC MAP)-*** DBH awarded a contract to Children's National Health System in March 2015 to support ongoing development of behavioral health screening by primary care providers (pediatricians), that includes the DC MAP mental health consultation project. It provides pediatricians with immediate access to mental health and/or psychiatric consultation as children/youth are identified as potentially needing behavioral health services. This project supports pediatricians in competently providing behavioral health care within their practice if appropriate or supports the timely linkage to the right behavioral health services. The education of primary care providers through the learning collaborative also continues as well as educational presentations within the primary care provider's office. This contract also supports the development of a psychiatric medication monitoring committee to the review children/youth prescribed multiple psychotropic medications.
- ***Collaboration Across Grants-*** The collaboration across the three (3) DBH grants (DC Gateway Project SOC grant, State Youth Treatment grant (SYT), and Now is the Time-Healthy Transitions grant (NITT- HT)) continues. The staff from all three (3) grants are

actively involved with the youth driven work group developing the Youth Peer Specialist training program. SYT and NITT-HT staff attend the SOC Management and Implementation/Roundtable meetings and a SYT Transition Age Youth (TAY) Council meeting includes DC Gateway Project staff. This combined advisory council has broad family and youth involvement along with various community organizations. The DC Gateway Project and the NITT Healthy Transitions Grant collaborated with youth Technical Assistance providers and Youth MOVE National to provide a youth "kick-off" in January 2015. At the M & I/Roundtable meeting the development of culturally appropriate behavioral health programming for the LGBTQI population was discussed. Now a work group is developing recommendations for serving LBGTQI TAY behavioral health needs and will be reporting these recommendations to the SYT/TAY Council.

- ***CAFAS/PECFAS-*** The ***Child and Family Services Agency*** (CFSA) implemented the CAFAS/PECFAS for all children/youth in July 2015. This includes 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. The ***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. The ***Department of Human Services*** (DHS) utilizes the CAFAS for all youth actively enrolled in the Parent and Adolescent Support Services (PASS) and in the Alternatives to Court Experience (ACE) diversion program. DHS utilizes the CAFAS data to measure outcomes of both of these short-term programs. The ***Department of Behavioral Health*** (DBH) continues to utilize the CAFAS/PECFAS across all 25 child serving providers. Between January 1 and March 20, 2015, 2,123 assessments were completed and from April 1 through June 22, 2015, 1,952 assessments were done. The CAFAS/PECFAS total score is used to inform the types and quantity of services that are automatically approved for inclusion in the child/youth's plan of care.

O. Transition Age Youth Initiatives: Youth and young adult initiatives are coordinated within the DBH Child and Youth Services Division by the Transition Age Youth Coordinator.

- **Now Is The Time (NITT): Healthy Transitions:** The purpose of this SAMHSA grant is to develop a system of care for transition age youth (TAY) and young adults. DBH is the lead agency for this initiative to design and implement a transition age youth (TAY) focused system of care in partnership with key District agencies (CFSA, DYRS, DCPS, Department of Employment Services), core service agencies (CSAs), community-based organizations, health care providers, and family and youth networks. This system of care, called the DC Transition Age Youth Initiative, is for ages 16- 25 with services provided by the DBH CSAs. They will provide TAY specific care planning, wraparound, evidence-based practices and recovery supports, and will employ Transition Specialists specifically trained to diagnose and assess TAY clients and provide customized, individual plans of care to successfully transition them to adulthood. The evidence-based and informed practices and recovery supports to be expanded during this initiative include: 1) a combined Transitions to Independence Process (TIP) and Assertive Community Treatment (ACT) program known as TACT; 2) Adolescent Community

Reinforcement Approach (A-CRA); 3) Supported Employment; and 4) Supportive Housing. This Initiative will also broaden and improve outreach to, and early identification and screening of, TAY with mental health conditions, substance use disorders and co-occurring disorders. Initially the program will target youth, young adults and their families in Wards 7 and 8 (though not to the exclusion of TAY throughout the District) and lessons learned from these wards will be applied as the program systematically expands to other wards. Youth, young adults and their families will inform all aspects of the Initiative including planning, education, outreach and identification, social marketing, and evaluation, and transition age youth will be represented on the key oversight body for the initiative.

- **Transition Age Youth Housing Initiative:** On March 26, 2015, District of Columbia Mayor Muriel Bowser and Deputy Mayor for Health and Human Services Brenda Donald opened Wayne Place, a transition age youth transitional housing facility. Wayne Place 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 includes life skill training for youth and young adults who need support to live independently and succeed. Wayne Place, a complex of six (6) buildings with 22 two-bedroom apartments, provides the opportunity for 44 young people to live at this facility. Half of the beds are being utilized by youth linked to CFSA and half are linked to DBH. As of July 13, 2015, DBH interviewed 34 applicants and approved 20. CFSA reviewed 22 applicants and approved 17. A total of 56 applications were received and 37 (66%) were approved. Also, a total of 34 transition age youth (20 DBH and 14 CFSA) had moved into Wayne Place. This initiative received partial Mental Health Block Grant funding in FY 2015.

P. 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 DBH FY 2015 YSS-F survey is in the data collection phase that is expected to be completed by the end of September 2015. The data reported is for the DBH FY 2014 YSS-F survey. The parents/guardians of children/adolescents sample size was 416. The findings are reported across the seven (7) domains.

- ***Access to Care-*** 77% of respondents reported positively about access.
- ***Participation in Treatment Planning-*** 83% of respondents reported participation in this domain.
- ***Cultural Sensitivity of Provider-*** 93% of respondents reported high cultural sensitivity of staff.
- ***Social Connectedness-*** 89% of respondents reported positively to this domain.
- ***Functioning-*** 64% of respondents reported positively to this domain.
- ***Outcomes-*** 66% of respondents reported positively about outcomes for their children.
- ***Satisfaction with Services-*** 75% of respondents reported positively about general satisfaction for their children.

Q. Youth Mental Health First Aid: Primarily designed for adults including family members, caregivers, school staff, health and human services workers, etc., who work with young people 12-25, and is also appropriate as a peer support program for older adolescents. The curriculum spans mental health challenges for youth, review of normal adolescent

development, and intensive guidance through the action plan for both crisis and non-crisis situations. Topics include anxiety, depression, substance use, disorders in which psychosis may occur, disruptive behavior disorders (including AD/HD), and eating disorders. As of June 2015, DBH and community certified Youth MHFA trainers conducted 18 courses training 459 individuals. The trainee affiliations included: D.C. public and public charter schools, faith-based organizations, university, DBH staff and providers, family organizations, District agencies, prevention centers, health alliances, housing, services for children with special needs, and community organizations.

R. Child and Youth System of Care Mental Health Block Grant (MHBG) Funded Projects: Several MHBG projects were implemented during FY 2015 that focus on children/ youth and families.

- ***Maternal Mental Health Initiative-*** The Mary's Center for Maternal and Child Care, Inc. *Maternal Mental Health (MMH) Program* goal was to establish a formal MMH program to expand upon the detection, referral and treatment of Perinatal Mood and Anxiety Disorders (PMADs) that is already in place at the two (2) clinics in the District. The target population is 1,500 unduplicated perinatal patients.
- ***Early Childhood Initiative-*** The Latin American Montessori Bilingual Public Charter School (LAMB) *Healthy Communities Project* goal is to provide early childhood prevention and intervention for mental health disorders and potential substance use to 347 students in grades pre-K through 5th grade.
- ***Women with Dependent Children-*** The District Alliance for Safe Housing (DASH), Inc. *Mental Health and Family Wellness Programming Project* support four (4) programs: continuation of Effective Black Parenting evidence-based intervention; an Attachment Program for DASH newer parents who are struggling with their infants given their trauma histories; the addition of a Trauma Recovery and Empowerment Model (TREM) group; and the implementation of the GAIN-SS screening tool. The target group is women with children living at or below the federal poverty, with histories of trauma, mental illness, and co-occurring disorders. The program includes 42 families with 52 dependent children 18 and under.
- ***Parent and Child Advocacy-*** The Advocates for Justice and Education *DC Behavioral Access Project* goal is to ensure early intervention strategies are employed in response to mental health crisis and behavior issues; community based supports are in place to support healthy integration into the community; and direct advocacy for services in an effort to improve parent engagement and children's access to appropriate mental health services. The activities include 50 parents of children with acute behavioral health concerns; 75 parents trained on topics related to behavioral health disorders; and 5 trainings for parents navigating the system of care.
- ***Parent Education-*** The Collaborative Solutions for Communities *Parent Education and Support Project (PESP) Recovery Project* enhances the clinical oversight and supervision needed to provide high level substance abuse and mental health counseling, and services to an additional 20 PESP parents.
- ***Youth Development Initiative-*** The Teens Run DC *Running, Mentoring, and Academic Enrichment Program* implemented two (2) new initiatives to: 1) provide academic support to students, and 2) recruit mentors to support all volunteers in relationship

building and youth development components of the program. The target group is youth ages 11-19 with over 100 total participants and 40 in the intensive program.

- ***Health and Wellness Initiative-*** The Bridges Resources In Communities, Inc**.** *Promoting Mental Health/Wellness and Drug-Free Living East of the River Project* expands existing drug education services to include mental health specific sessions facilitated by a trained mental health expert with existing ties and experience in the communities served. The target group is 30 youth ages 12- 21 to include 15 Ward 7 and 15 Ward 8 youth and a minimum of 5 Ward 7 parents and 5 Ward 8 parents per month.
- ***Youth Well-Being Initiative-*** The One Common Unity *Fly By Light: Discover Your True Nature (FBL) Project* goal is to address the pervasive culture of psychological and physical violence that surrounds youth in the District. This is achieved by developing high impact programming for youth that provides clear alternatives to violence, increases the self-esteem of participants and helps them to lead mentally stable and emotionally balanced lives. The target group is 80 high risk youth, ages 14 -18 that includes students from four (4) high schools whose issues include chronic depression, re-occurring substance use, previous incarceration, foster care, victims of domestic violence, and discrimination based on sexual orientation.
- **Youth and Caregivers Support Initiative-** The Fihankra Akoma Ntoaso (FAN) *Positive Youth Development (PYD) Alumni and Caregiver Support Programs: Expanding Support for Emotional Health Amongst Teens in Foster Care* provides: 1) targeted case management and structured peer group activities to support the emotional health of youth and young adults; 2) extends and expands alumni and caregiver support services; and 3) builds a community based resource system that supports enhanced mental health outcomes for young people who might not take advantage of more traditional mental health services. The target group is 25 current or former foster youth 18-21 who have graduated from FAN's youth programs; and 25 caregivers of teens currently or formerly in foster care to help these family members better support the emotional health of the youth in their care.

V. Behavioral Health Data Summary

The ***Behavioral Health Barometer District of Columbia, 2013*** (first edition) is one of a series of state and national reports that provide a snapshot of behavioral health in the United States. The reports present a set of mental health and substance use disorder indicators measured through data collection efforts sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA). A summary of mental health and substance use disorder findings follows.

A. Youth Mental Health and Treatment

- Depression: Past-Year Major Depressive Episode (MDE) among Persons Age 12-17 (2008-2012)- In the District of Columbia about 2,000 youth (6.1% of all youth per year) had at least one MDE within the year prior to being surveyed. The percentage did not change significantly over this period. The District rate of MDE among youth was similar to the national rate in 2011-2012 (District 7.2% and national 8.7%).

- Treatment for Depression: Past-Year Depression Treatment among Persons Age 12-17 with MDE (2006-2012)- About 1,000 youth with MDE (38.4% of all youth with MDE per year) received treatment for their depression within the year prior to being surveyed. The District rate of treatment for depression among youth with MDE was similar to the national rate in 2006-2012.

B. Adult Mental Health and Treatment

- Treatment for Any Mental Illness (AMI): Past-Year Mental Health Treatment/Counseling among Persons Age 18 or Older with AMI (2008-2012)- About 35,000 adults with AMI (38.6% of all adults with AMI per year) received mental health treatment or counseling within the year prior to being surveyed. The District rate of mental health treatment among adults with AMI was similar to the national rate in 2008-2012.

- Serious Mental Illness (SMI): Past-Year SMI among Persons Age 18 or Older (2008-2012)- About 14,000 adults (2.9% of all adults per year) had SMI within the year prior to being surveyed. The District rate of SMI among adults was lower than the national rate in 2011-2012 (District 3.3% and national 4.0%).

- Mental Health Consumers: Reporting Improved Functioning from Treatment Received in the Public Mental Health System (2012)- The adults in the District in 2012 age 18 or older reporting improved functioning was 95.4%, which was higher than the national data at 71.2%. The youth age 17 or younger reporting improved functioning was 68.8%, which is lower than the national data at 70.0%.

- Thoughts of Suicide: Past-Year Serious Thoughts of Suicide among Persons Age 18 or Older (2008-2012)- About 23,000 adults (4.8% of all adults) had serious thoughts of suicide within the year prior to being surveyed. The percentage did not change significantly over this period. The District percentage of adults with suicidal thoughts was similar to the national percentage (District 4.2% and national 3.8%).

C. Youth Substance Use

- Past-Month Illicit Drug Use Persons Age 12-17 (2008-2012)- About 5,000 youth (14.2% of all youth per year) reported using illicit drugs within the month prior to being surveyed. The District rate of illicit drug use among youth in 2011-2012 was higher than the national rate (District 12.6 and national 9.8%).

- Past-Month Cigarette Use Persons Age 12-17 (2008-2012)- About 3,000 youth (7.4% of all youth per year) reported using cigarettes within the month prior to being surveyed. The District rate of cigarette use among youth in 2011-2012 was lower than the national rate (District 4.7% and national 7.2%).

- Mean Age of First Use of Selected Substances Persons Age 12-17 (2008-2012)- The mean age of first marijuana use was 13.9 years, and the mean age of first cigarette use was 13.2 years.

- Persons Age 12-17 Who Perceived No Great Risk from Smoking One or More Packs of Cigarettes a Day (2008-2012)- About 2 in 5 in 2011-2012 perceived no great risk from smoking one or more packs of cigarettes a day, a rate higher than the national rate (District 39.8% and national 34.1%). Also, the District's rate increased from 2008 to 2012.

- Persons Age 12-17 Who Perceived No Great Risk from Smoking Marijuana Once a Month (2008-2012)- About 4 in 5 in 2011-2012 perceived no great risk from smoking marijuana once a month, a rate higher than the national rate (District 79.3% and national 73.0%). Also, the District's rate increased from 2008 to 2012.

- Persons Aged 12-17 Who Perceived No Great Risk from Having Five or More Drinks Once or Twice a Week (2008-2012)- About 1 in 2 in 2011-2012 perceived no great risk from drinking five or more drinks once or twice a week, a rate lower than the national rate (District 56.7% and national 59.8%).

D. Youth and Adult Substance Use and Treatment

- Persons Aged 12 or Older Past Year Alcohol Dependence or Abuse (2008-2012)- About 59,000 persons (11.3% of all persons in this age group per year) were dependent on or abused alcohol within the year prior to being surveyed. The percentage increased over this period. The District rate of alcohol dependence or abuse was higher than the national rate in 2011-2012 (District 11.7% and national 6.6%).

- Persons Age 12 or Older Past Year Illicit Drug Dependence or Abuse (2008-2012)- About 23,000 persons (4.5% of all persons in this age group per year) were dependent on or abused illicit drugs within the year prior to being surveyed. The percentage did not change significantly over this period. The District rate of illicit drug dependence or abuse was higher than the national rate in 2011-2012 (District 3.5% and national 2.7%).

- Enrollment in Substance Use Treatment Single-Day Counts (2008-2012)- In a single-day count in 2012, 4,217 persons in the District were enrolled in substance use treatment, a decrease from 4,498 persons in 2008.

- Substance Use Problems among Persons Enrolled in Substance Use Treatment Single-Day Count (2012)- Among persons in the District enrolled in substance use treatment in a single-day count in 2012, 50.1% were in treatment for a drug problem only, 10.7% were in treatment for an alcohol problem only, and 39.3% were in treatment for problems with both drugs and alcohol.

VI. Behavioral Health Assessment and Plan - (This Section entered in webBGAS)

A. Planning Steps- Strengths, Unmet Needs, Quality and Data Collection Readiness
B. Planning Tables
C. Table 1 Priority Areas and Annual Performance Indicators
D. Table 2 State Agency Planned Expenditures
E. Table 3 State Agency Planned Block Grant Expenditures by Service

F. Table 6b MHBG Non-Direct Service Activities Planned Expenditures
G. Environmental Factors and Plan
H. State Behavioral Health Council (input on Mental Health Block Grant Application, members, member by type) and opportunity for public comment

Planning Steps

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

Narrative Question:

This step should identify the unmet services needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the populations relevant to each block grant within the state's behavioral health 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 these unmet service needs and gaps.

The state's priorities and goals must be supported by a data-driven process. 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 set 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, the annual State and National Behavioral Health Barometers, 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 abuse prevention, and substance abuse 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 behavioral health services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

SAMHSA's Behavioral Health Barometer is intended to provide a snapshot of the state of behavioral health in America. This report presents a set of substance use and mental health indicators measured through two of SAMHSA's populations- and treatment facility-based survey data collection efforts, the NSDUH and the National Survey of Substance Abuse Treatment Services (N-SSATS) and other relevant data sets. Collected and reported annually, these indicators uniquely position SAMHSA to offer both an overview reflecting the behavioral health of the nation at a given point in time, as well as a mechanism for tracking change and trends over time. It is hoped that the National and State specific Behavioral Health Barometers will assist states in developing and implementing their block grant programs.

SAMHSA will provide each state with its state-specific data for several indicators from the Behavioral Health Barometers. States can use this to compare their data to national data and to focus their efforts and resources on the areas where they need to improve. 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[18] 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.

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

Footnotes:

Step Two: Identity the unmet needs and critical gaps within the current system.

The three (3) initiatives below have been DBH priorities since the Department's inception on October 1, 2013. They require significant planning, system transformation, and development.

1. Health Homes:

The District has long recognized the need for more integrated behavioral and physical care to improve the overall health status of individuals with serious mental illness. The Centers for Medicare and Medicaid Services (CMS) introduced the Health Home model as a systems approach to allow providers to coordinate and provide access for behavioral and primary health care to these vulnerable individuals. DBH (formerly DMH) determined that using the Health Home model would best enable the provider system to support these individuals in a sustainable and effective way in the community. The agency expects that implementation of Health Homes will lead to greater overall health and compliance with both behavioral and primary care, which will in turn lead to fewer hospitalizations and emergency room visits and an overall enhancement in the quality of life.

2. Substance Use Disorder Treatment and Recovery Services

DBH was created from the merger of the District's mental health and addiction systems (the Department of Mental Health and the Department of Health/Addiction Prevention and Recovery Administration/APRA). At that time DOH/APRA had been trying to implement a State Plan Amendment (SPA) approved in 2012 called Adult Substance Abuse Rehabilitation Services (ASARS), which would allow Medicaid reimbursement for certain substance use disorder treatment services. After the merger the decision was made to create new certification standards that would incorporate the requirements of the ASARS SPA and would also reflect the new American Society of Addiction Medicine (ASAM) criteria and the differing Levels of Care. These changes, as well as aligning the certification application with other programs offered by DBH, will allow a higher quality, more person-centered substance use disorder treatment and recovery system in the District of Columbia. Additionally being able to receive Medicaid reimbursement for most of the treatment services will enable DBH to offer additional recovery support services, which were previously funded through a grant, without interruption in services.

3. Prevention

DBH prevention continues discussions with the DBH Children and Youth Division, the service area that has a strong program of school-based education and mental health assessment services for both public and charter schools. DBH substance use prevention services are directed to community settings and do not include support for school-based services. SUD's historical role with school-based initiatives has been to serve on District level advisory committees and provide technical guidance for substance use prevention as part of an overall health and wellness strategy.

A second need is to redefine "evidence-based preventive interventions" in ways that address SAMHSA requirements but align with the needs of an urban area with culturally diverse populations. DBH prevention plans to address this need through the PFS Evidence-Based Workgroup and subsequently identify a broader mix of preventive interventions that have a plausible connection to the DC EOW data and target outcomes.

DBH prevention currently uses the following Center for the Application of Prevention Technology approach to defining "evidence-based":

"Strength of evidence is critical to selecting approaches that are likely to work. But not all evidence-based approaches or interventions are right for communities. Best fit interventions are those approaches or interventions that 1) most clearly impact the substance abuse or related behavioral health problem in your community and 2) are most appropriate, given the community needs, resources, and readiness to act.

DBH prevention began addressing gaps in services for selective and indicated populations. A risk reduction assessment was completed with 500 community-based agencies, parents, and youth to identify barriers, gaps and population needs. Following the assessments, the Department developed and piloted a curriculum. The Department is creating a risk reduction code (pre-engagement) and working with the DC Department of Health Finance with the goal to support evidence-based selective and indicated population services through Medicaid funds. This will also diversify the funding base for prevention.

There remains a need to integrate three levels of prevention outcomes and measures (changes in risk and protective factors, community changes, and behavioral outcomes) in grant and contract Request for Applications and scope of work requirements. This change places greater emphasis on the prevention programs grants management process and implementation of the online DIRS system.

DBH prevention program grants management staff will have a broader role in FY 2016 and 2017 that includes development of prevention spending plans and tracking fiscal operations. These shifts require strengthening current management and staff roles and responsibilities, developing more detailed process steps and timelines and monitoring measurable data outcome indicators in prevention grant and contract scopes of work. The goal is to monitor population-based primary prevention grant progress, address compliance and corrective action if needed.

Strengthening grants and contract program management functions will require adding and monitoring baseline outcome indicators in sub-grants (e.g. risk and protective factors, community changes in policies/programs and practices, and behavioral outcomes for District youth). The program grants management and contract function will also oversee grant program management of Partnership for Success sub-recipients including a Proposition 71 Public Education campaign, DC EOW and Evaluation, DC Prevention Center PFS Coordinators, and the High Need Communities Grants.

DBH Prevention identified the need to expand and develop the District's prevention workforce. DBH is exploring a role in credentialing the prevention workforce and establishing prevention program standards in new Chapter 63 Behavioral Health Standards. In addition, the Department is exploring options for a sustainable workforce capacity building strategy that includes levels of training, technical assistance and coaching. DBH prevention continues to promote and seek funding for the Prevention Leadership Center as a resource for coordinated and sustainable capacity building services.

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.

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

Footnotes:

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).

The Department has the current capability to generate extensive custom data reports using SSRS (a SQL Server statistics program fully incorporated into DATA). This capability has already been used in FY 2013 to inform strategic planning, monitoring activities and quality improvement planning. SSRS is sufficient for the majority of APRA's data needs. There are more sophisticated reports which are beyond the capacity of SSRS to complete and these reports are purchased from FEI (the developer of the DATA System). These reports are procured out of the system enhancement budget which is housed under the Organizational Development and Office of Programs and Policy.

However, DBH recently implemented a new electronic health record (iCAMS) that allows for clinical documentation, as well as billing. Information can be extracted at the client, program, and provider level. Because not all contracted providers are entering information directly into iCAMS, the data has to be combined in an SQL server data warehouse. Because the data from the previous billing system already resides in this warehouse, this will minimize the recoding needed to continue reporting on CLD. Unlike the previous system, iCAMS allows for historical information to be pulled, so DBH will now be able to report on status at intake and at discharge (or at the time of reporting).

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.).

As a result of the newly implemented health record, iCAMS will now be able to collect data from the SUD and Mental Health data system, as well as Medicaid and other claims based data.

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)?

Yes, DBH is currently able to collect and report on client level data. DBH used the SUD TEDS and NOMS format in FY14 and FY15 to report client level data out of our previous data system. DBH will continue to report on TEDS and NOMS out of iCAMS.

If not, what changes will the state need to make to be able to collect and report on these measures?

DBH will work to report on more measures than in the past, including status at intake and discharge/time of report, now that iCAMS allows for this history.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Community Recovery Supports

Priority Type: SAT

Population(s): IVDUs

Goal of the priority area:

Support the implementation of the District's strategic plan to develop and promote an integrated recovery oriented system of care.

Objective:

Strategies to attain the objective:

Facilitate the bringing together of individuals in recovery from across the District to partner with APRA in creating a recovery oriented system of care.
Support Recovery Coaching/Peer specialist training opportunities for individuals in care and their supporters.
Engage the community in an ongoing process to assess their recovery support needs, and continue to build out the recovery service provider network to include those identified needs.

Review agency policies and make appropriate revisions to better support recovery principles and practices across the agency.

Partner with people in recovery from mental and substance use disorders, as well as their family members, to build and strengthen communities of care which support resiliency, recovery & wellness.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage of drug screens at Level I OMT programs indicating positive results for substances other than methadone

Baseline Measurement: In Fiscal Year 2013, 46.76% of drug screens collected at Level I OMT programs were positive

First-year target/outcome measurement: No greater than 44% of drug screens collected at Level I OMT programs will be positive for

Second-year target/outcome measurement: No greater than 41% of drug screens collected at Level I OMT programs will be positive for a substance other than methadone.

Data Source:

Aggregate annual report from the laboratory contracted to conduct all drug screens funded under the public system in the District of Columbia.

Description of Data:

The results of all drug screens collected and processed are aggregated and reported to DBH/APRA on bi-weekly, monthly and yearly bases.

Data issues/caveats that affect outcome measures::

The laboratory compiles client-level reports as well as aggregates. However, they are reported in PDF format, making it difficult to perform client-level analyses on the data. The largest caveat here is that it is difficult to determine the degree to which the positive results are localized to a specific cohort of the population served or more evenly distributed among the population.

Priority #: 2

Priority Area: Data Quality and Outcomes

Priority Type: SAT

Population(s): PWWDC

Goal of the priority area:

APRA intends to continue it's provision of ongoing support for, and expansion of APRA's electronic health records system to other District agency partners, to ensure the District's capacity to collect integrated, inter-agency, clinical, process and outcome data for all of the identified target populations, including substance abuse pregnant women, and women with dependent children in need of treatment.

Objective:

Strategies to attain the objective:

Work with electronic health record vendor to build system enhancements to more reliably capture each target population group, identify new clinical co-occurring indicators, and track more robust service coordination and integration processes.

Work with e-health record vendor to integrate electronic health record management within the merged DBH.

Finalize e-health record sharing/access partnerships with relevant District partner agencies, for example CFSA, CSOSA, DYRS, to ensure better integrated care and services for the individuals in care throughout the District.

Disseminate treatment and recovery support management information system (DATA) data for policy and program planning. Improve the quality and accessibility of surveillance, outcomes and performance and evaluation information for APRA, District agency partners, stakeholders, and policymaker.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of SUD pregnant women entering the system for treatment

Baseline Measurement: 45 substance abusing women entered the substance use system in FY 2014.

First-year target/outcome measurement: 50 substance abusing women will have entered the behavioral health system.

Second-year target/outcome measurement: 65 substance abusing women will have entered the behavioral health system.

Data Source:

Client assessment data reported from the state's EHR system.

Description of Data:

DATA reports indicate the pregnancy status of women assessed in the ARC or any other assessment and referral site during a particular time period.

Data issues/caveats that affect outcome measures::

No issues are currently foreseen that will affect the outcomes measures.

Indicator #: 2

Indicator: Number of women served in specialty services for women or women with dependent children.

Baseline Measurement: 214 unduplicated clients were served in specialty programs for women. 0 clients were served in specialty programs for women with dependant children.

First-year target/outcome measurement: 200 clients will be served in specialty programs for women or women with dependent children. Of this number, 50 will be served in specialty programs for women with dependent children.

Second-year target/outcome measurement: 250 clients will be served in specialty programs for women or women with dependent children. Of this number, 75 will be served in specialty programs for women with dependent children.

Data Source:

Client information aggregated in the electronic health record for all clients receiving substance use services paid for by a public

funding stream in the District of Columbia.

Description of Data:

Clients served under one of these programs is determined by building an electronic report of all clients for whom a record of a clinical service within the applicable time period occurred.

Data issues/caveats that affect outcome measures::

The District has just implement services for Pregnant and Postpartum Women with Dependent Children in 4th quarter 2015. These programs are just starting to accept clients. Thus there may be some start up and engagement issues. However, the District has requested TA from SAMHSA to assist in the start-up and PPW Network building.

Priority #: 3

Priority Area: Access, Screening and Early Intervention

Priority Type: SAT

Population(s): HIV EIS

Goal of the priority area:

Enhance the quality of, and expand the number of access and referrals points within the behavioral health continuum, to better support geographic, demographic, and comorbidity needs. Continue to support the expansion of capacity identifying HIV positive and at-risk clients.

Objective:

Strategies to attain the objective:

Engage hospitals in behavioral health screening and referral opportunities to and from the SUD system.

Identify an initial round of strategic partners to operate as additional access and referral sites to the current SUD Access system. Develop a process through our certification division regulations to ensure the quality and fidelity of each new access and referral site.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of HIV tests conducted at the SUD assessment and referral centers

Baseline Measurement: 1675 HIV tests conducted at the Assessment and Referral Center

First-year target/outcome measurement: 2800 HIV tests to be conducted at combined participating DBH/APRA locations

Second-year target/outcome measurement: 4200 HIV tests to be conducted at combined participating DBH/APRA locations

Data Source:

Data on tests conducted is collected by the Districts EHR system by collecting pre/post counseling and linkages to care.

Description of Data:

The number of tests and their results are regularly reported in aggregate to DBH/APRA.

Data issues/caveats that affect outcome measures::

No such issues are foreseen at present.

Indicator #: 2

Indicator: Percentage of those with a positive PPD linked to specialty medical service

Baseline Measurement: Baseline to be developed during FY 2014.

First-year target/outcome measurement: 90% of clients with positive PPD to have a documented attempt at linkage to a specialty medical service.

Second-year target/outcome measurement: 95% of clients with positive PPD to have a documented attempt at linkage to a specialty medical service.

Data Source:

Information to be collected by staff in the Assessment and Referral Center. Detoxification and Residential Treatment providers to report monthly on the linkages attempted/completed among this cohort.

Description of Data:

Clients with a positive PPD are defined as those who have a newly identified positive as well as those who report a positive PPD in the past regardless of treatment history.

Data issues/caveats that affect outcome measures::

No such issues are foreseen at this time.

Priority #: 4

Priority Area: Policy and Prevention

Priority Type: SAP

Population(s): Other (Children/Youth at Risk for BH Disorder)

Goal of the priority area:

Continue to implement an integrated prevention system to reduce priority risk factors and increase protective factors that reduce substance use in the District by children, youths, and families, to include health promotion activities in the community and workplace.

Objective:

Strategies to attain the objective:

Continue to fund DC Prevention Centers as dynamic hubs that engage, support and help connect the many community elements that are needed to prevent the onset and reduce the progression of alcohol, tobacco and other drug (ATOD) and interrelated problems that place youth at risk. Continue development and implementation of the DC Prevention Leadership Corps that is youth led and adult support in DC communities. Strengthen the risk and protective factor data profiles by adding measures of Adverse Childhood Experiences (ACE) and include the findings in prevention behavioral health planning and integration strategies.

Continue to implement Community Conversations and the APRA guidebook as a supplemental tool to assess community perceptions, attitudes and intent to use ATOD.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of youth trained in the DC Prevention Leadership Corps

Baseline Measurement: 300

First-year target/outcome measurement: 350

Second-year target/outcome measurement: 400

Data Source:

Prevention Division manually collect registration and sign in sheet information for each training session throughout the year.

Description of Data:

Data collected on the number of youth trained to be peer community change agents, educating their families and communities on the various drugs, alcohol, and other substances negatively impacting the community, and how to rise above the influence.

Data issues/caveats that affect outcome measures::

At this time, it is a manual data collection process.

Indicator #:	2
Indicator:	Increased community capacity that supports individuals to work together to affect conditions that increase risk for tobacco, alcohol, marijuana and other emerging drug use among youth.
Baseline Measurement:	11,700 adults and 9,875 youth reached through planned prevention strategies in FY 2015 (21,575 individuals total). 1,450 technical assistance encounters were provided to prevention stakeholders in FY 2015. Less than 20% of tobacco licensees will sell tobacco to underage youth during random sample compliance checks.
First-year target/outcome measurement:	11,800 adults and 10,000 youth will be reached through planned prevention strategies in FY 2016 (21,800 individuals total). 1,460 technical assistance encounters will be provided to prevention stakeholders in FY 2016. Less than 20% of tobacco licensees will sell tobacco to underage youth during random sample compliance checks.
Second-year target/outcome measurement:	11,850 adults and 10,050 youth will be reached through planned prevention strategies in FY 2017 (21,900 individuals total). 1,475 technical assistance encounters will be provided to prevention stakeholders in FY 2017. Less than 20% of tobacco licensees will sell tobacco to underage youth during random sample compliance checks.

Data Source:

DIRS SABG modules for DC Prevention Centers and DBH prevention staff

Description of Data:

Both DC Prevention Centers and DBH prevention staff enters monthly data into the DIRS SABG modules. Data collected mirrors the information in the SABG prevention set-aside requirements and includes demographics on those reached through planned prevention strategies and technical assistance encounters.

Data issues/caveats that affect outcome measures::

Indicator #:	3
Indicator:	Program monitoring that ensures federal funds address national outcome measures, high performance standards, and statutory requirements.
Baseline Measurement:	New process measures for program grants management roles and responsibilities that are consistent with DBH fiscal operations. Spending plans developed for the four DC Prevention Center SABG funded grants and monitor programmatic progress according to DC and DBH guidelines. Baseline established for completing Notices of Grant Awards and scopes of work, within established timelines with the DBH finance operations. Completed a minimum of one onsite program grant review and a follow-up report within established timelines. Completed the SABG application and the SABG annual report within SAMHSA and DBH timelines.
First-year target/outcome measurement:	Use the process measures to develop flow charts for grants management roles and responsibilities that are consistent with DBH Grants Management and establish quality improvement measures for FY 2016 and FY 2017. Develop baseline measures for ensuring that prevention sub-grant spending plans are being implemented within guidelines established by DBH. Develop program grants management work plans for each sub-grant and establish timelines that are tracked by the grants management specialist and manager. Develop SABG prevention set-aside work plans for the application and the SABG annual reports and track progress.
Second-year target/outcome measurement:	Update grants management flow charts, based on quality improvement changes identified in Year One. Update baseline measures for ensuring prevention sub-grant spending plans are being implemented within DBH guidelines. This requires extensive collaboration and coordination with DBH Financial Grants Management staff. Update program grants management work plans for each sub-grant, establish timelines that are tracked by the grants management specialist and manager, and identify areas for capacity building services. Develop SABG prevention set-aside work plans for the application and the annual reports, track progress, and identify areas for improvement.

Data Source:

Flow charts and work plans will be integrated into the DIRS DBH module and staff will enter information monthly.

Description of Data:

The grants and contract manager will provide oversight on progress and areas for improvement.

Data issues/caveats that affect outcome measures::

Indicator #:	4
Indicator:	Partnerships that support development and implementation of the broad conceptual framework that addresses prevention risk factors associated with substance abuse and interrelated adolescent problems.
Baseline Measurement:	Revisit FY 2015 District priority risk and protective factors, baseline measures and projections. Revisit District level distal or behavioral outcome priorities, baseline measures and projections. Set District level baseline measures for Community Changes in policies, programs and practices.
First-year target/outcome measurement:	Track District wide progress in meeting and/or exceeding Year One projections for priority risk and protective factors. Track District wide progress in meeting and/or exceeding Year One projections for distal or behavioral targets. Track District wide progress in meeting and/or exceeding Year One projections for community changes. • c.
Second-year target/outcome measurement:	Track District wide progress in meeting and/or exceeding Year Two projections for priority risk and protective factors. Track District wide progress in meeting and/or exceeding Year Two projections for distal or behavioral targets. Track District wide progress in meeting and/or exceeding Year Two projections for community changes.

Data Source:

DCEOW - 2015 Epidemiological Outcomes Report

Description of Data:

The 2015 Epidemiological Outcomes Report includes data on demographics, consumption, consequences, and risk factors that have been derived from records, surveys, and related reports gathered by the DBH DCEOW.

Data issues/caveats that affect outcome measures::

Historically, there have been challenges in collecting a consistent level of data across all eight (8) wards within the District; specifically as it pertains to high school youth. The major challenge has been in eliminating identifiers that would make it possible to know the exact population(s) reflected in the data.

Priority #: 5

Priority Area: Health and Wellness Integration

Priority Type: SAT

Population(s): TB

Goal of the priority area:

Reduce health disparities, and support trauma informed integrated and coordinated care for people with co-occurring disorders within the behavioral health sphere as well as those with other co-occurring health conditions such as HIV/AIDS and Hepatitis.

Objective:

Strategies to attain the objective:

Engage the provider network in identifying and implementing evidence based practices best suited to respond to the trauma and co-occurring disorders impacting our client population.

Engage the provider network in developing collaborative relationships with local primary care service providers to ensure that client's medical needs are being met

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Percentage of those with a positive PPD linked to specialty medical service
Baseline Measurement:	Baseline to be developed during FY 2014.
First-year target/outcome measurement:	90% of clients with positive PPD to have a documented attempt at linkage to a specialty medical service.
Second-year target/outcome measurement:	95% of clients with positive PPD to have a documented attempt at linkage to a specialty medical service.

Data Source:

Information to be collected by staff in the Assessment and Referral Center. Detoxification and Residential Treatment providers to report monthly on the linkages attempted/completed among this cohort.

Description of Data:

Clients with a positive PPD are defined as those who have a newly identified positive as well as those who report a positive PPD in the past regardless of treatment history.

Data issues/caveats that affect outcome measures::

No such issues are foreseen at this time.

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Activity	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	$7,910,162		$0	$1,103,347	$25,149,616	$0	$384,600
a. Pregnant Women and Women with Dependent Children*	$348,390		$0	$0	$1,200,000	$0	$0
b. All Other	$7,561,772		$0	$1,103,347	$23,949,616	$0	$384,600
2. Substance Abuse Primary Prevention	$2,234,558		$0	$2,579,597	$577,774	$0	$0
3. Tuberculosis Services	$0		$0	$0	$104,094	$0	$0
4. HIV Early Intervention Services	$348,390		$0	$0	$0	$0	$0
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non-24 Hour Care							
8. Mental Health Primary Prevention							
9. Evidenced Based Practices for First Episode Psychosis (10% of the state's total MHBG award)							
10. Administration (Excluding Program and Provider Level)	$607,656		$0	$0	$1,419,612	$0	$0
11. Total	$11,100,766	$0	$0	$3,682,944	$27,251,096	$0	$384,600

* Prevention other than primary prevention

Footnotes:

District's Fiscal 12 month fiscal year run 10/1 thru 9/30. The expenditures being projected will be captured as such. The amount in column A have been revised to add the carryover funds below.
Carryover Amounts include:
Pregnant Women and Women with children=$384,390
Admin: $259,266 of Carryover + $348,390 of Current funds=$607,656
Prevention: $840,999 of Carryover + $1,393,559 of current funds=$2,234,558

Treatment: $2,684,315 of Carryover + $4,877,457 of current funds=$7,561,772

Planning Tables

Table 3 State Agency Planned Block Grant Expenditures by Service

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Service	Expenditures
Healthcare Home/Physical Health	$1,000,000
General and specialized outpatient medical services;	
Acute Primary Care;	
General Health Screens, Tests and Immunizations;	
Comprehensive Care Management;	
Care coordination and Health Promotion;	
Comprehensive Transitional Care;	
Individual and Family Support;	
Referral to Community Services;	
Prevention Including Promotion	$

Screening, Brief Intervention and Referral to Treatment ;	
Brief Motivational Interviews;	
Screening and Brief Intervention for Tobacco Cessation;	
Parent Training;	
Facilitated Referrals;	
Relapse Prevention/Wellness Recovery Support;	
Warm Line;	
Substance Abuse Primary Prevention	$2,234,558
Classroom and/or small group sessions (Education);	
Media campaigns (Information Dissemination);	
Systematic Planning/Coalition and Community Team Building(Community Based Process);	
Parenting and family management (Education);	
Education programs for youth groups (Education);	
Community Service Activities (Alternatives);	
Student Assistance Programs (Problem Identification and Referral);	

Employee Assistance programs (Problem Identification and Referral);	
Community Team Building (Community Based Process);	
Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental);	
Engagement Services	$
Assessment;	
Specialized Evaluations (Psychological and Neurological);	
Service Planning (including crisis planning);	
Consumer/Family Education;	
Outreach;	
Outpatient Services	$1,100,000
Individual evidenced based therapies;	
Group Therapy;	
Family Therapy ;	
Multi-family Therapy;	

Consultation to Caregivers;	
Medication Services	$3,000,000
Medication Management;	
Pharmacotherapy (including MAT);	
Laboratory services;	
Community Support (Rehabilitative)	$
Parent/Caregiver Support;	
Skill Building (social, daily living, cognitive);	
Case Management;	
Behavior Management;	
Supported Employment;	
Permanent Supported Housing;	
Recovery Housing;	
Therapeutic Mentoring;	
Traditional Healing Services;	

Recovery Supports	$1,000,000
Peer Support;	
Recovery Support Coaching;	
Recovery Support Center Services;	
Supports for Self-directed Care;	
Other Supports (Habilitative)	$
Personal Care;	
Homemaker;	
Respite;	
Supported Education;	
Transportation;	
Assisted Living Services;	
Recreational Services;	
Trained Behavioral Health Interpreters;	

Interactive Communication Technology Devices;	
Intensive Support Services	$1,558,446
Substance Abuse Intensive Outpatient (IOP);	
Partial Hospital;	
Assertive Community Treatment;	
Intensive Home-based Services;	
Multi-systemic Therapy;	
Intensive Case Management ;	
Out-of-Home Residential Services	$1,207,762
Crisis Residential/Stabilization;	
Clinically Managed 24 Hour Care (SA);	
Clinically Managed Medium Intensity Care (SA) ;	
Adult Mental Health Residential ;	
Youth Substance Abuse Residential Services;	
Children's Residential Mental Health Services ;	

Therapeutic Foster Care;	
Acute Intensive Services	$
Mobile Crisis;	
Peer-based Crisis Services;	
Urgent Care;	
23-hour Observation Bed;	
Medically Monitored Intensive Inpatient (SA);	
24/7 Crisis Hotline Services;	
Other	$
Total	$11,100,766

Footnotes:

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Expenditure Category	FY 2016 SA Block Grant Award
1 . Substance Abuse Prevention* and Treatment	$4,877,457
2 . Substance Abuse Primary Prevention	$1,393,559
3 . Tuberculosis Services	$0
4 . HIV Early Intervention Services**	$348,390
5 . Administration (SSA Level Only)	$348,390
6. Total	$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: 10/1/2015 Planning Period End Date: 9/30/2017

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

Community-Based Process	Universal	$449,081
	Selective	$0
	Indicated	$0
	Unspecified	$0
	Total	$449,081
Environmental	Universal	$0
	Selective	$0
	Indicated	$0
	Unspecified	$62,693
	Total	$62,693
Section 1926 Tobacco	Universal	$0
	Selective	$60,000
	Indicated	$0
	Unspecified	$0
	Total	$60,000
Other	Universal	$0
	Selective	$0
	Indicated	$0
	Unspecified	$0
	Total	$0
Total Prevention Expenditures		$1,393,559
Total SABG Award*		$6,967,796
Planned Primary Prevention Percentage		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: 10/1/2015 Planning Period End Date: 9/30/2017

Activity	FY 2016 SA Block Grant Award
Universal Direct	$363,756
Universal Indirect	$580,098
Selective	$315,918
Indicated	$133,787
Column Total	$1,393,559
Total SABG Award*	$6,967,796
Planned Primary Prevention Percentage	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: 10/1/2015 Planning Period End Date: 9/30/2017

Targeted Substances	
Alcohol	þ
Tobacco	é
Marijuana	þ
Prescription Drugs	é
Cocaine	é
Heroin	é
Inhalants	é
Methamphetamine	é
Synthetic Drugs (i.e. Bath salts, Spice, K2)	þ
Targeted Populations	
Students in College	é
Military Families	é
LGBT	é
American Indians/Alaska Natives	é
African American	é
Hispanic	é
Homeless	é
Native Hawaiian/Other Pacific Islanders	é
Asian	é
Rural	é
Underserved Racial and Ethnic Minorities	é

Footnotes:

Planning Tables

Table 6a SABG Resource Development Activities Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

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

Footnotes:

Table 5A. has been corrected to truly reflect where this activity occurs, This function strictly occurs within treatment. No Prevention funds are

used in this function.

Environmental Factors and Plan

1. The Health Care System and Integration

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.[26] 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.[27] It has been acknowledged that there is a high rate of co- occurring mental illness and substance abuse, with appropriate treatment required for both conditions.[28] Overall, America has reduced its heart disease risk based on lessons from a 50-year research project on the town of Framingham, MA, outside Boston, where researchers followed thousands of residents to help understand what causes heart disease. The Framingham Heart Study produced the idea of "risk factors" and helped to make many connections for predicting and preventing heart disease.

There are five major preventable risks identified in the Framingham Heart Study that may impact people who live with mental illness. These risks are smoking, obesity, diabetes, elevated cholesterol, and hypertension. These risk factors can be appropriately modified by implementing well-known evidence–based practices[29] [30] that will ensure a higher quality of life.

Currently, 50 states have organizationally consolidated their mental and substance abuse 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.[31] Specific to children, many children and youth with mental illness and substance use issues are more likely to be seen in a health care setting than in the specialty mental health and substance abuse system. In addition, children with chronic medical conditions have more than two times the likelihood of having a mental disorder. In the U.S., more than 50 percent of adults with mental illness had symptoms by age 14, and three-fourths by age 24. It is important to address the full range of needs of children, youth and adults through integrated health care approaches across prevention, early identification, treatment, and recovery.

It is vital that SMHAs' and SSAs' programming and planning reflect the strong connection between behavioral, physical and population/public health, with careful consideration to maximizing impact across multiple payers including Medicaid, exchange products, and commercial coverages. Behavioral health disorders are true physical disorders that often exhibit diagnostic criteria through behavior and patient reports rather than biomarkers. Fragmented or discontinuous care may result in inadequate diagnosis and treatment of both physical and behavioral conditions, including co-occurring disorders. For instance, persons receiving behavioral health treatment may be at risk for developing diabetes and experiencing complications if not provided the full range of necessary care.[32] In some cases, unrecognized or undertreated physical conditions may exacerbate or cause psychiatric conditions.[33] Persons with physical conditions may have unrecognized mental challenges or be at increased risk for such challenges.[34] Some patients may seek to self-medicate due to their chronic physical pain or become addicted to prescribed medications or illicit drugs.[35] In all these and many other ways, an individual's mental and physical health are inextricably linked and so too must their health care be integrated and coordinated among providers and programs.

Health care professionals and consumers of mental illness and substance abuse treatment recognize the need for improved coordination of care and integration of physical and behavioral health 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.[36]

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[37] Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health 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 mental and substance abuse treatment 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 electronic health records (EHRs) and telehealth are examples of important strategies to promote integrated care.[38] 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 behavioral health prevention, care, 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[39] and ACOs[40] may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting behavioral health 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.

The Affordable Care Act is an important part of efforts to ensure access to care and better integrate care. Non-grandfathered health plans sold in the individual or the small group health insurance markets offered coverage for mental and substance use disorders as an essential health benefit.

SSAs and SMHAs also may work with Medicaid programs and Insurance Commissioners to encourage development of innovative demonstration projects and waivers that test approaches to providing integrated care for persons with mental illness and substance use disorders and other vulnerable populations.[41] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[42]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[43] Roughly, 30 percent of dually eligible persons have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[44] SMHAs and SSAs also should collaborate with Medicaid, insurers and insurance regulators to develop policies to assist those individuals who experience health coverage eligibility changes due to shifts in income and employment.[45] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or finding a provider.[46] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health 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 ensure access and integrated prevention care and recovery support in all vulnerable populations including, but not limited to college students and transition age youth (especially those at risk of first episodes of mental illness or substance abuse); American Indian/Alaskan Natives; ethnic minorities experiencing health and behavioral health disparities; military families; and, LGBT individuals. SMHAs and SSAs should discuss with Medicaid and other partners, gaps that may exist in services in the post-Affordable Care Act environment and the best uses of block grant funds to fill such gaps. SMHAs and SSAs should work with Medicaid and other stakeholders to facilitate reimbursement for evidence-based and promising practices.[47] It also is important to note CMS has indicated its support for incorporation within Medicaid programs of such approaches as peer support (under the supervision of mental health professionals) and trauma-informed treatment and systems of care. Such practices may play an important role in facilitating integrated, holistic care for adults and children with behavioral health conditions.[48]

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.[49] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists and others will need to understand integrated care models, concepts and practices.

Another key part of integration will be defining performance and outcome measures. Following the Affordable Care Act, the Department of Health and Human Services (HHS) and partners have developed the NQS, 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.[50]

SAMHSA recognizes that certain jurisdictions receiving block grant funds – including U.S. Territories, tribal entities and those jurisdictions that have signed compacts of free association with the U.S. – may be uniquely impacted by certain Affordable Care Act and Medicaid provisions or ineligible to participate in certain programs.[51] 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 illnesses and substance use disorders.

Numerous provisions in the Affordable Care Act and other statutes improve the coordination of care for patients through the creation of health homes, where teams of health care professionals will be charged with coordinating care for patients with chronic conditions. States that have approved Medicaid State Plan Amendments (SPAs) will receive 90 percent Federal Medical Assistance Percentage (FMAP) for health home services for eight quarters. At this critical juncture, some states are ending their two years of enhanced FMAP and returning to their regular state FMAP for health home services. In addition, many states may be a year into the implementation of their dual eligible demonstration projects.

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

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs as of January 1, 2016?
2. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
3. Who is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe the monitoring process.
4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?
5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?
6. Is the SSA/SMHA is involved in the various coordinated care initiatives in the state?
7. Is the SSA/SMHA work with the state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHCs), other primary care practices, and the publicly funded behavioral health providers?
8. Are state behavioral health facilities moving towards addressing nicotine dependence on par with other substance use disorders?
9. What agency/system regularly screens, assesses, and addresses smoking among persons served in the behavioral health system?

10. Indicate tools and strategies used that support efforts to address nicotine cessation.
    - Regular screening with a carbon monoxide (CO) monitor
    - Smoking cessation classes
    - Quit Helplines/Peer supports
    - Others_____
11. The behavioral health providers screen and refer for:
    - Prevention and wellness education;
    - Health risks such as heart disease, hypertension, high cholesterol, and/or diabetes; and,
    - Recovery supports

Please indicate areas of technical assistance needed related to this section.

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http://www.promoteacceptance.samhsa.gov/10by10/default.aspx; JW Newcomer and CH Hennekens, Severe Mental Illness and Risk of Cardiovascular Disease, JAMA; 2007; 298: 1794-1796; Million Hearts, http://www.integration.samhsa.gov/health-wellness/samhsa-10x10 Schizophrenia as a health disparity, http://www.nimh.nih.gov/about/director/2013/schizophrenia-as-a-health-disparity.shtml

[28] Comorbidity: Addiction and other mental illnesses, http://www.drugabuse.gov/publications/comorbidity-addiction-other-mental-illnesses/why-do-drug-use-disorders-often-co-occur-other-mental-illnesses Hartz et al., Comorbidity of Severe Psychotic Disorders With Measures of Substance Use, *JAMA Psychiatry*. 2014;71(3):248-254. doi:10.1001/jamapsychiatry.2013.3726; http://www.samhsa.gov/co-occurring/

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[31] Social Determinants of Health, Healthy People 2020, http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39;

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

Footnotes:

The Health Care system and Integration
DBH has been engaged in various activities focusing on the broader behavioral and primary care health needs of it client population, to include its integrated care project. In a collaborative partnership with the Department of Health (DOH), and its provider network, DBH is piloting the use of care Navigators. This process is responsive to the unique needs of individuals with behavioral health conditions and the challenges to getting and keeping the individuals enrolled. This model, if successful, will be beneficial to our HBx Navigator partnership, and can be rolled out more broadly across the network.
The District through its Electronic Health Record (EHR), ICAMS, conducts eligibility and enrollment screenings of all clients entering into treatment programs and a (270/271); which is Medicaid's eligibility screen is done to ensure benefit verification and maximization
The District is currently developing a comprehensive inclusion plan for community behavioral health provider participation in the networks of the QHPs. This will include adequate training, TA and assisting its providers in enrolling in the networks.
Under the SABG grant, about 311 individuals served are uninsured. This amount is based on the maximum number of clients the block grant is funding for mostly medication management under Opioid treatment services.
In 2013, 311 individuals served under the SABG. DBH anticipates serving more individuals CY 2016 and C2017 as the services provided more clients be paid for under the Medicaid State Plan Amendment (SPA) which therefore made available more SABG fund which means more were clients served.
These 5 providers represent only a subset of the Department's Substance Use Disorder portfolio of about 40 treatment providers. All of DBH Substance Use Disorder treatment providers are required by DCMR Chapter 63 standards to be Medicaid certified by the appointed timeframes. By May 2016, all of the SUD providers will be Medicaid providers or participating in a QHP. By this date, the recertification process will improve access to care, increase adherence to treatment and follow-up on referrals, increase collaboration among providers, decrease use of unneeded emergency services and develop the integration of individualized care plan.

Environmental Factors and Plan

2. Health Disparities

Narrative Question:

In accordance with the *HHS Action Plan to Reduce Racial and Ethnic Health Disparities*[52], *Healthy People, 2020*[53], *National Stakeholder Strategy for Achieving Health Equity*[54], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures 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, and people living with HIV/AIDS or other chronic diseases/impairments) 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 standards).[55]

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the 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 top Secretarial priority in the Action Plan is to "[a]ssess 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."[56]

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, in accordance with section 4302 of the Affordable Care Act, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status.[57] 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.[58] 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, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health 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 population 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 being served or 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, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection, and sexual orientation (i.e., lesbian, gay, bisexual).

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

1. Does the state track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBT, and age?
2. Describe the state plan to address and reduce disparities in access, service use, and outcomes for the above subpopulations.
3. Are linguistic disparities/language barriers identified, monitored, and addressed?
4. Describe provisions of language assistance services that are made available to clients served in the behavioral health provider system.
5. Is there state support for cultural and linguistic competency training for providers?

Please indicate areas of technical assistance needed related to this section.

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[55] http://www.ThinkCulturalHealth.hhs.gov

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[57] http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208

[58] http://www.whitehouse.gov/omb/fedreg_race-ethnicity

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

Footnotes:

Does the state track access or enrollment in services types of services (including language services) received and outcomes by race, ethnicity, gender, LGBT, and age?
The Electronic Health Record (EHR) System identifies and tracks each of these categories and is able to generate reporting as needed for specific programmatic decision-making. DBH has the ability through the EHR to track and document each client's primary language. The largest cohort of non-English speaking clients DBH sees is Spanish-speaking, and contracted with DBH are two adult providers and one youth provider with the capacity to offer services entirely in Spanish. DBH's Assessment and Referral Center currently employs 5 full-time staff members who are fluent in Spanish.
Describe the state plan to address and reduce disparities in access, service use and outcomes for the above subpopulation.

In accordance with the Memorandum of Agreement (MOA) between DBH and the Child and Family Services Agency (CFSA), CFSA provides services and family stabilization resources to families and children alleged to be abused and/or neglected through the coordination of public and private partnerships.
CFSA personnel conducts screenings on selected cohorts of youth
and adults with child welfare involvement using the Global Assessment of Individual Needs Short Screener (GAIN-SS). Those whose screening results indicate that a full assessment is indicated are referred electronically to the appropriate location for a full
assessment and, subsequently, treatment services as appropriate. The screening, referral and information sharing processes all take place electronically using the EHR System.
The MOA lays out rules and policies regarding access to the EHR System, data sharing, and protections for confidential information and ongoing communication between the two agencies at the administrative level to monitor and improve the quality of coordination.
This collaboration reduces disparities for some of the District's most vulnerable residents. CFSA serves residents who are disproportionately low income African-American women, many of whom are single parents, and their children. Those with child welfare involvement are particularly vulnerable to health disparities. The collaboration has already improved the capacity to identify substance use disorders through screening with the GAIN-SS, and the training of CFSA front line staff in Screening, Brief
Intervention and Referral to Treatment (SBIRT). Treatment access has been improved through a dedicated assessor in the Assessment and Referral Center specifically for child welfare-involved clients. This has already had a demonstrable effect in reducing call-to-appointment time at the Center for CFSA-affiliated clients significantly. The Office of Quality Assurance has also undertaken a targeted project to build capacity around HIV education, testing, and case management within the treatment network. Building upon the new internal capacity to conduct HIV testing in the Assessment and Referral Center through the Minority AIDS Initiative, this initiative will provide programs with technical assistance around facilitating access to HIV testing, educating clients in the most current information on HIV and providing effective case management to those who are HIV positive (e.g. linkage to primary and specialty medical care). DBH is also in the process of working with two providers that have agreed to provide services for women with children: SOME and Samaritan Inns. Thea Bowman House for Women and Children is SOME's new inpatient substance abuse treatment program where mothers can get help without being separated from their children. Thea Bowman House provides treatment for up to 14 homeless and low-income mothers, each with one or two children 10 years old or younger. The program also accepts pregnant women. Samaritan Inns Women with Children Program will create a safe home, housing up to 12 women and 16 children, where mothers recovering from substance abuse can receive treatment and family services while establishing a foundation for long-term independent living.
Are linguistic disparities/language barriers identified, monitored, and addressed?
DBH has the capability through the EHR System to document every client's primary language. This information can be easily aggregated to assess any trends in primary language entering the system. The largest and most specific cohort of non-English speakers DBH sees in the treatment system is Spanish-speakers. DBH currently contracts with three adult providers and one youth provider with the internal capacity to offer services entirely in Spanish. As of this writing, the Assessment

and Referral Center employs two full-time staff members who are fluent in Spanish. The EHR System also keeps profile information of all provider staff with accounts in the system. Among the EHR System points in this profile is language capacity. Users are required to document which languages they speak and their degree of fluency. This information can be aggregated at will by DBH and clients seeking services at the Assessment and Referral Center, or other DBH intake location, can be matched with programs employing culturally compatible staff.

Describe provisions of language assistance services that are made available to clients served in the behavioral health provider system.

Clients that enter the behavioral health provider system are provided access to services that are culturally appropriate, including the use of adaptive equipment, sign language, interpreter, or translation services as appropriate.

Is there state support for cultural and linguistic competency training for providers?

The District provides support for cultural and linguistic competency training through: The DBH Training Institute: Assesses the needs of the network for training Provides training to providers for special needs population The DBH Language line. Included into all DBH contracts, providers must service all non-English speaking and hearing impaired.

3. Use of Evidence in Purchasing Decisions

Narrative Question:

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including mental health and substance abuse services. Over the past several years, SAMHSA has received many requests from CMS, HRSA, SMAs, state behavioral health authorities, legislators, and others regarding the evidence of various mental and substance abuse 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 Institute of Medicine (IOM) recommend that evidence play a critical role in designing health and behavioral health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. Since 2001, SAMHSA has sponsored a National Registry of Evidenced-based Programs and Practices (NREPP). NREPP[59] is a voluntary, searchable online registry of more than 220 submitted interventions supporting mental health promotion and treatment and substance abuse prevention and treatment. The purpose of NREPP is to connect members of the public to intervention developers so that they can learn how to implement these approaches in their communities. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

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[60], The New Freedom Commission on Mental Health[61], the IOM[62], and the NQF.[63] 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."[64] SAMHSA and other federal partners (the Administration for Children and Families (ACF), the HHS Office of Civil Rights (OCR), and CMS) have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, identify specific strategies for embedding these practices in provider organizations, and recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. These are services that have not been studied, but anecdotal evidence and program specific data indicate that they are effective. 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 Protocols (TIPs)[65] are best practice guidelines for the treatment of substance abuse. The Center for Substance Abuse Treatment (CSAT) 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 substance abuse treatment facilities as alcohol and other drug disorders are increasingly recognized as a major problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (KIT)[66] was developed to help move the latest information available on effective behavioral health 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 behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, 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 mental health and substance abuse services.

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

1. Describe the specific staff responsible for tracking and disseminating information regarding evidence-based or promising practices.
2. How is information used regarding evidence-based or promising practices in your purchasing or policy decisions?
3. Are the SMAs and other purchasers educated on what information is used to make purchasing decisions?
4. Does the state use a rigorous evaluation process to assess emerging and promising practices?
5. Which value based purchasing strategies do you use in your state:
    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 incentives to drive quality.

d. Provider involvement in planning value-based purchasing.

e. Gained consensus on the use of accurate and reliable measures of quality.

f. Quality measures focus on consumer outcomes rather than care processes.

g. Development of strategies to educate consumers and empower them to select quality services.

h. Creation of a corporate culture that makes quality a priority across the entire state infrastructure.

i. The state has an evaluation plan to assess the impact of its purchasing decisions.

Please indicate areas of technical assistance needed related to this section.

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[59] Ibid, 47, p. 41

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[61] 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.

[62] 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.

[63] National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

[64] http://psychiatryonline.org/

[65] http://store.samhsa.gov

[66] http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345

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

Footnotes:

1)Does your state have specific staff that is responsible for tracking and disseminating information regarding evidence-based or promising practices?

Through the collaborative work of APRA's Divisions of Prevention, Treatment, Recovery, and Performance Improvement evidence-based and promising practices are tracked, vetted, disseminated, and implemented. The Divisions collectively recommend Evidence Based Practices for Substance abuse prevention, treatment, and recovery that are emerging at the national level which are determined to be best practices for the local demographic. The Divisions work closely together to continuously improve the quality of services under their purview. The Divisions generate status reports that disseminate information regarding formularies of evidence based practices, and recommend trainings, provide technical assistance and guidance, and construct policy according to best practices for substance abuse standards. All providers that the District purchases services from are required to utilize interventions that are registered or approved by SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP). All Substance Abuse treatment and recovery programs are required to be certified through APRA's Certification and Regulation Division (CRD), including private, non-contracted substance abuse treatment and recovery programs. In conjunction with the Office of Quality Assurance and the Treatment Division, the District's training department seeks promising practices and evidence based practices and makes this information available to the provider network.

2) Did you use information regarding evidence-based or promising practices in your purchasing or policy decisions?

a) What information did you use?
b) What information was most useful?

The District requires by policy and per contract that all substance abuse treatment providers implement evidence based practice that is registered or approved by SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP). For the adult treatment system, the District does not specify which EBP that a treatment provider must use. The District, however, will only purchase services that adhere to an EBP. Adult substance abuse treatment providers within the network must use an evidence based screening and assessment tool. Currently, the District is using the Global Assessment of Individual Need – Short Screener (GAIN-SS) for both the adult and adolescent system. The District uses the Treatment Assignment Protocol (TAP) as the standardized assessment tool for level of care (LOC) assessment using the American Society for Addictions Medicine's Patient Placement Criteria (ASAM). The District requires the adolescent system to use the GAIN-I as the standard evidence based assessment tool for substance use disorders. The most useful resources the District relies on when gathering EBP information is the NREPP website. Our State Subject Matter Experts utilized various aspects of the information on the website such as EBP reviews, summaries, and effectiveness measures. This information helps direct our Quality Assurance process, treatment outcome expectations, and training needs.

APRA Division of Prevention base information for identifying Evidence-Based Program (strategies) is from federal databases, the Institute of Medicine's Preventing Mental, Emotional, and Behavioral Disorders Among Young People, SAMHSA's Leading Change plan, Center for Disease Control s and the Society of Prevention Research. EBP's that address the unique needs of an urban environment and culturally diverse populations are integrated into APRA Prevention Request for Applications as requirements.

This information guided the development of four DC Prevention Centers in 2010. The Strategic Prevention Framework State Incentive Grant is the catalyst for pilot strategies that are funded and evaluated to determine long term r utility in the District of Columbia. Pilot projects include: four Parent Partnership Grants for selective and indicated populations; 7 Community Evidence-Based Prevention Grants; four CORE Coordinators to assess the need for I Prevention across the 8 wards; and a Synthetic Marijuana public awareness and community action initiative. APRA

prevention technical experts use District and ward DC Epidemiological Outcomes

Workgroup (DCEOW) data to providecore strategies: information dissemination, education, community processes, environmental, alternatives, and problem identification and referral.

3) How have you used information regarding evidence-based practices?
a) Educating State Medicaid agencies and other purchasers regarding this information?
b) Making decisions about what you buy with funds that are under your control?

As stated in the previous question, the District uses EBP reviews, summaries, and effectiveness measures to direct our Quality Assurance process, treatment outcome expectations, and training needs. APRA is the clearinghouse for our State Medicaid Program. The District demonstrates the thoughtfulness of purchasing treatment services by designing our State Plan Amendment (the District plan to pay for substance abuse services through Medicaid) to compliment a variety of services implemented in several EBP's. Acting as the clearinghouse, APRA ensures that treatment funds spent for substance abuse treatment, both federal and local dollars, are only spent on services that are implemented under an evidence based practice.

APRA plans to use evaluation data from the Strategic Prevention Framework State Incentive Grant to make decisions on leveraging using Medicaid funds for evidence-based universal, selective, and indicated prevention strategies.

4. Prevention for Serious Mental Illness

Narrative Question:

SMIs such as schizophrenia, psychotic mood disorders, bipolar disorders and others produce significant psychosocial and economic challenges. Prior to the first episode, a large majority of individuals with psychotic illnesses display sub-threshold or early signs of psychosis during adolescence and transition to adulthood.[67] The “Prodromal Period” is the time during which a disease process has begun but has not yet clinically manifested. In the case of psychotic disorders, this is often described as a prolonged period of attenuated and nonspecific thought, mood, and perceptual disturbances accompanied by poor psychosocial functioning, which has historically been identified retrospectively. Clinical High Risk (CHR) or At-Risk Mental State (ARMS) are prospective terms used to identify individuals who might be potentially in the prodromal phase of psychosis. While the MHBG must be directed toward adults with SMI or children with SED, including early intervention after the first psychiatric episode, states may want to consider using other funds for these emerging practices.

There has been increasing neurobiological and clinical research examining the period before the first psychotic episode in order to understand and develop interventions to prevent the first episode. There is a growing body of evidence supporting preemptive interventions that are successful in preventing the first episode of psychosis. The National Institute for Mental Health (NIMH) funded the North American Prodromal Longitudinal study (NAPLS), which is a consortium of eight research groups that have been working to create the evidence base for early detection and intervention for prodromal symptoms. Additionally, the Early Detection and Intervention for the Prevention of Psychosis (EDIPP) program, funded by the Robert Wood Johnson Foundation, successfully broadened the Portland Identification and Early Referral (PIER) program from Portland, Maine, to five other sites across the country. SAMHSA supports the development and implementation of these promising practices for the early detection and intervention of individuals at Clinical High Risk for psychosis, and states may want to consider how these developing practices may fit within their system of care. Without intervention, the transition rate to psychosis for these individuals is 18 percent after 6 months of follow up, 22 percent after one year, 29 percent after two years, and 36 percent after three years. With intervention, the risk of transition to psychosis is reduced by 54 percent at a one-year follow up.[68] In addition to increased symptom severity and poorer functioning, lower employment rates and higher rates of substance use and overall greater disability rates are more prevalent.[69] The array of services that have been shown to be successful in preventing the first episode of psychosis include accurate clinical identification of high-risk individuals; continued monitoring and appraisal of psychotic and mood symptoms and identification; intervention for substance use, suicidality and high risk behaviors; psycho-education; family involvement; vocational support; and psychotherapeutic techniques.[70] [71] This reflects the critical importance of early identification and intervention as there is a high cost associated with delayed treatment.

Overall, the goal of early identification and treatment of young people at high clinical risk, or in the early stages of mental disorders with psychosis is to: (1) alter the course of the illness; (2) reduce disability; and, (3) maximize recovery.

****It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Please indicate areas of technical assistance needed related to this section.

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[69] Whiteford, H.A., Degenhardt, L., Rehm, J., Baxter, A.J., Ferrari, A.J., Erskine, H.E., Charlson, F.J., Norman, R.E., Flaxman, A.D., Johns, N., Burstein, R., Murray, C.J., & Vos T. (2013). Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. Lancet. Nov 9;382(9904):1575-1586.

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[71] McGorry, P., Nelson, B., Phillips, L.J., Yuen, H.P., Francey, S.M., Thampi, A., Berger, G.E., Amminger, G.P., Simmons, M.B., Kelly, D., Dip, G., Thompson, A.D., & Yung, A.R. (2013). Randomized controlled trial of interventions for young people at ultra-high risk of psychosis: 12-month outcome. J Clin Psychiatry. Apr;74(4):349-56.

Footnotes:

Prevention for Serious Mental Illnesses
The child and youth service system implements a number of prevention and early intervention services. These services include: 1) Parent Infant Early Childhood Enhancement Program (comprehensive services to children and families that focus on supporting cognition, language, motor skills, adaptive skills and social emotional functioning; 2) Healthy Start Project (addresses the medical and mental health challenges of women of childbearing age to reduce infant mortality by improving the emotional, mental and physical health of pre- and postnatal women); 3) Early Childhood Mental Health Consultation Program – Healthy Futures (center-based and child and family-centered consultation services to the staff and family members at child development centers); 4) Primary Project (evidence-based, early intervention/prevention program for identified children in Pre-kindergarten through 3rd grade who have mild problems with social-emotional adjustment in the classroom); and 5) School Mental Health Program (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).

Also, the child and youth services program implements a number of evidence-based practices. They include: 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 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) Multi-Systemic Therapy for Youth with Problem Sexual Behavior- for ages 10-17 and is an intensive family and community based program that addresses factors that influence problem sexual behavior, focusing on the offender’s home/family, school, neighborhood and peers; and 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 successful achievement of their goals.

Environmental Factors and Plan

5 Evidence-Based Practices for Early Intervention (5 percent set-aside)

Narrative Question:

P.L. 113-76 and P.L. 113-235 requires that states set aside five percent of their MHBG allocation to support evidence-based programs that provide treatment to those with early SMI including but not limited to psychosis at any age.[72] SAMHSA worked collaboratively with the NIMH to review evidence-showing efficacy of specific practices in ameliorating SMI and promoting improved functioning. NIMH has released information on Components of Coordinated Specialty Care (CSC) for First Episode Psychosis. Results from the NIMH funded Recovery After an Initial Schizophrenia Episode (RAISE) initiative[73], a research project of the NIMH, suggest that mental health providers across multiple disciplines can learn the principles of CSC for First Episode of Psychosis (FEP), and apply these skills to engage and treat persons in the early stages of psychotic illness. At its core, CSC is a collaborative, recovery-oriented approach involving clients, treatment team members, and when appropriate, relatives, as active participants. The CSC components emphasize outreach, low-dosage medications, evidenced-based supported employment and supported education, case management, and family psycho-education. It also emphasizes shared decision-making as a means to address individuals' with FEP unique needs, preferences, and recovery goals. Collaborative treatment planning in CSC is a respectful and effective means for establishing a positive therapeutic alliance and maintaining engagement with clients and their family members over time. Peer supports can also be an enhancement on this model. Many also braid funding from several sources to expand service capacity.

States can implement models across a continuum that have demonstrated efficacy, including the range of services and principles identified by NIMH. Using these principles, regardless of the amount of investment, and with leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, every state will be able to begin to move their system toward earlier intervention, or enhance the services already being implemented.

It is expected that the states' capacity to implement this programming will vary based on the actual funding from the five percent allocation. SAMHSA continues to provide additional technical assistance and guidance on the expectations for data collection and reporting.

Please provide the following information, updating the State's 5% set-aside plan for early intervention:

1. An updated description of the states chosen evidence-based practice for early intervention (5% set-aside initiative) that was approved in its 2014 plan.
2. An updated description of the plan's implementation status, accomplishments and/ any changes in the plan.
3. The planned activities for 2016 and 2017, including priorities, goals, objectives, implementation strategies, performance indicators, and baseline measures.
4. A budget showing how the set-aside and additional state or other supported funds, if any, for this purpose.
5. The states provision for collecting and reporting data, demonstrating the impact of this initiative.

Please indicate areas of technical assistance needed related to this section.

[72] http://samhsa.gov/sites/default/files/mhbg-5-percent-set-aside-guidance.pdf

[73] http://www.nimh.nih.gov/health/topics/schizophrenia/raise/index.shtml?utm_source=rss_readers&utm_medium=rss&utm_campaign=rss_full

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

Footnotes:

Evidence Based Practices for Early Intervention (5% Set-aside)
District of Columbia Successes Generated by the 5% Set-Aside
The Mandate: The Substance Abuse and Mental Health Services Administration (SAMHSA) required states to amend their FY 2014-2015 Mental Health Block Grant Behavioral Health Assessment and Plan to outline a process that would describe an evidence-based program that addresses the needs of individuals with early serious mental illness, including psychotic disorders. SAMHSA increased the state's Mental Health Block Grants by 5% to provide funds for this initiative.
The Model: The District of Columbia Department of Behavioral Health (DBH) used an existing service delivery program that combines the Transition to Independence (TIP) model (an evidence supported model) with the Assertive Community Treatment (ACT) model for transition aged youth and young adults (an evidence-based practice), which is called the TACT Program.
The Providers: There are two (2) DBH mental health rehabilitation services (MHRS) providers, Community Connections and Family Preservation Services of DC that operate TACT Programs.
The Target Population: The target population is youth and young adults age 18-29 served by the two (2) TACT Programs.
The Budget: The amount of funds available to the District from the SAMHSA Mental Health Block Grant for evidence-based projects for early intervention (5% set-aside) was $46,696.00.
The Planned Activities: The primary activities include: 1) a focus group with TIP and TACT programs; 2) first psychosis episode and related training; and 3) a pilot study with the two (2) TACT programs.
Focus Group: DBH program staff decided to convene a focus group with the providers in lieu of conducting a survey (the original plan). The purpose of the focus group with the TIP and TACT Programs was to obtain information about services and supports including non-traditional and person-centered services that would enhance successful implementation of these program models and the lives of the youth and young adults served. This activity was convened on August 15, 2014 at the DBH Child and Youth Services Division (CYSD) community site. The co-facilitators were the designated CYSD Program Manager for this initiative and the Program Manager for the Mental Health Block Grant. The discussion topics included: 1) traditional services and supports provided and those most utilized by transition age youth (TAY); 2) non-traditional services and supports provided and those most utilized by TAY; 3) non-traditional services and supports the agencies would like to provide TAY but are not currently available; 4) non-traditional services and supports not currently available that TAY have requested; 5) non-traditional services and supports available through community or other resources that are needed and/or TAY have requested; 6) partnerships developed to access some of the non-traditional services and supports that are available; 7) methods used to routinely assess TAY level of satisfaction with the services and supports provided; 8) methods routinely used to obtain input from TAY about improving the services and supports provided; 9) access to person-centered funding for TAY and the funding priorities; and 10) process to confirm that TAY agree with agency priorities. The focus group discussions generated important ideas and issues that were summarized.
First Psychosis Episode Training: DBH partnered with the National Institute of Mental Health (NIMH) to provide a first episode psychosis (FEP) educational and training event for Department staff, consumers/clients, providers and other community partners. On November 10, 2014 Drs. Amy B. Goldstein and Susan T. Azrin from NIMH conducted a presentation on Prevention and Early Intervention of Psychosis: Lessons Learned from the NIMH RAISE Project. The presentation topics included: 1) schizophrenia overview; 2) rationale for early intervention in psychosis; 3) NIMH Recovery After an Initial Schizophrenia Episode (RAISE) initiative; 4) Coordinated Specialty Care (CSC) model; 5) financing CSC programs; and 6) next steps. The presentation was quite informative and well received. The event was attended by 52 individuals. Social Workers and Addiction Counselors received continuing education units.
DBH staff also participated in a series of webinars on FEP and related topics. They included:
Strategies for Funding Coordinated Specialty Care Initiatives, June 30, 2015
Using the 5% MHBG Set-Aside to Support Programming for First Episode Psychosis: Activities and Lessons Learned from the State of Ohio, June 29, 2015
Lessons Learned in Implementing Models for Early Intervention in Psychosis, June 5,

2015
An Overview of Coordinated Specialty Care (CSC) for Persons with First Episode Psychosis: A Presentation to State Planning Councils, April 13, 2015
Inventory and Environmental Scan of Evidence - Based Practices for Treating Persons in Early Stages of Serious Mental Disorders: Resource Overview, February 11, 2015
First Episodes of Psychosis as it pertains to the Mental Health Block Grant: FEP Modeling Tool, October 28, 2014
First Episodes of Psychosis as it pertains to the Mental Health Block Grant: Definition and Prevalence, October 22, 2014
Community Outreach and Prevention as an Element of Early Intervention in Psychosis, July 22, 2014
Funding Strategies for Early Psychosis Intervention Models, July 9, 2014
Prep for Success: Lessons Learned in Implementing Models for Early Intervention in Psychosis, June 5, 2014
Cognitive Behavioral Therapy and its Use with Persons in Early Stages of Serious Mental Illness, May 29, 2014
Components of Coordinated Specialty Care for First Episode Psychosis: Guidance Related to the 5% Set-Aside, May 2, 2014
TACT Program Pilot Study: DBH contracted with two (2) transition age youth/young adult TACT Programs to conduct a mini-pilot study using a sample of their program participants. They were each awarded $23,348.00. The goals of the pilot are to: 1) examine the system's ability to identify FEP onset and the length of time before treatment is received; and 2) use the findings to inform the District's ability to implement Components of a Coordinated Specialty Care for First Episode Psychosis program. The project activities involve: 1) developing a project report that includes a participant profile (onset of FEP and/or other mental health disorders, behavioral and social characteristics); 2) including peer input into the project through focus groups, other forms or activities; and 3) providing project participants with traditional and non-traditional supports, opportunities and experiences that enhance positive growth and development. The projects are underway and will be completed at the end of September 2015.
Other Related Initiatives: DBH is involved in two (2) other initiatives related to the pilot study that are described below.
National Council Community of Practice (CoP) on Early Onset Schizophrenia (EOS)- DBH was accepted into the National Council's CoP on EOS in February 2015 and joined the National Council in early March 2015. The DBH/DC team completed a strengths, weaknesses, opportunities, and threats (SWOT) analysis to identify opportunities and barriers to the development of a strategic plan for the implementation of early intervention services in late March 2015. The team has attended all learning opportunities, including the monthly mandatory webinars and one-on-one office hours calls with early onset experts. The DBH/DC team recently partnered with the Washington Community Mental Health Council (another member of the CoP on EOS) to begin peer-to-peer calls focusing on the development of a strategic planning tool that will help each team build capacity and knowledge about first episode psychosis that will ultimately result in more funding from our respective state/District legislatures.
Develop RAISE-like or Other Program- Inspired by the RA1SE project, DBH set out to develop a local program for early onset schizophrenia. In December 2014, DBH reached out to community partners who share this interest. By January 2015, a working group was created that now includes representatives from the Green Door, Psychiatric Institute of Washington, Children's National Health System, the District's Department of Health Care Finance (DHCF), and DBH. This group has been reviewing prodromal schizophrenia and first episode psychosis initiatives across the country, with the intention of tailoring a program that best meets the needs of the District's at-risk population. The DBH/DC team has reached out to core services agencies (CSAs) and local hospitals in search of a clinical home for an EOS program. The current and planned activities include: 1) the Green Door and the Psychiatric Institute of Washington (PIW) have agreed to pool resources and house the program between their sites; 2) the Green Door and PIW are currently conducting internal needs assessments to determine the amount of start-up money required to bring in requisite staffing, training, and possibly architectural changes to launch a RA1SE-inspired EOS program; 3) upon completion of the needs assessment, the DBH/DC team will seek the start-up money through a Block Grant; and 4) DBH has also begun to receive technical assistance from SAMHSA on identifying funding mechanisms for

the non-Medicaid reimbursable EOS program services.
Technical Assistance through SAMHSA- In May 2015, DBH developed a technical assistance request through the SAMHSA TA Tracker to support its collaboration with public and private community partners in developing an Early Onset Schizophrenia initiative. Specifically, this partnership would most benefit from technical assistance in identifying viable mechanisms for funding and financially sustaining this initiative in the District. The TA request was approved in June 2015. There have been follow-up discussions with the SAMHSA contractor and the DBH/DC team about the best way to proceed. The DBH/DC team is trying to determine the model that will be implemented.
The goals and outcomes that the DBH/DC team would like to achieve as a result of the technical assistance include:
Goal 1: Assess the current status of the Early Onset Schizophrenia initiative financing and sustainability strategies nationwide.
Outcome: The DBH/DC team will identify the strategies that can be successfully implemented in the District.
Goal 2: Assess the pros and cons of public-private partnerships in financing and sustaining Early Onset Schizophrenia initiatives.
Outcome: The DBH/DC team will run a cost-benefit analysis of partnering in the up-front and ongoing financial support of a local Early Onset Schizophrenia initiative.
Goal 3: Assess the extent to which Early Onset Schizophrenia services are Medicaid reimbursable in other cities/states.
Outcome: All Medicaid reimbursable services will be appropriately billed.

Environmental Factors and Plan

6. Participant Directed Care

Narrative Question:

As states implement policies that support self-determination and improve person-centered service delivery, one option that states may consider is the role that vouchers may play in their overall financing strategy. Many states have implemented voucher and self-directed care programs to help individuals gain increased access to care and to enable individuals to play a more significant role in the development of their prevention, treatment, and recovery services. The major goal of a voucher program is to ensure individuals have a genuine, free, and independent choice among a network of eligible providers. The implementation of a voucher program expands mental and substance use disorder treatment capacity and promotes choice among clinical treatment and recovery support providers, providing individuals with the ability to secure the best treatment options available to meet their specific needs. A voucher program facilitates linking clinical treatment with other authorized services, such as critical recovery support services that are not otherwise reimbursed, including coordination, childcare, motivational development, early/brief intervention, outpatient treatment, medical services, support for room and board while in treatment, employment/education support, peer resources, family/parenting services, or transportation.

Voucher programs employ an indirect payment method with the voucher expended for the services of the individual's choosing or at a provider of their choice. States may use SABG and MHBG funds to introduce or enhance behavioral health voucher and self-directed care programs within the state. The state should assess the geographic, population, and service needs to determine if or where the voucher system will be most effective. In the system of care created through voucher programs, treatment staff, recovery support service providers, and referral organizations work together to integrate services.

States interested in using a voucher system should create or maintain a voucher management system to support vouchering and the reporting of data to enhance accountability by measuring outcomes. Meeting these voucher program challenges by creating and coordinating a wide array of service providers, and leading them though the innovations and inherent system change processes, results in the building of an integrated system that provides holistic care to individuals recovering from mental and substance use disorders. Likewise, every effort should be made to ensure services are reimbursed through other public and private resources, as applicable and in ways consistent with the goals of the voucher program

Please indicate areas of technical assistance needed related to this section.

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

Footnotes:

6. Participant Directed Care

The Department of Behavioral Health (DBH) Person-Centered Project was initially launched in FY 2012 and continues to grow. The goal has been to provide a recovery-oriented and person-centered approach to care by supporting person-centered assessment and treatment planning throughout the system. The initial phase included assembling a person-centered committee of peers and representatives from DBH and community behavioral health provider agencies to plan a comprehensive launch strategy. Additional accomplishments included partnering with Diane Grieder and Neal Adams, national experts in person-centered care and authors of “Treatment Planning for Person-Centered Care,” the development of person-centered practice guidelines and the delivery of person-centered instructor training to the entire DBH provider network. As of June 2015, more than 4,500 classroom attendees were trained in behavioral health concepts, and over 7,500 continuing education contact hours were awarded to over 1,000 licensed attendees.

Environmental Factors and Plan

7. Program Integrity

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 behavioral health services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 USC §§ 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 USC § 300x– 55, 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 to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for substance abuse, SAMSHA will release guidance imminently to the states on use of block grant funds for these purposes. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The Affordable Care Act may offer additional health coverage options for persons with behavioral health conditions and block grant expenditures should reflect these coverage options. The MHBG and SABG resources are to be used to support, not supplant, individuals and services that will be covered through the Marketplaces and Medicaid. SAMHSA will provide additional guidance to the states to assist them in complying with program integrity recommendations; develop new and better tools for reviewing the block grant application and reports; and train SAMHSA staff, including Regional Administrators, in these new program integrity approaches and tools. In addition, SAMHSA will work with CMS and states to discuss possible 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 abuse programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the SABG and MHBG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include:(1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered mental health and substance abuse benefits; (3) ensuring that consumers of substance abuse and mental health services have full confidence in the confidentiality of their medical information; and (4) monitoring use of behavioral health benefits in light of utilization review, medical necessity, etc. Consequently, states may have to reevaluate their current management and oversight strategies to accommodate the new priorities. They may also be required 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 consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a program integrity plan regarding the SABG and MHBG funds?
2. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?
3. Describe the program integrity activities the state employs for monitoring the appropriate use of block grant funds and oversight practices:
    a. Budget review;
    b. Claims/payment adjudication;
    c. Expenditure report analysis;
    d. Compliance reviews;
    e. Client level encounter/use/performance analysis data; and
    f. Audits.
4. Describe payment methods, used to ensure the disbursement of funds are reasonable and appropriate for the type and quantity of services delivered.
5. Does the state provide assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
6. How does the state ensure block grant funds and state dollars are used for the four purposes?

Please indicate areas of technical assistance needed related to this section.

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

Footnotes:

Program Integrity
The SAPT- Block Grant program integrity activities include: 1) adherence to requirements set forth in the District's City-Wide Grants Manual and Source Book, 2) Department of Behavioral Health (DBH) policy; and 3) DBH funded programs and sub-grantee award process including DBH fiscal and program monitoring.
Mayor's Office of Partnerships and Grant Services (OPGS): This Office serves as the District government's grants clearinghouse in order to effectively administer mandatory policies and procedures that govern the solicitation of competitive grant funds among District agency grant seekers and their prospective grantees and/or sub-grantees. The City-Wide Grants Manual and Source Book establishes best practices policies and procedures for the application for, acceptance of, and disbursement of private, federal and local grant funds. The Sourcebook also provides an overview of the minimum requirements for the programmatic and financial operation of grants and sub-grants awarded by the District and any of its covered agencies.
Department of Behavioral (DBH) Health Policy 716.6 Screening for Eligibility to Participate in Federal Health Care Programs and to Contract with the District of Columbia Government: The Department will not contract with or employ individuals or entities that are ineligible to participate in federal health care programs or are ineligible to contract with the government of the District of Columbia. Section 4d. Exclusion List contains three (3) lists that provide information on any individual or entity excluded from participation in any federal health care program or from contracting with the District of Columbia. They include: 1) the List of Excluded of Individuals/Entities (LEIE) database maintained by the Department of Health and Human Services (DHHS), Office of Inspector General, (OIG) of individuals or entities excluded by the OIG; 2) the General Services Administration (GSA) Excluded Parties List System (EPLS), which contains debarment actions taken by various Federal agencies, including exclusion actions taken by the OIG; and 3) the District of Columbia Excluded Party List maintained by the District's Debarment and Suspension Panel. The Mental Health Block Grant sub-grantee organizations are screened against these lists.
SAPT- Block Grant DBH and Sub-Grantee Awards: The process begins with the notice of funding availability (NOFA) and request for applications (RFA) announcement, which widely distributed and follows the OPGS and Sourcebook requirements. The proposals are reviewed that will include the DBH Behavioral Health Council input. The review panel recommendations are forwarded to the DBH Director for review and final approval.
DBH SAPT- Block Grant Program and Fiscal Monitoring: The fiscal grant monitors conduct an orientation that addresses issues related to: 1) use of grant funds; 2) administrative requirements; 3) board of directors; 4) audits; 5) reporting requirements; 6) fund disbursement plan; 7) advance invoice submission; 8) expenditure report submission; 9) allowable and unallowable costs; 10) food costs; 11) travel procedures; 12) budget modifications; 13) interest checks; and 14) program close-out. They also collect fiscal information from the sub-grantees, enter the financial information into the DBH financial management system, monitor fiscal activity and reporting, and conduct payment processing. The Mental Health Block Grant Program Manager oversees the programmatic aspects of the DBH programs and sub-grantee awards. This includes: 1) review and approve the sub-grantee progress and other reports; 2) review and approve sub-grantee requests for program and budget modifications prior to implementing the proposed changes; 2) review the Mental Health Block Grant weekly expenditure report; and 3) work with the sub-grantee and fiscal monitors to resolve any issues related to the project.

Environmental Factors and Plan

8. Tribes

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[74] 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 67% of American Indian and Alaska Natives live off-reservation. SSAs/SMHAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the state. 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.

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

1. Describe how the state has consulted with tribes in the state and how any concerns were addressed in the block grant plan.
2. Describe current activities between the state, tribes and tribal populations.

Please indicate areas of technical assistance needed related to this section.

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[74] http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president

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

Footnotes:

Tribes
This environmental factor is not applicable to the District of Columbia.

Environmental Factors and Plan

9. Primary Prevention for Substance Abuse

Narrative Question:

Federal law requires that states spend no less than 20 percent of their SABG allotment on primary prevention programs, although many states spend more. Primary prevention programs, practices, and strategies are directed at individuals who have not been determined to require treatment for substance abuse.

Federal regulation (45 CFR 96.125) requires states to use the primary prevention set-aside of the SABG 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 abuse. The program must include, but is not limited to, the following strategies:

- Information Dissemination provides knowledge and increases awareness of the nature and extent of alcohol and other drug use, abuse, and addiction, as well as their effects on individuals, families, and communities. It also provides knowledge and increases awareness of available prevention and treatment programs and services. It is characterized by one-way communication from the information source to the audience, with limited contact between the two.
- Education builds skills through structured learning processes. Critical life and social skills include decision making, peer resistance, coping with stress, problem solving, interpersonal communication, and systematic and judgmental capabilities. There is more interaction between facilitators and participants than there is for information dissemination.
- Alternatives provide opportunities for target populations to participate in activities that exclude alcohol and other drugs. The purpose is to discourage use of alcohol and other drugs by providing alternative, healthy activities.
- Problem Identification and Referral aims to identify individuals who have indulged in illegal or age-inappropriate use of tobacco, alcohol or other substances legal for adults, and individuals who have indulged in the first use of illicit drugs. The goal is to assess if their behavior can be reversed through education. This strategy does not include any activity designed to determine if a person is in need of treatment.
- Community-based Process provides ongoing networking activities and technical assistance to community groups or agencies. It encompasses neighborhood-based, grassroots empowerment models using action planning and collaborative systems planning
- Environmental Strategies establish or changes written and unwritten community standards, codes, and attitudes. The intent is to influence the general population's use of alcohol and other drugs.

States should use a variety of strategies that target populations with different levels of risk. Specifically, prevention strategies can be classified using the IOM Model of Universal, Selective, and Indicated, which classifies preventive interventions by targeted population. The definitions for these population classifications are:

- Universal: The general public or a whole population group that has not been identified based on individual risk.
- Selective: Individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.
- Indicated: Individuals in high-risk environments that have minimal but detectable signs or symptoms foreshadowing disorder or have biological markers indicating predispositions for disorder but do not yet meet diagnostic levels.

It is important to note that classifications of preventive interventions by strategy and by IOM category are not mutually exclusive, as strategy classification indicates the type of activity while IOM classification indicates the populations served by the activity. Federal regulation requires states to use prevention set-aside funding to implement substance abuse prevention interventions in all six strategies. SAMHSA also recommends that prevention set-aside funding be used to target populations with all levels of risk: universal, indicated, and selective populations.

While the primary prevention set-aside of the SABG must be used only for primary substance abuse prevention activities, it is important to note that many evidence-based substance abuse prevention programs have a positive impact not only on the prevention of substance use and abuse, but also on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. This reflects the fact that substance use and other aspects of behavioral health share many of the same risk and protective factors.

The backbone of an effective prevention system is an infrastructure with the ability to collect and analyze epidemiological data on substance use and its associated consequences and use this data to identify areas of greatest need. Good data also enable states to identify, implement, and evaluate evidence-based programs, practices, and policies that have the ability to reduce substance use and improve health and well-being in communities. In particular, SAMHSA strongly encourages states to use data collected and analyzed by their SEOWs to help make data- driven funding decisions. Consistent with states using data to guide their funding decisions, SAMHSA encourages states to look closely at the data on opioid/prescription drug abuse, as well as underage use of legal substances, such as alcohol, and marijuana in those states where its use has been legalized. SAMHSA also encourages states to use data-driven approaches to allocate funding to communities with fewer resources and the greatest behavioral health needs.

SAMHSA expects that state substance abuse agencies have the ability to implement the five steps of the strategic prevention framework (SPF) or an equivalent planning model that encompasses these steps:

1. Assess prevention needs;
2. Build capacity to address prevention needs;
3. Plan to implement evidence-based strategies that address the risk and protective factors associated with the identified needs;
4. Implement appropriate strategies across the spheres of influence (individual, family, school, community, environment) that reduce substance abuse and its associated consequences; and
5. Evaluate progress towards goals.

States also need to be prepared to report on the outcomes of their efforts on substance abuse- related attitudes and behaviors. This means that state-funded prevention providers will need to be able to collect data and report this information to the state. With limited resources, states should also look for opportunities to leverage different streams of funding to create a coordinated data driven substance abuse prevention system. SAMHSA expects that states coordinate the use of all substance abuse prevention funding in the state, including the primary prevention set-aside of the SABG, discretionary SAMHSA grants such as the Partnerships for Success (PFS) grant, and other federal, state, and local prevention dollars, toward common outcomes to strive to create an impact in their state's use, misuse or addiction metrics.

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

1. Please indicate if the state has an active SEOW. If so, please describe:
    - The types of data collected by the SEOW (i.e. incidence of substance use, consequences of substance use, and intervening variables, including risk and protective factors);
    - The populations for which data is collected (i.e., children, youth, young adults, adults, older adults, minorities, rural communities); and
    - The data sources used (i.e. archival indicators, NSDUH, Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System, Monitoring the Future, Communities that Care, state-developed survey).
2. Please describe how needs assessment data is used to make decisions about the allocation of SABG primary prevention funds.
3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?
4. Please describe if the state has:
    a. A statewide licensing or certification program for the substance abuse prevention workforce;
    b. A formal mechanism to provide training and technical assistance to the substance abuse prevention workforce; and
    c. A formal mechanism to assess community readiness to implement prevention strategies.
5. How does the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?
6. Does the state have a strategic plan that addresses substance abuse prevention that was developed within the last five years? If so, please describe this plan and indicate whether it is used to guide decisions about the use of the primary prevention set-aside of the SABG.
7. Please indicate if the state has an active evidence-based workgroup that makes decisions about appropriate strategies in using SABG primary prevention funds and describe how the SABG funded prevention activities are coordinated with other state, local or federally funded prevention activities to create a single, statewide coordinated substance abuse prevention strategy.
8. Please list the specific primary prevention programs, practices and strategies the state intends to fund with SABG primary prevention dollars in each of the six prevention strategies. Please also describe why these specific programs, practices and strategies were selected.
9. What methods were used to ensure that SABG dollars are used to fund primary substance abuse prevention services not funded through other means?
10. What process data (i.e. numbers served, participant satisfaction, attendance) does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?
11. What outcome data (i.e., 30-day use, heavy use, binge use, perception of harm, disapproval of use, consequences of use) does the state intend to collect on its funded prevention strategies and how will this data be used to evaluate the state's prevention system?

Please indicate areas of technical assistance needed related to this section.

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

Footnotes:

Please revise the District's response to Narrative 9 (Primary Prevention for Substance Abuse) (1) to indicate whether the District has an active evidence-based workgroup that makes decisions about appropriate strategies in using SABG primary prevention funds and (2) to confirm the District's understanding that inclusion in the National Registry of Evidence-based Programs and Practices (NREPP) does not in itself

constitute status as an evidence-based program.

Response:
The DC EOW, co-chaired by Research Triangle International, acts as an evidence-based work group designed to utilize risk and protective factor data, incidence and prevalence data to inform prevention on estimating service needs, what prevention resources to target, selecting the most appropriate preventive interventions and best practices, and evaluating the effects of the prevention system.

Thank you for your response to the earlier revision request on Narrative 9 regarding specific programs, practices, and strategies funded by the SABG primary prevention set-aside. Additional information is needed with respect to education strategies. The District's description of education strategies appears to be largely focused on training and technical assistance for DBH, DC Prevention Center, and sub-recipient staff as opposed to other members of the public such as youth, parents, and the general public. As noted in the application instructions, education is described as follows: "Education builds skills through structured learning processes. Critical life and social skills include decision making, peer resistance, coping with stress, problem solving, interpersonal communication, and systematic and judgmental capabilities." Please revise the District's response to include a description of any additional education strategies the District intends to fund with the SABG primary prevention set-aside. Please note that it appears that certain of these activities might be described by the District as "community education" under community-based process strategies.

RESPONSE:

• DBH staff will continue to educate the community on ATOD specific information from non-SABG funded public education campaign materials as the primary tools.
• DBH staff will work closely with DC Prevention Center staff to support community education through District and National Campaigns.

In Narrative 9, the District describes a number of Synar related activities as environmental strategies. However, Table 5a indicates that SABG funds will not be used in connection with the Synar program. Please revise the District's response to specify which activities will be funded by the SABG primary prevention set-aside.

RESPONSE:
DBH will revise tables 5a, and 5b. to accurately reflect the projected expenditure under 1926 Tobacco and not environmental. In addition the Synar activities cited within the narrative under environmental should be re-categorized as such.

Please revise the District's response to Narrative 9 to describe specific problem identification and referral programs, practices, and strategies the District intends to fund with the SABG primary prevention set-aside. Please note that the application instructions state that "problem identification and referral aims to identify individuals who have indulged in illegal or age-inappropriate use of tobacco, alcohol or other substances legal for adults, and individuals who have indulged in the first use of illicit drugs. The goal is to assess if their behavior can be reversed through education. This strategy does not include any activity designed to determine if a person is in need of treatment."

RESPONSE:
DBH will make the necessary modifications to the SABG funded DC Prevention Centers scope of work in 2016 and 2017 to support the Partnership for Success as a mechanism to establish a DBH workgroup on youth behavior health issues across prevention treatment and recovery. The focus is on high need communities and populations with identified disparities.
In addition, the DC Prevention Centers will support the development/implementation of an individual Risk Reduction strategy/curricula that uses the five step SPF process to identify indicated and selective adolescent populations and assess if there are best practices/resources available to change their current behavior.

Through Strategic Prevention Framework Partnership for Success (PFS) funds, the DCEOW is being broadened to include new District agency partners. DBH is also working with the DC EOW sub-recipient to build internal prevention capacity and achieve the following DCEOW goals:

- Continue to update District and Ward alcohol, tobacco, and other drug databases that include consumption patterns, consequences, risk and protective factors, and demographics.
- 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.
- Utilize risk and protective factor data, incidence and prevalence data to estimate service needs, target prevention resources, select and/or or development appropriate preventive interventions and evaluate the effects of the prevention system.
- Develop District and Ward reports for policy and program planners and community stakeholders.

DC EOW consumption, consequences, and risk and protective factor data is gleaned from:

- District's Youth Risk Behavior Survey (YRBS) administered every two years to both public and Charter schools
- District's Behavioral Risk Factor Surveillance System
- SAMHSA survey and special sub-state reports
- DBH youth and adult treatment data system (i.e., age of first use; young adults; adults and older adults; number of children living at home that may be at higher risk; and primary drug)
- Archival and social indicator from District agency partners
- Demographic data from the District Office of Planning
- Community Changes in policies, programs, and prevention practices resulting from DC Prevention Center Community Prevention Network SPF strategic plans
- Implementation of a readiness survey to be piloted through SPF-Partnership for Success and then taken to scale through SABG funded services
- Implementation of a revised customer satisfaction survey

Community Conversations serve as an additional and timely data source on local conditions (e.g., neighborhoods, populations, disparities, and emerging drug issues). In 2015, DBH revised the Community Conversations protocol and expanded the work into a guidance document, templates for data collections, and key findings. This information is entered into the online DIRS as part of the monthly DC Prevention Center program report process.

In addition to these standard data sets, DBH planned a 2015 pilot random sample telephone survey through Braun Inc. (Princeton, New Jersey) to gather Ward level data not available through YRBS or NSHU. Based on the results, DBH may seek additional funding to administer this survey in alternate YRBS years.

Representative DC EOW demographic findings such as the following are used for District and Ward prevention planning:

- The overall population of the District has grown to more than 601,423 residents, a rapid growth of more than 5.2% since the 2000 U.S. Census.
- Of the total residents, approximately 51% are Black, 38% White, and 9% Hispanic.
- Each Ward has a relatively similar population size (70,000-80,000); however, the demographic make-up differs greatly among the Wards.
- The number of youth under age 18 has decreased across the District whereas the number of young adults 18 to 25 ha increased substantially.
- The Washington Metropolitan Area is a primary recipient of new immigrants, ranking fifth among the top immigrant-receiving communities. Since 2000, the region has received 3.5% of all new immigrants into U.S. communities.
- About 20% of residents in the Washington Metropolitan Area are foreign-born, compared with 12% nationwide. The residents include: Hispanic/Latino (3.95); Asian (36%) with the next largest group coming from India, Korea, China, Mexico, and Vietnam. While African immigrants make up about 4% of the foreign-born population in the U.S., they make up three and a half times that proportion (14%) in the Washington Metropolitan Area.

The top 10 DC EOW findings from 2006-2013 also focus population based prevention planning at District and Ward levels:

- Underage youth (age 12 to 20) past-month binge drinking decreased from 23%

to 18%.
- Perception of great risk from binge drinking among District youth (age 12 to 17) remained stable for the first five years then increased significantly from 43% between 2011 and 2012 to 48% between 2012 and 2013.
- Consistently over the past six years, fewer youth in Ward 3 perceived a great risk from binge drinking compared to District youth overall.
- A lower percentage of District public high school students reported first trying alcohol before age 13 in 2012 (22%) than in 2007 (25%). A lower percentage of District public high school students reported that they had ever had a drink of alcohol 2012 (58%) than in 2007 (67%). Additionally, a lower percentage of students reported drinking alcohol in the past month in 2012 (31%) than in 2007 (34%). These trends mirror trends among U.S. high school students overall.
- Among District young adults (age 18 to 25), the percentages using alcohol, binge drinking, or perceiving a great risk of binge drinking did not change significantly.
- A higher percentage District public high school students reported first trying marijuana before age 13 in 2012 (18%) than in 2007 (11%). This percentage increased at a faster rate in the District than among U.S. high school students overall (from 8% in 2007 to 9% in 2012).
- A higher percentage of District high school students reported using marijuana in the past month in 2012 (32%) than in 2007 (21%). Only 23% of their U.S. counterparts reported using marijuana in the past month in 2012.
- The percentage of District youth (age 12 to 17) reporting great perceived risk from monthly marijuana use decreased (from 27% to 22%).
- The percentage of District young adults (age 18 to 25) reporting great perceived risk from monthly marijuana use decreased (from 17% to 12%); however there was no significant change in reported past-month marijuana use among young adults.
- The percentage of District youth that disapprove of someone their age using marijuana at least once a month has declined since 2006-2007 (from 79% to 72% in 2012-2013).

Sample copies of 2015 DC EOW Highlights and the 8 DC EOW Ward Reports are in Attachment C.

The needs assessment data is used for SABG District and Ward Strategic Prevention Framework planning purposes. The four DC Prevention Centers receive annual DC EOW data reports on priority needs within their two Wards along with District data and findings across all 8 Wards. In addition, the data drives information for DBH strategic planning documents and quarterly reports submitted to the Executive Office of the Mayor. DBH prevention has continued to develop the prevention system and build the capacity of its prevention workforce. As noted in Step One of this application, DBH has supported ongoing Strategic Prevention Framework capacity building trainings, technical assistance and coaching opportunities. In 2015, DBH supported trainings for DBH prevention staff, and DC Prevention Center staff in all required ICRC credentialing trainings. The national exam will be provided onsite in October 2015 and participants will have an additional testing opportunity if they do not pass the first exam. This support is expected to result in a minimum of 25 DBH certified prevention specialists. DBH prevention is currently developing a work plan to continue the IC&RC core trainings and testing to other target District and community partners in FY 2015-2016.

In preparation for integrating prevention into Medicaid in 2016-2017, DBH is working on a seven step process to prepare the workforce:

1. Identify/design and price an array of universal, selective and indicated preventive interventions that address the identified needs of an urban area and culturally diverse populations;
2. Expand and build the capacity of qualified prevention provider networks;
3. Develop continuous quality improvement and performance-based outcomes and review systems;
4. Design the mechanism to process prevention claims and pay providers;
5. Determine effective dosages of prevention for whole populations;
6. Retool the prevention field by finding more efficient and cost effective ways to deliver prevention, improve access to services, and fully integrated the behavioral health research into practice; and
7. Support the ongoing development of prevention program standards and provider

certification.
DBH prevention has one Full-time employee that is the point person for coordination of capacity building services. This includes training, technical assistance, social marketing development, website and social media services. Two new locally funded community coordinators FTE's were in the FY 2015 Mayor's Budget; however, due to FY 2016 funding constraints, the positions will not be hired until FY 2017.
Through the SAMHSA Strategic Prevention Enhancement (SPE) discretionary grant, DBH completed four mini-plans and a Five Year Strategic Prevention Plan in August 2012. The plan has been used to guide the overall prevention direction but needs to be updated in FY 2016. The extensive DBH SUDS leadership changes and merger into the Department of Behavioral Health has been a challenge in fully developing a new prevention plan. That being said, the SSA prevention infrastructure and general direction has been consistent since 2010.
The SABG Prevention Set-Aside funds in FY 2016-2017 will address priorities designed to strengthen and sustain the infrastructure and community prevention system:

- Funds for four DC Prevention Center sub-grantees that serve two wards each (Wards 1 and 2; Wards 3 and 4; Wards 5 and 6; Wards 7 and 8). Their grant scope of work involves three primary functions (community education. community leadership; and community changes) and approximately 20 flexible strategies in order to address whole population prevention. The three functions and flexible strategies align with the SABG six core strategies: information dissemination, education, community-based processes, alternatives, environmental, problem identification and referral.
- DC Prevention Centers will continue to submit monthly program progress report information through the online DIRS system. DIRS was enhanced in 2015 to capture the same process data required in the SABG prevention set-aside data tables, demographic information, people served, strategies implemented).
- DBH will continue to fund prevention FTE's (six full-time DBH Full-Time Employees that includes a program manager that oversees program grants and contract management functions, certification and program standard operations and three FTE's); one Public Health Analyst that administers the Synar Program; and one Public Health Advisor that coordinates Strategic Prevention Framework capacity building and community partnership development services.
- A sub-grant to recruit, train, and manage youth for Synar compliance checks.

- Integrate PFS funds for DC EOW efforts and system evaluation to determine measurable progress on three levels: 1) Changes in priority risk and protective factors (e.g., age of initiation, perceptions of risk, peer disapproval, community laws and norms); 2) Community changes (policies, programs and practices); 3) Distal/behavioral health outcomes (frequency of use including 30 day and lifetime).

- Collaboration with DBH financial services to develop and track sub-grantee spending plans. There are different District funding codes for tracking prevention expenditures (local, SABG Prevention Set-Aside, federal discretionary funds). DIRS also has separate program reporting modules for SABG prevention-aside funds and federal discretionary grants.

The Substance Abuse Prevention and Treatment Block Grant (SABG) Prevention Set-Aside funds will continue to support:

- Four DC Prevention Centers that serve two Wards each, focus on data-driven community-based processes, address the six core strategies and the spectrum of preventive populations (universal, selective, indicated).

- Six District agency full-time prevention employees that provide SABG funded system -wide planning, program grants management and accountability, data and evaluation, workforce development and capacity building services. This work provides needed infrastructure and context for building capacity of the community prevention system.

DC Epidemiological Outcomes Workgroup (DCEOW) goals will be sustained through local and Strategic Prevention Framework Partnership for Success funds:

- Continue updating District and Ward alcohol, tobacco and other drug data that that includes consumption, consequences, risk and protective factors, demographics and health disparities.

- 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.

- 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.

- 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 insure that prevention efforts reach those young people exposed to many risk factors during their development.

The DC EOW will be expanded in FY 2016 beyond current representatives:

- Department of Health
- Department of Behavioral Health
- Child and Family Services Agency
- DC Metropolitan Police Department
- Criminal Justice Coordinating Council
- Alcohol Beverage Regulatory Agency
- Department of Consumer and Regulatory Affairs
- Children’s National Health System
- DC Pretrial Services Agency
- Department of Transportation
- DC Hospital Association
- The Children’s Trust
- Legacy Foundation
- DBH DC Prevention Center representative

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 DC Youth Risk Behavior Survey, NSDUH, Behavioral Risk Factor Surveillance System and archival indicators. A new DC Ward level telephone survey will be piloted to address Ward gaps in youth and adult data, especially risk and protective factors.

The District also supports a comprehensive approach to prevention and will continue to use SABG funds to target the general public and sub-groups that are at high risk for substance use disorders. DC EOW data underscores the need to prevent new users and to reduce risk in all areas of a young person’s life at early ages of development. More intensive and costly preventive interventions are needed for older youth and young adults as documented by behavioral health assessment and treatment data. DBH plans to maximize SABG prevention set-aside funds over the next two years by leveraging Medicaid dollars for selective and indicated populations.

This requires drafting prevention standards and practice guidelines for new Chapter 63 regulations. It will also require DBH to:

1. Expand and build the capacity of qualified behavioral health prevention provider networks;
2. Strengthen continuous quality improvement and performance-based outcomes and review systems;
3. Identify the online mechanism to process prevention claims and pay providers;
4. Identify, design and price selective and indicated preventive interventions that address the identified needs of an urban areas with culturally diverse populations;
5. Find more efficient and cost effective ways to deliver prevention services, provide access to services and fully integrate prevention research into practice;
6. Continue to support ICRC Certification as part of the Chapter 63 Standards.

In Fiscal Year 2016 and 2017, SABG Prevention Set-Aside funds will be directed toward the following primary prevention and six core strategies that include the spectrum of populations: universal, selective and indicated.

1. Information Dissemination

The Strategic Prevention Framework State Incentive Grant (SPF SIG) supported 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). The Synthetic Marijuana website will be expanded to synthetic drugs and sustained through local funding. SABG Prevention Set-Aside resources will expand DBH Prevention Website operations beginning in FY 2016.

The DBH Prevention Public Health Analyst will serve as lead for information dissemination. The goal is to disseminate targeted prevention messages and resources to DC youth and adults via the four DC Prevention Centers, 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); 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 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) on a regular basis 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;
- Repost follower and non-follower related prevention messages as appropriate.

Through non-SABG funds, DBH will expand the Synthetic Marijuana/Drug campaign for youth and young adults in FY 2016. Local funds are supporting a new Preventing Underage Marijuana Use Campaign to be launched in December 2015. That initiative is being planned and coordinated with the Director of the Department of Health, a co-chair for the Mayor’s Initiative 71 Task Force. The public education campaign is a component of the broader comprehensive Initiative 71 work plan. DBH prevention staff and DCPC will continue to disseminate “There’s A Reason” Campaign resources this fiscal year. That campaign was adapted from the SAMHSA “Talk.They Hear You” Public Education Campaign and documenting measurable results.

Digital engagement, campaigns, and DBH prevention branding will be updated on a quarterly basis. Content is based on formative evaluation designed to reach target audiences and segments for targeting. These social marketing campaigns include community engagement components supported by the four DC Prevention Centers.

DBH will continue to brand prevention as an integral component in achieving the agency mission. In 2015, new resources were developed are being disseminated in FY 2016. The resources include: a DCPC Ward and DBH graphic design with the Mayor's logo; DCPC signage, banners, table top exhibits, letterhead and business cards, newsletter templates, flyer templates, and stock photos for use in flyers . Information dissemination data is collected, analyzed and reported through the online Program Grant monitoring and evaluation system, Data Infrastructure Resource System (DIRS). The DBH prevention staff DIRS report module and the DCPC block grant program module include data requirements in the SABG strategic plan and annual report. Non-SABG funds will support the evaluation of digital media strategies through a web metric tool.

2. Education

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 trainings 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 ICRC Prevention Specialist trainings and testing for certification.
- Trainings and technical assistance tailored to effective prevention approaches in working with selective and indicated populations.
- Trainings 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 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) other DBH substance use prevention sub-recipients; 4) 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:

- Continue core trainings and certification testing that will target more than 50 new certified prevention associates or prevention specialists by September 30, 2017;

- Plan with the DBH Training Institute to offer and sustain core prevention certification trainings trainings online or onsite;

- 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 DCPC will continue to support educational events that are based on identified substance use prevention need; in high need communities with low capacity; and with populations that have documented disparities.

3. Community-Based Process

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 to 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 FY 2016 scope of work includes the following requirements:

Administrative Leadership:

- Ensure staffing patterns that include one full-time Project Director/Coordinator and two Community Mobilizer FTE's that share responsibilities for the three core functions.
- Attend DBH required roundtables, technical assistance and trainings.
- 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 with 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 in order 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 develop 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 implementation of the SPF logic model and action plan
- Document community changes by tracking changes in policies, programs, and practices related to 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; 3) distal or behavioral outcomes.

DCPC grants are competitive every three years and a FY 2017 Request for Application will be posted in spring 2016. DBH will modify the existing scope of work based on DCEOW data and evaluation findings.

Within the community-based process strategy, DCPC 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 better ensure SABG dollars are used to fund primary substance abuse prevention services not funded

through other means.

4. Alternatives

Alternative strategies will continue to be supported at the District level through DBH prevention staff and through DCPC 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. While the emphasis is on earning money and learning skills to succeed in the work world, the program provides an array of opportunities to involve youth in healthy, alternative activities that exclude alcohol and other drugs. Illustrative of that, DBH prevention staff and DCPC staff were recruited by the Executive Office of the Mayor to provide information and hold Community Conversations on synthetic drugs and underage drinking with SYEP youth across the 8 Wards. They sponsored or supported youth health fairs, drug-free l events and activities that involved the prevention Mobilzer. DCPC collaborates with community-based organizations and agencies on alternative activities as part of their community education and community prevention network action plans.

This fiscal year, DBH prevention will be more intentional in planning and supporting alternative activities for the SYEP Program during summer months and with District agency partners and DCPC 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 potential for evaluation.

5. Environmental

DBH prevention will continue to focus on the Synar requirements as a priority prevention strategy. In FY 2016 this includes:

- Improving the 4.3% non-compliance rate achieved in 2015.
- Posting, reviewing and awarding a $60,000 competitive grant award to recruit, train, and manage qualified youth for Synar compliance checks.
- Working with the DCPC and their community prevention networks to distribute new Synar Merchant Education materials to more than 950 licensed tobacco vendors. Materials include two-pocket folders with the updated DC underage sales to youth law, store front signs with the DC law, palm cards, and counter mats with the law. Materials were developed in three different languages, a response to stakeholder recommendations.
- Collaborating with the District’s regulatory agency on tobacco licensee related issues. This involves receipt of periodic updates on the tobacco licensee list in order to improve accuracy of the list.
- Continuing a partnership with the Legacy Foundation on Synar and tobacco-related studies.

DBH prevention staff and DCPC will disseminate underage drinking social marketing materials in FY 2016 to increase understanding of District laws pertaining to youth. The preventing underage marijuana use social marketing campaign will also focus on the laws pertaining to passage of Initiative 71 and the behavioral health risks associated with underage use. The Prevention Chief and the Prevention Public Health Analyst will continue to serve on the Initiative 71 Public Education Campaign workgroup that includes the DBH Director, Department of Health Director, DBH Chief of Staff, and the Substance Use Disorders Interim Deputy Director.

The underage marijuana use campaign creative plan will be reviewed and approved and a Mayor’s launch is scheduled for early FY 2016. DCPC and their community prevention networks will be actively involved in both campaigns this fiscal year to increase awareness of the behavioral health risks and need for compliance with the laws.

DBH prevention staff will continue to serve on District task forces such as the

Criminal Justice Coordinating Council Synthetic Drug Workgroup to identify policy and program environmental changes needed to address synthetic drug issues. The DBH Prevention Chief will continue to participate on the Heroin Task Force chaired by the Director of the Department of Health and attended by the DBH Director and other executive leadership.

The DCEOW and SAMHSA Barometer data documents the need to continue our focus on underage drinking, underage marijuana use, and synthetic drugs.

6. 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 being assessed and treated through the four youth substance use disorders treatment programs while behavioral health needs of transitional age youth continue to increase.

The FY 2016 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.

The DBH Office of Policies and Programs has scheduled a Senior Leadership Retreat for November 2015 to plan around integration of prevention, treatment and recovery for behavioral health. The retreat will allow prevention to identify a more strategic role in planning and leveraging resources for universal, selective and indicated populations.

Other FY 2016 plans included:

- A public education campaign through treatment funds to increase consumer awareness of DBH system services;
- Broader awareness of the 24 hour DBH Access Help Line that provides immediate information and assistance for prevention, treatment and recovery behavioral health services;
- Inclusion of prevention standards in Chapter 63, a first step in accessing Medicaid funds for selective and indicated populations;
- Using Partnership for Success as a mechanism to establish a DBH workgroup on youth behavior health issues across prevention treatment and recovery. The focus is on high need communities and populations with identified disparities.
- Revising and developing a Risk Reduction strategy/curricula that uses the five step SPF process for indicated and selective adolescent populations.

SABG Question 9 Revised-3.3.16

The Substance Abuse Prevention and Treatment Block Grant (SABG) Prevention Set-Aside funds will continue to support:

- Four DC Prevention Centers that serve two Wards each, focus on data-driven community-based processes, address the six core strategies and the spectrum of preventive populations (universal, selective, indicated).

- Six District agency full-time prevention employees that provide SABG funded system - wide planning, program grants management and accountability, data and evaluation, workforce development and capacity building services. This work provides needed infrastructure and context for building capacity of the community prevention system.

DC Epidemiological Outcomes Workgroup (DCEOW) goals will be sustained through local and Strategic Prevention Framework Partnership for Success funds:

- Continue updating District and Ward alcohol, tobacco and other drug data that that includes consumption, consequences, risk and protective factors, demographics and health disparities.

- 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.

- 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.

- 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 insure that prevention efforts reach those young people exposed to many risk factors during their development.

The DC EOW will be expanded in FY 2016 beyond current representatives:

- Department of Health
- Department of Behavioral Health
- Child and Family Services Agency
- DC Metropolitan Police Department
- Criminal Justice Coordinating Council
- Alcohol Beverage Regulatory Agency
- Department of Consumer and Regulatory Affairs
- Children's National Health System
- DC Pretrial Services Agency
- Department of Transportation
- DC Hospital Association
- The Children's Trust
- Legacy Foundation
- DBH DC Prevention Center representative

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 DC Youth Risk Behavior Survey, NSDUH, Behavioral Risk Factor Surveillance System and archival indicators. A new DC Ward level telephone survey will be piloted to address Ward gaps in youth and adult data, especially risk and protective factors.

The District also supports a comprehensive approach to prevention and will continue to use SABG funds to target the general public and sub-groups that are at high risk for substance use disorders. DC EOW data underscores the need to prevent new users and to reduce risk in all areas of a young person's life at early ages of development. More intensive and costly preventive interventions are needed for older youth and young adults as documented by behavioral health assessment and treatment data. DBH plans to maximize SABG prevention set-aside funds over the next two years by leveraging Medicaid dollars for selective and indicated populations. This requires drafting prevention standards and practice guidelines for new Chapter 63 regulations. It will also require DBH to:

1. Expand and build the capacity of qualified behavioral health prevention provider networks;
2. Strengthen continuous quality improvement and performance-based outcomes and review systems;
3. Identify the online mechanism to process prevention claims and pay providers;
4. Identify, design and price selective and indicated preventive interventions that address the identified needs of an urban areas with culturally diverse populations;

5. Find more efficient and cost effective ways to deliver prevention services, provide access to services and fully integrate prevention research into practice; and
6. Continue to support ICRC Certification as part of the Chapter 63 Standards.

In Fiscal Year 2016 and 2017, SABG Prevention Set-Aside funds will be directed toward the following primary prevention and six core strategies that include the spectrum of populations: universal, selective and indicated.

1. Information Dissemination

The Strategic Prevention Framework State Incentive Grant (SPF SIG) supported 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). The Synthetic Marijuana website will be expanded to synthetic drugs and sustained through local funding. SABG Prevention Set-Aside resources will expand DBH Prevention Website operations beginning in FY 2016.

The DBH Prevention Public Health Analyst will serve as lead for information dissemination. The goal is to disseminate targeted prevention messages and resources to DC youth and adults via the four DC Prevention Centers, 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); 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 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) on a regular basis 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;
- Repost follower and non-follower related prevention messages as appropriate.

Through non-SABG funds, DBH will expand the Synthetic Marijuana/Drug campaign for youth and young adults in FY 2016. Local funds are supporting a new Preventing Underage Marijuana Use Campaign to be launched in December 2015. That initiative is being planned and coordinated with the Director of the Department of Health, a co-chair for the Mayor's Initiative 71 Task Force. The public education campaign is a component of the broader comprehensive Initiative 71 work plan. DBH prevention staff and DCPC will continue to disseminate "There's A Reason" Campaign resources this fiscal year. That campaign was adapted from the SAMHSA "Talk. They Hear You" Public Education Campaign and documenting measurable results.

Digital engagement, campaigns, and DBH prevention branding will be updated on a quarterly basis. Content is based on formative evaluation designed to reach target audiences and segments for targeting. These social marketing campaigns include community engagement components supported by the four DC Prevention Centers.

DBH will continue to brand prevention as an integral component in achieving the agency mission. In 2015, new resources were developed are being disseminated in FY 2016. The resources include: a DCPC Ward and DBH graphic design with the Mayor's logo; DCPC signage, banners, table top exhibits, letterhead and business cards, newsletter templates, flyer templates, and stock photos for use in flyers .

Information dissemination data is collected, analyzed and reported through the online Program Grant monitoring and evaluation system, Data Infrastructure Resource System (DIRS). The DBH prevention staff DIRS report module and the DCPC block grant program module include data requirements in the SABG strategic plan and annual report. Non-SABG funds will support the evaluation of digital media strategies through a web metric tool.

2. 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 trainings 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 ICRC Prevention Specialist trainings and testing for certification.
- Trainings and technical assistance tailored to effective prevention approaches in working with selective and indicated populations.
- Trainings 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 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) other DBH substance use prevention sub-recipients; 4) 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:

- Continue core trainings and certification testing that will target more than 50 new certified prevention associates or prevention specialists by September 30, 2017;
- Plan with the DBH Training Institute to offer and sustain core prevention certification trainings online or onsite; 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 DCPC will continue to support educational events that are based on identified substance use prevention need; in high need communities with low capacity; and with populations that have documented disparities.

3. Community-Based Process

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 to 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 FY 2016 scope of work includes the following requirements:

Administrative Leadership:

- Ensure staffing patterns that include one full-time Project Director/Coordinator and two Community Mobilizer FTE's that share responsibilities for the three core functions.
- Attend DBH required roundtables, technical assistance and trainings.
- 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 with 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 in order 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 develop 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 implementation of the SPF logic model and action plan
- Document community changes by tracking changes in policies, programs, and practices related to 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; 3) distal or behavioral outcomes.

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6. Synar (1926 Tobacco)

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7. 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 being assessed and treated through the four youth substance use disorders treatment programs while behavioral health needs of transitional age youth continue to increase.

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- Broader awareness of the 24 hour DBH Access Help Line that provides immediate information and assistance for prevention, treatment and recovery behavioral health services;
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- Revising and developing a Risk Reduction strategy/curricula that uses the five step SPF process for indicated and selective adolescent populations.

Environmental Factors and Plan

10. Quality Improvement Plan

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.

In an attachment to this application, states should submit a CQI plan for FY 2016-FY 2017.

Please indicate areas of technical assistance needed related to this section.

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

Footnotes:

Quality Improvement Plan
CQI Plan for FY 2016/2017

In addition to becoming a data driven agency, DBH 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. The Department has instituted a number of internal and external workgroups that informs the CQI process and helps to promote a Total Quality Management (TQM) environment. Adopting the TQM philosophy will establish a new culture for behavioral health that will promote growth and longevity, build partnerships and meaningful collaborations with community agencies. This will also allow the agency to thrive in the 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.

There are at eight major principles of the TQM. They include: customer focused mission; strong leadership; recruitment of stakeholders as change agents; system wide process approach; promoting efficient and effective systems; data driven decisions; continual improvement; and, fostering mutually beneficial relationships. Since 2013, the Department has been developing a foundation of CQI/TQM that will continue in 2016/17. Our focus is to become a customer focused agency that creates a team of change agents that will be instrumental in accomplishing our goals to improve the system of care for our clients.

Our customers consist of: clients who are seeking treatment or recovery services; providers that look toward the SSA for oversight, guidance and support; community partners that also serve our clients; and, internal staff. In effort to learn more about these stakeholders and become more customer focused, the Department has begun to address the needs of our customers by instituting a process for client satisfaction surveys, provider meetings that illicit structured feedback and creating meaningful partnerships with community agencies. The Department has also created a Clinical Director's Practice Guideline work group that facilitates the improvement of clinical practice by fostering peer leadership and encouraging the clinical directors to become change agents within their agency. In 2016/17, the focus of the Department has also created a Clinical Director's Practice Guideline work group is be to assist them in incorporating CQI tools into their clinical process and help them to create a culture of quality improvement with their staff. The Department has developed an internal provider review roundtable to create efficient and effective systems that will move us towards achieving our goals. This is done through a review of all departments' data on provider performance. DBH has also instituted monthly staff meetings that focus on creating teams that are energized and feel like they are actively contributing towards achieving goals. Responsibilities related to the CQI/TQM process will be included in employee performance plans are created to make sure that every person in the agency is working towards achieving the goals for their department that also feed into the overall goal for the agency.

In effort to engage our external stakeholders the Department has created a CQI Council comprised of internal and external staff to identify problems and use CQI tools (e.g., flowcharting, statistical process control, Pareto analysis, cause and effect diagrams, etc.) to improve service delivery. Additionally, DBH has created a Recovery Advisory Council (RAC) comprised of stakeholders and consumers that advise on long term planning, create a community voice for recovery and participate in creating a recovery oriented system of care in the District of Columbia. Also, Department has engaged other government partners in the CQI process to improve access and services for the clients we share.

A component of the CQI process is the development of a comprehensive plan to monitor the delivery of all services that 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. There are certain data sources the Department has consistently utilized for planning purposes such as the Treatment Episode Data Set (TEDS) and National Outcome Measures (NOMS). As Recovery Support Services are fully integrated into the network's continuum in the District, similar measures will be refined accordingly to reflect the new landscape. More recently, the Department has developed core metrics to evaluate performance and outcomes achievement. These measures have been informed by; the Department's strategic objectives, programmatic priorities and available staff and IT resources. The measures are as follows:

Treatment :
1) Discharge Type Distribution: The distribution of, specifically, successful completions, dropouts, treatment terminations and referrals to other services.
2) Length of stay: The number of days between the admission date and the last date of service. This information is consolidated into clusters unique to the facility's level of care. Facility-level aggregates are collected as well as level of care aggregates (all residential, all detox, etc.)
3) Continuum of Care Usage: The number of clients successfully completing each residential provider who are connected to outpatient follow-up services as well as the number referred to Recovery Support Services. This metric is presented as a 2 X 2 matrix with the quadrants representing treatment only, recovery support only, both services, neither service. This measure is aggregated at the facility level as well as a combined measure for all residential facilities.
4) Service Type Distribution: The number of billed sessions of every service type within a given time frame (group counseling, individual counseling, family counseling, case management, assessment, and treatment plan development and/or modification). Due to the current billing format, this metric can only be applied to outpatient programs.
5) Encounter Note Turnaround Time: The number of days that pass between the date of the service and the date the note is created. This metric has been developed to give providers feedback on their adherence to the Medicaid requirement of documenting service within 48 hours. These data are presented visually in a column chart with each column corresponding to a specific range of turnaround time. Presented in this manner, the program can learn not only the degree to which it is in compliance of the future rule, but also how close it is to compliance with the rule.
Recovery:
1) What percentage of clients have had new arrests since the onset of services?
2) What percentage of clients are in independent living at discharge?
3) What percentage of clients are employed at discharge?
4) What percentage of clients are attending self-help (e.g. 12-step meetings) in the community at discharge?
Finance:
1) Does the program have a documented 90-day cash reserve?
2) What is the current asset-to-liabilities ratio? Target for this indicator is 1:1.
3) Does the program have a current Clean Hands Status? This status indicates the program is in compliance with all tax obligations.
4) Is the Triennial audit current? The Management Letter Comments and provider responses must be included in the documentation for this requirement to be satisfied.
These are APRA's current metrics for evaluating critical outcomes and measuring the effectiveness of services. APRA will monitor these core metrics for every provider regularly over the course of five years. This plan will be revised after one year and the secondary set of metrics will be revisited to match our new improvement initiatives. At that point, metrics may be added if there is a gap in the information necessary to monitor outcomes effectively or if changes in the strategic plan of the agency necessitate new measurements of performance. An existing metric may be eliminated or replaced if that action is justified by revisions to the agency strategic plan and/or improvements in collection methodology. The data that emerges from these metrics, trended over time, will give APRA/DBH the information it needs to determine the programmatic improvements occurring within the system. The Department will take this information into account when developing: priorities for training; technical assistance; staffing; enhancements to the EHR; and, procurements of new software for monitoring purposes. Additionally, these metrics will inform the process of developing the Key Performance Indicators (KPIs) for DBH. The KPIs are a set of agency-wide measurements submitted to the City Council and the Office of the Mayor to provide ongoing feedback to the public on the performance of District Government agencies.
The Department will conduct Customer Service Surveys in the Assessment and Referral Center and at contracted treatment providers to evaluate the client perspective on services rendered within the public substance abuse system. This information will inform decisions and priorities in training, technical assistance and further exploration through monitoring. The ARC will re-examine the survey content annually and make necessary revisions. This process will: remove any items that are no longer relevant; revise items that require refined wording or clarity; add items that

reflect emergent focus areas in customer service; and, take into account client feedback. The data from previous rounds of surveying, and feedback from personnel conducting the survey, will be taken into account when revising the survey items. Complaints are documented and submitted on Unusual Incident/Grievance Report Form. The Office of Accountability reviews the information and a Notice of Investigation is sent to the provider or administration. The facility or administration will have a 10-day period to respond to the Notice of Investigation. The facility or administration must: confirm or deny each stated allegation; provide a detailed explanation of the circumstances relevant to each allegation; take actions to address any allegation for which there is a factual basis; and, take steps to decrease the likelihood of recurrence (both immediate and long-term). In addition, the response must include the documents identified in the attached Request for Documents. If necessary, the facility or administration may request an extension of up to 10 calendar days in order to complete the investigation. Written findings of the investigation must be submitted to the Department within 24 hours of completing the investigation. As part of the CQI process, the Department has adopted a standard grievance investigation process. Every person that files a grievance receives a receipt that acknowledges that his or her grievance has been entered in a formalized process. The Risk Manager identifies the issues and makes a determination if actions are needed to prevent additional harm before the investigation begins. The investigative team then gathers and analyzes information to develop recommendations. The Department has developed a Continuity of Operations Plan (COOP) plan in collaboration with the Department of Homeland Security and Emergency Management Agency. The COOP is initiated in the case of a critical incident. Emergency planning exercises are conducted regularly as practicing is essential to ensure effective execution of the COOP during actual critical incidents.

Environmental Factors and Plan

11. Trauma

Narrative Question:

Trauma [75] is a widespread, harmful and costly public health problem. It occurs as a result of violence, abuse, neglect, loss, disaster, war and other emotionally harmful 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 behavioral health 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, that is, based on the knowledge and understanding of trauma and its far-reaching implications.

The effects of traumatic events place a heavy burden on individuals, families and communities and create challenges for public institutions and service systems [76]. Although many people who experience a traumatic event will go on with their lives without lasting negative effects, others will have more difficulty and experience traumatic stress reactions. Emerging research has documented the relationships among exposure to traumatic events, impaired neurodevelopmental and immune systems responses, and subsequent health risk behaviors resulting in chronic physical or behavioral health disorders. Research has also indicated that with appropriate supports and intervention, people can overcome traumatic experiences. However, most people go without these services and supports.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. 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 behavioral health 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.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often themselves re-traumatizing, making it necessary to rethink doing “business as usual.” These public institutions and service settings are increasingly adopting a trauma-informed approach guided by key principles of safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues, and incorporation of trauma-specific screening, assessment, treatment, and recovery practices.

To meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed approach consistent with “SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach”. [77] This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be supportive and avoid traumatizing the individuals again. It is suggested that the states uses SAMHSA’s guidance for implementing the trauma-informed approach discussed in the Concept of Trauma [78] paper.

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

1. Does the state have policies directing providers to screen clients for a personal history of trauma and to connect individuals to trauma-focused therapy?
2. Describe the state’s policies that promote the provision of trauma-informed care.
3. How does the state promote the use of evidence-based trauma-specific interventions across the lifespan?
4. Does the state provide trainings to increase capacity of providers to deliver trauma-specific interventions?

Please indicate areas of technical assistance needed related to this section.

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75 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.*

76 http://www.samhsa.gov/trauma-violence/types

77 http://store.samhsa.gov/product/SMA14-4884

78 *Ibid*

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

Footnotes:

Trauma

Does the state have policies directing providers to screen clients for a personal history of trauma and to connect individuals to trauma-focused therapy?

As part of the screening and assessment process with DBH, whether through the agency's Assessment and Referral Center (ARC) or one of its contracted detox service providers, there is a thorough biopsychosocial assessment conducted on each individual entering our system. This process consists of a GAIN SS screen to identify the severity of need for further substance use or mental health challenge assessment. If further assessment is identified, the individual is 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 correlates 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 at one of the two designated detox entry sites into the treatment system. The Department is reviewing its Chapter 63 regulations, the foundation for District substance abuse service provision, to include more explicit policies in support the use of specific EBP's including those to address trauma issues. The Department is also currently reviewing its policies around trauma screening, to incorporate screens for Adverse Childhood Experiences (ACE), to better inform individual treatment plans

Describe the state's policies that promote the provision of trauma-informed care.

All District funded substance use providers are governed by the agency's Title 22A, Chapter 63 Certification Standard, which clearly speaks to the need for providers to coordinate individualized care for the population seeking services, by connecting them to services matched to their identified problem and treatment goals. This policy incorporates the need to match individuals in care with trauma histories, to the appropriate trauma-focused care. This is the only way to ensure that individuals with histories of trauma recognize and acknowledge the role that trauma played in their lives, in order for them to work on changing any negative behaviors associated with the trauma.

How does the state promote the use of evidence-based trauma-specific interventions across the lifespan?

DBH, working with our contracted provider network has identified the initial implementation costs of EBP development as a barrier to greater dissemination of such practices in the District. The Department is prioritizing seeking out a diverse funding stream and community partnerships to assist the providers in overcoming this obstacle. The Department has trained some providers in Integrated Dual Diagnosis Treatment. Our partnership with the Child and Family Services Agency will create opportunities for providers to be trained in Trauma Systems Therapy.

What types of trainings do you provide to increase capacity of providers to deliver trauma-specific interventions?

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. National research has shown that childhood trauma injures a children's brain and impairs physical development and function. The result is that these adverse childhood experiences (ACE) have a negative impact have a conservative estimate of 70 percent of the population. If there's one trauma, there is 95 percent likelihood that there are other types of trauma. ATOD are often the way children and adolescents cope with trauma. When they are adults, the trauma experienced as a child can become legal or social problems including chronic diseases such as diabetes, heart disease, depressing and lung cancer. The Department's Office of Prevention is focusing the DCEOW 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, 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 model 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 greater

risk than those living elsewhere. For example, we know there is substantially higher prevalence of illicit drug use among inner-city residents than among those who reside in suburban or rural areas. It is essential that these high-risk communities be specifically identified so that the available drug control resources can be provided to them on a priority basis. 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, APRA 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.

Does the state provide trainings to increase capacity of providers to deliver trauma-specific interventions?

CFSA has been awarded a $3.2 million ($640,000 per year for five years) federal grant, which will be used to make trauma-informed care 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 addressing trauma in two ways (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. TST focuses on the child and on his/her relationships and surroundings.

Environmental Factors and Plan

12. Criminal and Juvenile Justice

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 substance abuse and mental health problems. Successful diversion from or re-entering the community from detention, jails, and prisons is often dependent on engaging in appropriate substance use and/or mental health treatment. Some states have implemented such efforts as mental health, veteran and drug courts, crisis intervention training and re-entry programs to help reduce arrests, imprisonment and recidivism.[79]

The SABG and MHBG 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. Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance use disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: drug courts and mental health courts. In addition to these behavioral health problem-solving courts, some jurisdictions operate courts specifically for DWI/DUI, veterans, families, and reentry, as well as courts for gambling, domestic violence, truancy, and other subject-specific areas.[80] [81] Rottman described the therapeutic value of problem-solving courts: "Specialized courts provide a forum in which the adversarial process can be relaxed and problem-solving and treatment processes emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs." Youths 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.[82]

Expansions in insurance coverage will mean that many individuals in jails and prisons, who generally have not had health coverage in the past, will now be able to access behavioral health services. Addressing the behavioral health needs of these individuals can reduce recidivism, improve public safety, reduce criminal justice expenditures, and improve coordination of care for a population that disproportionately experiences costly chronic physical and behavioral health conditions. Addressing these needs can also reduce health care system utilization and improve broader health outcomes. Achieving these goals will require new efforts in enrollment, workforce development, screening for risks and needs, and implementing appropriate treatment and recovery services. This will also involve coordination across Medicaid, criminal and juvenile justice systems, SMHAs, and SSAs.

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 mental and/or substance use disorders from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment; loss of eligibility 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.

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

1. Are individuals involved in, or at risk of involvement in, the criminal and juvenile justice system enrolled in Medicaid as a part of coverage expansions?
2. Are screening and services provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?
3. Do the SMHA and SSA coordinate with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities and the reentry process for those individuals?
4. Are cross-trainings provided for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

Please indicate areas of technical assistance needed related to this section.

[79] http://csgjusticecenter.org/mental-health/

[80] The American Prospect: In the history of American mental hospitals and prisons, *The Rehabilitation of the Asylum*. David Rottman,2000.

[81] A report prepared by the Council of State Governments. Justice Center. Criminal Justice/Mental Health Consensus Project. New York, New York for the Bureau of Justice Assistance Office of Justice Programs, U.S. Department of Justice, Renee L. Bender, 2001.

[82] 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 Renée L. Binder. OJJDP Model Programs Guide

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

Footnotes:

Criminal and Juvenile Justice
Are individuals involved in, or at risk of involvement in, the criminal and juvenile justice system enrolled in Medicaid as part of coverage expansions?

Yes. The Department of Behavioral Health (DBH) enrolls individuals involved in the criminal and juvenile justice systems in Medicaid as a part of coverage expansion. Through the establishment of DBH, we have focused public awareness and policy attention on the implementation of behavioral health by further investigating each client's insurance posture and engaging and enrolling people into Medicaid with substance use and/or mental health disorders who are in the justice system. We know that treatment is effective and recovery is possible, even with criminal justice involvement. Therefore, we have devised a system that best supports Medicaid participation, healthy individuals and a strong community, which includes extensive partnership with the criminal justice community. The criminal justice community benefits from DBH which integrates treatment and mental health services for District of Columbia residents, as well as residents within the criminal justice system, with both mental health and substance use disorders. DBH provides integrated care that provides SUD treatment and supports for individuals with mental health care for the dually diagnosed. A significant number of the criminal justice population has both mental health and substance use disorders at the same time. In the past treatment and supports were delivered separately, which required people seeking help for both illnesses to navigate two separate agencies, this was particularly onerous for individuals with criminal justice involvement. Therefore, with integrated treatment, any combination of needs is addressed properly. Our integrated system effectively serves individuals involved in the criminal justice system with co-occurring disorders whether they are seeking help for substance use disorders or mental health conditions.

Are screening and services provided prior to adjudication and/or sentencing for individuals with mental health and/ or substance use disorders?

Yes. DBH consists of 86 providers that treat approximately 35,000 residents for one or the other disorder, with a number of providers being dual diagnose capable. DBH ensures that pre-trial providers are competent to assess for both mental health and substance use disorders at the same time so we can design the 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.
Currently, DBH pre-trial services include:
D GAIN Short Screener (GAIN SS): The Short Screener essentially provides a screening to determine level of substance abuse severity and MH severity. A positive result will initiate a referral for a full assessment using the Treatment Assignment Protocol (TAP).

Treatment Assignment protocol (TAP): The TAP provides the court with the appropriate placement into substance abuse treatment. Many Courts will rely on DBH's assessment and this can be incorporated into an order or probation requirement. With Client consent we release the assessment and drug screens to the court with appropriate referral information.
D Court Urgent Care Clinic (CUCC): Individuals receive immediate access to mental health services in the court house. CUCC provides screenings and mental health assessments for Pre-trial Services Agency (PSA), which recommends release conditions and makes referrals for mental health services to DBH and contacts CSAs for mental health information, screens candidates for Options Program. Individuals are referred from Traffic Court, PSA, Judges, community agencies and others.
D Options Program: Individuals who are not currently linked and have a history of non-compliance with court dates are referred to Options.
D Competency Assessments and Restoration Services: Competency Restorations occurs on an inpatient or outpatient basis, based upon the specific needs profile of the client, here in D.C.

Do the SMHA and SSA coordinate with the criminal justice system with respect to

diversion of individuals with mental health and/or substance use disorders, behavioral health services provided in correctional facilities and the reentry process for those individuals?

Yes. To better serve District residents who have become involved with the criminal justice system, substance abuse system, and/or the mental health system, DBH and it's criminal justice partners have been incorporating policies put in place by the Substance Abuse Treatment and Mental Health Services Integration Taskforce (SATMHSIT, 2009-2015). These policies were developed to improve treatment options available to defendants and ex-offenders. Through the services of the Court Urgent Care Clinic (CUCC) and the District of Columbia Superior Court (DCSC) diversion policies, the clinic provides court-based services for defendants with mental health disorders. Initially, the CUCC was incorporated to provide mentally ill defendants of the District's Misdemeanor and Traffic Community Court with immediate access to mental health services and connection to a DBH mental health provider. The CUCC has since expanded service delivery to accept referrals from the Pre-Trial Services Agency (PSA) and other courtrooms in the Superior Court of the District of Columbia. As well the CUCC expanded their array of services available 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. In order 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 is able to 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 in order to reduce behavioral symptoms that result in contact with the court and to improve the juvenile's functioning in the home, school, and community. Are cross trainings provided for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system.

Yes. DBH has a Training Institute that provides high-quality 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. As well there is a specific training course the Co-Occurring Certification Training (COD) which emphasizes dual diagnosis and co-occurring competent applications of service delivery. With the assistance of DBH the Metropolitan Police Department (MPD) has trained to over 730 MPD officers since the program's inception in April 2009. Approximately 125 new CIOs are trained every year, including people from other law enforcement agencies in the District such as the Capital Police, Protective Services Division, and the Metropolitan Police. In addition to these specially-trained officers, every MPD officer will receive mental health training to learn appropriate techniques to use when responding to calls-for-service involving mentally ill residents.

Environmental Factors and Plan

13. State Parity Efforts

Narrative Question:

MHPAEA generally requires group health plans and health insurance issuers to ensure that financial requirements and treatment limitations applied to M/SUD benefits are no more restrictive than the requirements or limitations applied to medical/surgical benefits. The legislation applies to both private and public sector employer plans that have more than 50 employees, including both self-insured and fully insured arrangements. MHPAEA also applies to health insurance issuers that sell coverage to employers with more than 50 employees. The Affordable Care Act extends these requirements to issuers selling individual market coverage. Small group and individual issuers participating in the Marketplaces (as well as most small group and individual issuers outside the Marketplaces) are required to offer EHBs, which are required by statute to include services for M/SUDs and behavioral health treatment - and to comply with MHPAEA. Guidance was released for states in January 2013.[83]

MHPAEA requirements also apply to Medicaid managed care, alternative benefit plans, and CHIP. ASPE estimates that more than 60 million Americans will benefit from new or expanded mental health and substance abuse coverage under parity requirements. However, public awareness about MHPAEA has been limited. Recent research suggests that the public does not fully understand how behavioral health benefits function, what treatments and services are covered, and how MHPAEA affects their coverage.[84]

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 behavioral health 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. 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. SMHAs and SSAs should collaborate with their state's 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.

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

1. What fiscal resources are used to develop communication plans to educate and raise awareness about parity?
2. Does the state coordinate across public and private sector entities to increase consumer awareness and understanding about benefits of the law (e.g., impacts on covered benefits, cost sharing, etc.)?
3. Does the state coordinate across public and private sector entities to increase awareness and understanding among health plans and health insurance issuers of the requirements of MHPAEA and related state parity laws and to provide technical assistance as needed?

Please indicate areas of technical assistance needed related to this section.

[83] http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf

[84] Rosenbach, M., Lake, T., Williams, S., Buck, S. (2009). Implementation of Mental Health Parity: Lessons from California. Psychiatric Services. 60(12) 1589-1594

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

Footnotes:

13. State Parity Efforts

The Department of Health Care Finance (DHCF), the state Medicaid agency, conducted a preliminary analysis of mental health services offered through DBH. The DHCF determined that the District was in parity with the physical health benefits offered through Medicaid. However, an analysis of the substance use disorder services is pending. DHCF anticipates additional technical assistance from the Centers from Medicare and Medicaid Services (CMS).

Environmental Factors and Plan

14. Medication Assisted Treatment

Narrative Question:

There is a voluminous literature on the efficacy of FDA-approved medications for 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 medication-assisted treatment of these disorders is described in SAMHSA TIPs 40[85], 43[86], 45[87], and 49[88]. SAMHSA strongly encourages the states to require that treatment facilities providing clinical care to those with substance use disorders be required to either have the capacity and staff expertise to use MAT or have collaborative relationships with other providers such that these MATs can be accessed as clinically indicated for patient need. 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.

SAMHSA strongly encourages states to require the use of FDA-approved MATs for substance use disorders where clinically indicated (opioid use disorders with evidence of physical dependence, alcohol use disorders, tobacco use disorders) and particularly in cases of relapse with these disorders. SAMHSA is asking for input from states to inform SAMHSA's activities.

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

1. How will or can states use their dollars to develop communication plans to educate and raise awareness within substance abuse treatment programs and the public regarding medication-assisted treatment for substance use disorders?
2. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that need access to medication-assisted treatment for substance use disorders, particularly pregnant women?
3. What steps will the state take to assure that evidence-based treatments related to the use of FDA-approved medications for treatment of substance use disorders are used appropriately (appropriate use of medication for the treatment of a substance use disorder, combining psychosocial treatments with 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, advocacy with state payers)?

Please indicate areas of technical assistance needed related to this section.

[85] http://store.samhsa.gov/product/TIP-40-Clinical-Guidelines-for-the-Use-of-Buprenorphine-in-the-Treatment-of-Opioid-Addiction/SMA07-3939

[86] http://store.samhsa.gov/product/TIP-43-Medication-Assisted-Treatment-for-Opioid-Addiction-in-Opioid-Treatment-Programs/SMA12-4214

[87] http://store.samhsa.gov/product/TIP-45-Detoxification-and-Substance-Abuse-Treatment/SMA13-4131

[88] http://store.samhsa.gov/product/TIP-49-Incorporating-Alcohol-Pharmacotherapies-Into-Medical-Practice/SMA13-4380

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

Footnotes:

Medication Assisted Treatment

The use of medications in substance use disorder treatment has a 40 year history. The medication used to treat SUD includes buprenorphine, methadone, disulfiram, acamprosate, naltrexone and injectable naltrexone. In the District, the four certified programs provide MAT services in four of the eight Wards for opioid addiction with the use of Methadone or injectable naltrexone medications. In addition, detoxification services are available in three certified programs which include a jail-based program and two detoxification programs.

In providing MAT services, providers must act for the benefit of the patient by providing competent, timely, evidenced based treatment practices or Beneficence; respect the rights of the patient to decide their treatment modality or Autonomy; do no harm or injure the patient by monitoring and making dose adjustments or Non-malfeasance; and act with fairness and advocate for clients or Justice. In the DBH Intake, clients are given a choice of program for treatment services after the comprehensive assessment. With the provider being certified under the regulations, this ensures beneficence and non-malfeasance. Advocacy begins when the client enters the DBH Intake. The staff gives the information to the "right" client for the "right" program for the "right" services. Within the four Wards, treatment services are available for the poverty stricken individual to the most affluent individual as it relates to socio-economic status.

How will or can states use their dollars to develop communication plans to educate and raise awareness within substance abuse treatment programs and the public regarding medication-assisted treatment for substance use disorders?

The District will develop a year plan with intense communications the first 90 days and established follow up scheduled. The communication avenues shall include PSA, billboards, social media, and television and fact sheets. The intent of the message is to de-stigmatize medication assisted treatment and strengthen the message of the positive outcomes of use of MAT such as family reunification and employment stability. Also, a visual campaign with a spoke person, either department heads or former or actual client to reinforce the message. Currently, DBH has on-going communications with the provider network. These are excellent venues to keep the message thriving. The provider meetings include the Monthly Provider Meetings, Meetings with MAT and emails. For community messaging, the Outreach Teams distribute flyers and postcards with information on how to assess SUD services.

What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that need access to medication-assisted treatment for substance use disorders, particularly pregnant women?

In the District, women with children and pregnant women have priority access to treatment. The Intake Center test for pregnancy and if positive the client is linked to SUD treatment and primary care for the unborn child and mother. Also, the Department has a Mobile Assessor (Social Worker) at the Child and Family Services Administration (CFSA), government agency focusing on women's needs for SUD screening and assessments to refer to treatment. Thus, access to SUD treatment for women was increased in that the women can be screened in multiple locations. Access to MAT service for special population is achieved by removing any barriers to service. The District provides a mobile vehicle for outreach in communities in most need of services. The services include on-site assessments and referral to SUD

services to pregnant women, post-partum and women with children. The District also assists and encourages providers to operate MATs for special populations. The District facilitates collaborative efforts with other organizations and agencies that services women and children to provide assessments on demand with seamless entry into treatment.

Women have unique circumstances which are distinct from other populations such as child care. Grants are offered assist programs with "daycare" for non-school age children. This helps the women to focus on the treatment regimen while in the program rather than caring for her children. Women are pre-occupied with feeding their family. Thus the programs providing services to this population incorporate resources such as TANF to purchase food and other necessities for their children. Women have gynecology care needs. Programs have trained staff or MOUs with OB-GYN facilities for this service. Having a physician or medical staff trained in OB-GYN and SUD proves helpful in servicing the women needs during treatment. Transportation is another concern for women with children. Again, assistance with fare cards or tokens are offered as an incentive in treatment.

What steps will the state take to assure that evidence-based treatments related to the use of FDA-approved medications for treatment of substance use disorders are used appropriately (appropriate use of medication for the treatment of a substance use disorder, combining psychosocial treatments with 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, advocacy with state payers)?

In the District, the FDA-approved medications used in SUD treatment are Methadone and injectable naltrexone medication. The programs provide SUD treatment to almost two thousand clients. The evidence based models used by the providers are designed to address their addictions and the impact on their lives, family and communities. Some of the programs have peer supports incorporated in SUD treatment services. The District's regulations require the MAT clinics to provide SUD treatment (group, individual, and counseling) in conjunction with MAT dosing. The outcomes are better when co-morbidities and social services are addressed in treatment. The Department focuses on the well-being of the individual to include SUD treatment, utilization of evidence based treatments models and primary health care of clients in MAT programs. The Department implements policy to ensure a quality improvement process and scheduled inspections. Providers are required to have a diversion policy that includes a "call back" or having clients to return to the program with bottles to ensure accountability of the medication. Advocacy starts at the point of entry into the SUD system from self-advocacy, family, staff and peers. The Department continues to raise advocate and raise awareness and remove the stigma of addiction. This involves influencing laws, sponsoring supportive recovery events, and disseminating materials.

Environmental Factors and Plan

15. Crisis Services

Narrative Question:

In the on-going development of efforts to build an evidence-based robust system of care for persons diagnosed with SMI, SED and addictive disorders 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 behavioral health crises.

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 behavioral health conditions and their families.

According to SAMHSA's publication, Practice Guidelines: Core Elements for Responding to Mental Health Crises[89] ,

> "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 behavioral health issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. The array of services and supports being used to address crisis response include the following:

Crisis Prevention and Early Intervention:

- Wellness Recovery Action Plan (WRAP) Crisis Planning
- Psychiatric Advance Directives
- Family Engagement
- Safety Planning
- Peer-Operated Warm Lines
- Peer-Run Crisis Respite Programs
- Suicide Prevention

Crisis Intervention/Stabilization:

- Assessment/Triage (Living Room Model)
- Open Dialogue
- Crisis Residential/Respite
- Crisis Intervention Team/ Law Enforcement
- Mobile Crisis Outreach
- Collaboration with Hospital Emergency Departments and Urgent Care Systems

Post Crisis Intervention/Support:

- WRAP Post-Crisis
- Peer Support/Peer Bridgers
- Follow-Up Outreach and Support
- Family-to-Family engagement
- Connection to care coordination and follow-up clinical care for individuals in crisis
- Follow-up crisis engagement with families and involved community members

Please indicate areas of technical assistance needed related to this section.

[89]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 use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Crisis Services

The Districts ability to deliver a comprehensive, multi-agency, culturally responsive, evidence-based earliest point of diversion service for persons with behavioral health disorders at risk for an event that significantly jeopardizes the client's treatment, recovery progress, health or safety. These are called "crisis services." These services are designed to stabilize individuals in psychological distress and engage them in the most appropriate course of treatment. In contrast to inpatient-based care, these services are designed to reach people in their own communities. The continuum of services includes telephone hotlines, peer crisis services, crisis intervention teams, mobile crisis services, crisis stabilization beds, short-term residential services, and more. The evidence that crisis services work is growing. The District has implemented guidelines to improve services for people with serious mental illness or emotional disorder who are in mental health crises. Trainings are available to persons and community to identify the values, principles, and infrastructure to support appropriate to the responses to mental health crises in various situations to be protected. The research shows, for example, that short-term residential stabilization services, which use 24-hour observation and supervision to prevent or resolve crises are as effective at improving symptoms as longer psychiatric inpatient care. Plus, patients report strong satisfaction with these services.

In the District's Assessment and Referral Center (ARC), there are 3-4 crises occurring weekly. The Intake Staff responds to behavioral health crises by quickly recognizing, intervening and de-escalating the client. The brief interventions along with evidence driven strategies includes a visual assessment, calming the client followed by the appropriate interventions. The ARC is equipped with oxygen, AED and vital signs monitoring machines to obtain baseline data with a progress note for a warm hand off to ambulance, hospitals and psychiatric services. The Social Workers, Counselors, and Nurses are crossed-trained with the emergency psychiatric division to recognize symptoms and to care for clients experiencing a psychiatric crisis. In addition, the staff received additional trainings in substance use disorder and mental health crisis and hold certifications in the courses. The District collaborates with the Police and emergency psychiatric division/Mobile Crisis for emergency crisis in the facility.
To preempt a crisis response, the nursing assessment includes linking clients to primary care and urgent care systems for services prior to going into treatment. The nursing assessment also includes a careful review of medications and ensuring a sufficient amount of medications, 30 day supply with refills, accompany the client into treatment. Medical and psychiatric components are addressed during the assessment. In addition, the ARC has a designated room for short term isolations from the general population until outside support system arrives and for health outbreaks such as Ebola. This room provides privacy, maintains the confidentiality and dignity of the client during the isolation. Staff remains with the client during the isolation, if needed. Most often, clients report to the Intake Center unaccompanied. When they are accompanied with family or Case Workers, after allowing permission and signing the consent, these persons are allowed to be a part of the screening.

The Comprehensive Psychiatric Emergency Program (CPEP) is a twenty-four hour/seven day a week operation that provides emergency psychiatric services, mobile crisis services and extended observation beds for individuals 18 years of age and older. Mobile crisis services teams respond to adults throughout the District who are experiencing a psychiatric crisis whether in the homes or on the street and who are unable or unwilling to travel to receive mental health services. Clinicians also are available to provide counseling support after traumatic events whether personal or community wide. The teams provide crisis stabilization including dispensing medication and perform assessment for voluntary and involuntary

hospitalizations and linkages to other services, such as crisis beds and substance abuse detoxification and treatment. The teams work with family members and the community based mental health provider, if appropriate, to help with follow up.

The Crisis Intervention Officer initiative (CIO) is a partnership between the Department of Behavioral Health and the Metropolitan Police Department (MPD) to strengthen the District's ability to support people with Behavioral Health issues who come to the attention of law enforcement but do not meet the threshold for arrest. Officers are trained to recognize the signs of mental illness, determine the most appropriate response, and use de-escalation techniques that build on their skills and training.

CPEP provides emergency psychiatric services 24 hours a day, seven days a week to evaluate patients who have a mental health concern or crisis. The psychiatric team works in consultation with emergency room physicians to provide specialized behavioral health assessments, including comprehensive psychiatric assessments, crisis intervention, recommendations for level of care including inpatient psychiatric hospitalization, and referrals to appropriate behavioral health resources. One of the District's services providers, the Psychiatric Institute of Washington (PIW), provides comprehensive behavioral healthcare for children, adolescents, adults and senior adults who have mental health and addictive illnesses. The short-term, acute care hospital offers inpatient, partial and intensive outpatient programs, as well as specialized treatment programs for chemical dependency.

Environmental Factors and Plan

16. Recovery

Narrative Question:

The implementation of recovery-based approaches is imperative for providing comprehensive, quality behavioral health 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 behavioral health 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. This includes the use of psychotropic or other medications for mental illnesses or addictions to assist in the diminishing or elimination of symptoms as needed. Further, the use of psychiatric advance directives is encouraged to provide an individual the opportunity to have an active role in their own treatment even in times when the severity of their symptoms may impair cognition significantly. Resolution of symptoms through acute care treatment contributes to the stability necessary for individuals to pursue their ongoing recovery and to make use of SAMHSA encouraged recovery resources.

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, 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. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- Drop-in centers
- Peer-delivered motivational interviewing
- Peer specialist/Promotoras
- Clubhouses
- Self-directed care
- Supportive housing models
- Recovery community centers
- WRAP
- Evidenced-based supported
- Family navigators/parent support partners/providers
- Peer health navigators
- Peer wellness coaching
- Recovery coaching
- Shared decision making
- Telephone recovery checkups
- Warm lines
- Whole Health Action Management (WHAM)
- Mutual aid groups for individuals with MH/SA Disorders or CODs
- Peer-run respite services
- Person-centered planning
- Self-care and wellness approaches
- Peer-run crisis diversion services
- Wellness-based community campaign

employment

SAMHSA encourages states to take proactive steps to implement recovery support services, and is seeking input from states to address this position. 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.

Recovery is based on the involvement of consumers/peers and their family members. States should work to support and help strengthen existing consumer, family, and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. There are many activities that SMHAs and SSAs can undertake to engage these individuals and families. In the space below, states should describe their efforts to engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system.

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

1. Does the state have a plan that includes: the definition of recovery and recovery values, evidence of hiring people in recovery leadership roles, strategies to use person-centered planning and self-direction and participant-directed care, variety of recovery services and supports (i.e., peer support, recovery support coaching, center services, supports for self-directed care, peer navigators, consumer/family education, etc.)?
2. How are treatment and recovery support services coordinated for any individual served by block grant funds?
3. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?
4. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services? Does the state have an accreditation program, certification program, or standards for peer-run services?
5. Does the state conduct empirical research on recovery supports/services identification and dissemination of best practices in recovery supports/services or other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system?
6. Describe how individuals in recovery and family members are involved in the planning, delivery, and evaluation of behavioral health services (e.g., meetings to address concerns of individuals and families, opportunities for individuals and families to be proactive in treatment and recovery planning).
7. Does the state support, strengthen, and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?
8. Provide an update of how you are tracking or measuring the impact of your consumer outreach activities.
9. Describe efforts to promote the wellness of individuals served including tobacco cessation, obesity, and other co-morbid health conditions.
10. Does the state have a plan, or is it developing a plan, to address the housing needs of persons served so that they are not served in settings more restrictive than necessary and are incorporated into a supportive community?
11. Describe how the state is supporting the employment and educational needs of individuals served.

Please indicate areas of technical assistance needed related to this section.

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

Footnotes:

Recovery

Descriptions of the District of Columbia's plan to continue providing recovery support services for people in recovery from substance use and or mental disorders.

Does the state have a plan that includes: the definition of recovery and recovery values, evidence of hiring people in recovery leadership roles, strategies to use person-centered planning and self-directed and participant-directed care, variety of recovery services and supports?

The Department of Behavioral Health (DBH) does not have a formal Recovery Plan. There is a draft proposed plan. However, the department is providing recovery support services. These services include: recovery evaluation; care coordination; life skills support; spiritual support; recovery coaching & mentoring; education support services; transportation support; parenting support; family support; recovery social activities; and environmental stability. The department under the training institute workforce development plan offers a two day training on client centered planning and participant-directed care. The Department has documented evidence of hiring and recruiting people in recovery in leadership roles as program staff, program directors, supervisors and program monitors through the Office of Consumer and Family Affairs.

Through the Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) grant DBH has assisted in the development of a consumer (mental health & substance use disorders) run advocacy group DC Recovery Advisory Council (DC RAC) 2013 to present. The goal of the council is to set up a frame work for a Recovery Oriented System of Care (ROSC) in the District of Columbia to include all disciplines, individuals and families. The DC RAC will recommend recovery based strategies to the Department of Behavioral Health and other Government agencies to improve, promote, prevent, and provide intervention, treatment and recovery support services in the District.

Technical Assistance Needs: The development of a behavioral health system-wide Recovery Plan.

How are treatment and recovery support services coordinated for any individual served by block grant funds?

The treatment and recovery support services are truly integrated in to the treatment continuum in the District. The District has recently finalized its regulatory chapter, Title 22A, Chapter 63 of the DCMR. These regulations govern treatment and recovery support services. Any individual eligible for care will receive an assessment to determine the intensity of treatment and recovery services.
Individuals eligible for care will receive a recovery support evaluation which guides service planning. Recovery support services are offered as an alternative to treatment, in conjunction with treatment, and/ or as a continuation in the recovery process. The recovery support services include: Recovery Support Evaluation; Recovery Support Management; Recovery Coaching; Life Skills Support Services; Education Support Services; Recovery Social Activities; and Transportation Services (Public);Spiritual Support Services; and Environmental Stability. The District is also working with stakeholders to identify opportunities to develop "Recovery High Schools." Block Grant funding is integrated in recovery support services with local funding. The District is in the process of seeking opportunities to implement Medicaid/ Medicare funding to cover recovery support services.

Does the state's plan include peer-driven services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?

Under the Department's Recovery Support Services and Office of Consumer and Family Affairs Divisions peer driven services are provided to meet the special needs of specific populations. The recovery support services provider network consist of community based, faith based, grassroots recovery programs, and traditional treatment services providers deliver peer driven support services for women, women

with dependent children, youth and young adults and family members, LGBTQI community, ex-Sex workers, persons diagnosed with trauma, criminal justice (re-entry) population, Air/Army National Guardsman/women, Veterans and their family members. All members of racial/ethnic groups are provided services in a culturally competent manner.

Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services? Does the state have an accreditation program, certification program, or standard for peer – run services?

The Department provides training support for the professional workforce on recovery principles under the Department of Behavioral Health Training Institute and the Office of Consumer and Family Affairs Peer Certification Program. The Substance Use Disorders Services Division will begin within the next six months providing a forty hour Recovery Coach Certification Program. The certification training modules will include the principles of recovery.

Does the state conduct empirical research on recovery supports/services identification and dissemination of best practices in recovery supports/services or other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system?

The District has been working with Stakeholders in developing a truly integrated Recovery Oriented System of Care. This is an area that the District plans on seeking Technical Assistance and Guidance through SAMHSA to help develop this area in the District.

Describe how individuals in recovery and family members are involved in the planning, delivery, and evaluation of behavioral health services?

The Department provides recovery support services for individuals in recovery and family members. Any resident of the District of Columbia can access recovery support services through the Assessment and Referral Center (ARC), Mobile Assessment and Referral Center (MARC), Community Outreach, and Individual recovery support services provider enrollment. Individuals may participate in recovery support services of their choice. Family members are engaged through participating in the Family and Marital Support Services.

Does the state support, strengthen, and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

The Department supports, strengthens, and expands recovery organizations, family peer advocacy, self-help programs, recovery networks, and newly formed recovery-oriented services through the department's recovery alumni groups, DC Recovery Advisory Council, Recovery Initiative Group, and the Departments Behavioral Health Council.

Technical Assistance Needs: The development of a behavioral health system-wide Recovery Oriented System of Care Plan.

Provide an update of how you are tracking or measuring the impact of your consumer outreach activities?

The Department monitors and tracks all consumer outreach activities through the Recovery Support Services Outreach Team and the Mobile Assessment Referral Center (MARC).

Describe efforts to promote the wellness of individuals served including tobacco cessation, obesity, and other co-morbid health conditions.

The Department works in collaboration with the Department of Heath tobacco cessation program, obesity and other co-morbid health conditions identified in the District of Columbia specific Wards census track.

Does the state have a plan, or is it developing a plan, to address the housing needs of persons served so that they are not served in settings more restrictive than necessary and are incorporated into a supportive community?

Under the Departments Recovery Support Services Division a recovery housing component

Environmental Stability (ES) was develop to provide short term (6 months) housing for person's who have participated in the department's substance use disorders treatment services and enrolled in recovery support services. The program was designed as a bridge to independent long term housing under collaborations with
Oxford Housing, Inc., and with local Single Residence Occupancies (SRO's): Samaritan Inns, So Others Might Eat (S.O.M.E.) and Access Housing, Inc. (Veterans).

Participation in the Environmental Stability Program allows an individual the freedom to participate in a non-restrictive environment that supports recovery. The individuals are able to come and go freely to work, school, and training, participate in family and community social events. Recovery support services are provided within each ES home. The ES homes or apartments are located in within the District 8 Wards and drug free zones. Please refer to the District's Olmstead Plan.

Describe how the state is supporting the employment and educational needs of individuals served?

Under the Departments Recovery Support Services Program employment readiness assessments, training and referrals are provided to individuals who request employment and education services. Individuals are also connected to the District community employment centers.

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead

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 substance abuse and mental illness on America's communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated arrangement appropriate 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 behavioral health 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 of 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 residences that have institutional characteristics to house persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain 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:

1. Describe the state's Olmstead plan including housing services provided, home and community based services provided through Medicaid, peer support services, and employment services.
2. How are individuals transitioned from hospital to community settings?
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?
4. Describe any litigation or settlement agreement with DOJ regarding community integration for children with SED or adults with SMI in which the state is involved?

Please indicate areas of technical assistance needed related to this section.

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

Footnotes:

DC—One Community For All

An Olmstead Community Integration Plan

Prepared by the DC Office of Disability Rights

Introduction and Background

On June 22, 1999, the United States Supreme Court ruled in Olmstead v. L.C., 527 U.S. 581, that the unjustified segregation or isolation of people with disabilities in institutions may constitute discrimination based on disability in violation of the Americans with Disabilities Act (ADA). Accordingly, the Court held that the ADA requires that States provide community-based treatment for persons with disabilities "when the State's treatment professionals determine that such placement is appropriate, the affected persons do not oppose such treatment, and the placement can be reasonably accommodated, taking into account the resources available to the States and the needs of others with . . . disabilities." 527 U.S. at 607.

In light of this decision, the District instituted a comprehensive working plan to serve qualified individuals with disabilities in accordance with the Supreme Court's holding in *Olmstead*. This plan establishes certain goals of the District to ensure that community-based treatment is provided to persons with disabilities, when such treatment is appropriate. However, this plan does not create independent legal obligations on the part of the District.

Mayor Vincent Gray and a wide range of District stakeholders including persons with disabilities directed and supported the Office of Disability Rights to develop the Olmstead Community Integration Plan in accordance with policies and procedures outlined in D.C. Act 16-595 the Disability Rights Protection Act of 2006. The District values its residents with disabilities as contributing members of society and understands the cost-effective benefits of supporting them with integrated, community-based services. The DC Olmstead Community Integration Plan, One Community for All is a policy document that details the rights of each person with a disability to self-determination in the District of Columbia.

One Community for All endeavors to meet the needs and preferences of the individual while allowing him or her to choose where s/he wants to live in the community with the appropriate supports and services consistent with the Olmstead decision and the resources available to the District to serve such individuals, taking into account the needs of others. The Plan is a living document, providing specific goals, action steps, and tools, while allowing for better flexibility and improved services for individuals with disabilities.

Nine (9) District agencies participating in this initiative are responsible for implementing the Plan. These District agencies include: Office of the State Superintendent for Education (OSSE), Office on Aging (DCOA), Department of Youth Rehabilitation

Services (DYRS), Department of Disability Services (DDS), Department of Human Services (DHS), Department of Behavioral Health (DBH), Child and Family Services Agency (CFSA), DC Public Schools (DCPS) and the Department of Health Care Finance (DHCF). These agencies are collaborating in the hope that the District of Columbia will become a national model for providing community services and supports to persons with disabilities.

The Fiscal Year (FY) 2015 Plan

For Fiscal Year 2015 (FY '15), the District's Plan will focus on the programs, services, and outcomes of the following agencies:

- DC Office on Aging (DCOA);
- Department of Behavioral Health (DBH);
- Department on Disability Services (DDS); and
- Department of Healthcare Finance (DHCF).

The above-named agencies provide direct service to a quantifiable population of District residents individually and with other District agencies and community partners. This year's Plan seeks to highlight collaboration among these agencies, as well as the Plan's remaining five (5) participating agencies, to illustrate the wrap-around, holistic approach to support provided by the District to individuals with disabilities who are transitioning into the community of their choice.

This year's Plan is designed to specifically address how these agencies carry out the Primary Service Agency Priorities set forth in the original iteration of DC—One Community for All published in April 2012. .[i]

The FY '15 Plan contains benchmarks for each of the above agencies. Each agency will report quarterly on the number of individuals with disabilities it has assisted in transition. Moreover, each agency will report on any qualitative measures it has taken to promote and support successful integration into community life for people with disabilities. These types of measures will include, but are not limited to the following:

- Outreach and training;
- Internal and external agency publications;
- Development of transition-relevant new community partnerships;
- Fostering of existing transition-relevant community partnerships; and
- Opportunities for input from persons with disabilities being served.

Last, the FY '15 Olmstead Plan will explore avenues to address the most prevalent barrier to successful, lasting transition for the disability community—accessible, affordable housing. To facilitate this effort, the DC Housing Authority (DCHA) and DC

Housing and Community Development (DHCD) will participate or provide comment on all District-wide housing issues related to DC's Olmstead Plan.

FY '15 Olmstead Planning Questions and Outline

Please address the following with respect to the particular population of individuals your agency serves.

Setting Priorities

1. When does your agency consider an individual to be "institutionalized" under the auspices of the Olmstead mandate?
   - ⎦ 91 days or more
   - ⎦ 181 days or more
   - ⎦ 365 days or more
   - ⎦ Other:_____

2. What policies/procedures does your Agency utilize for identifying individuals ready and invested for transition into the community?

3. How do you communicate with your target population and their families/caregivers/advocates/providers about community-based options?

4. What procedures or policies do you have in place to allow people with disabilities to assess the quality of the supports they receive?

5. What measures has your agency taken to address the needs of the following:

   a. Children who receive residential services from District agencies but live outside the District of Columbia.
   b. Adults who receive residential services from District agencies but reside outside the District of Columbia.
   c. Individuals who are long-term homeless and seeking permanent housing.
   d. Individuals who are soon to be released from jail/juvenile detention facilities.
   e. Individuals who are receiving services but still have significant unmet needs which put them **at risk** of placement in non-community-based settings.
   f. Individuals who do not receive services but are known to have unmet needs that put them at risk for placement in non-community-based settings.
   g. Individuals not receiving formalized services but live with a family member unable to support them effectively.

Interagency Collaboration

6. Explain specifically how your agency works with other participating agencies, District residents, and community stakeholders. Please identify the agency/agencies (Government and Community-based) and consider the following:
   a. Recommend community services and supports that allow an individual to select services and supports designed for their specific needs.
   b. Develop effective and timely transition plans for individuals who are placed in non-community-based settings.
   c. Conduct outreach on your services or other participating agencies' services specifically geared toward your service population.

Addressing Barriers

7. How does your agency address any or all of the following **barriers** to successful provision of community-based supports for individuals with disabilities? **Note:** address only those populations applicable to your agency's mission and vision.
   a. Lack of comprehensive information on the supports and services available.
   b. Impacts of transitioning to life in the community: discrimination, fear, and stigma.
   c. Unavailability of support services to assist with daily life for individuals with severe disabilities, such as education, transportation, and employment.
   d. Insufficient numbers of compensated, trained employees to work with the population of people with disabilities.
   e. Post-discharge into community-based living with subsequent assessment that transition is not meeting the needs of the individual.

DC Office on Aging (DCOA) FY 2015 Olmstead Planning Questions and Outline

Setting Priorities

1. **When does your agency consider an individual to be "institutionalized" under the auspices of the Olmstead mandate?**

   The nursing home transition and hospital discharge teams define "institutionalized" as 91 days or more.

2. **What policies/procedures does your Agency utilize for identifying individuals ready and invested for transition into the community?**

   The Agency receives referrals from individuals seeking services, family caregivers, healthcare professionals, or nursing home social workers. When an individual expresses interest in transitional assistance, a referral is sent to Information and Assistance. The referral is assigned to a transition care specialist.

   In addition, there is a screening done by the Transition Care Specialist for potential Money Follows the Person and Aging and Disability Resource Center Nursing Home Transition clients. The screening tool determines if the client is eligible for either nursing home transition through Money Follows the Person (MFP) (client must be a Medicaid beneficiary, be assessed at a nursing home level of care, and have viable housing or a housing voucher) or Aging Disability Resource Center (ADRC) (client does not meet the MFP eligibility requirements, but has expressed interest in leaving a nursing facility).

   - If the client is eligible for MFP, he/she will be assigned an MFP Transition Care Coordinator.
   - If the client is not eligible for MFP, but expresses interest in transitioning out of a nursing facility, he/she will be assigned a Transition Care Specialist on the Nursing Home Transition team.

3. **How do you communicate with your target population and their families/caregivers/advocates/providers about community-based options?**

   DCOA has a community outreach team that conducts outreach at various sites including Senior Wellness Centers, churches, and community events. The target population is also reached via DC Office on Aging website.

The hospital discharge team communicates directly with our targeted population and their support system via hospital visits, home visits, telephone, and/or email. This team also conducts hospital discharge planning presentations at local hospitals.

4. **What procedures or policies do you have in place to allow people with disabilities to assess the quality of the supports they receive?**

The procedures and policies for persons with disabilities, ages 18-59, is the same as persons 60 and older. Once we have received a case, reviewed options, and linked the individual with necessary resources, we provide case management services for 90 days. After 90 days, a customer satification survey is completed.

5. **What measures has your agency taken to address the needs of the following:**

   a. **Children who receive residential services from District agencies but live outside the District of Columbia.**

DC Office on Aging does not provide services to children who receive residential services from local DC agencies.

   b. **Adults who receive residential services from District agencies but reside outside the District of Columbia.**

The Nursing Home Transition Team and the Hospital Discharge Team assists adults who have been in a hospital or nursing facility outside the District of Columbia if they have been in the hospitals and nursing facility for 90 days or more, receive community-based Medicaid, and desire to transition back into the District of Columbia. However, if a person does not have Medicaid, both of these teams would work with staff, providing Options Counseling to the individual to inform them of potential resources. Options Counseling provides person-centered counseling to individuals, family members and/or significant others with support in their long-term care decisions to determine appropriate choices. During this process, a written action plan for receiving community resources is developed based on an individual's needs, preferences, values, and circumstances. Follow-up is provided by option counselors to ensure service delivery and customer satisfaction.

c. Individuals who have been homeless long-term, and are seeking permanent housing.

Individuals who are experiencing long-term homelessness and seeking housing are referred to DCOA's Housing Coordinator who assists individuals in locating permanent and/or afforable and suitable housing. The housing coordinator works with DC Housing Authority, So Others Might Eat, Pathways to Housing, Green Door, and Housing Counseling Services to locate housing.

d. Individuals who are soon-to-be released from jail/juvenile detention facilities.

Individuals who are re-entering the community can contact DC Office on Aging Information and Assistance Department for a referral to the Employment and Training Coordinator. Individuals can also receive other services once identified and/or requested.

e. Individuals who are receiving services but still have significant unmet needs, which put them at risk of placement in non-community-based settings.

Individuals receiving services who have significant unmet needs and are at risk of being placed in a non-community based setting can contact the DC Office on Aging Information and Assistance Department for a referral to the appropriate Aging Disability Resource Center ward social worker.

f. Individuals who do not receive services but are known to have unmet needs that put them at risk for placement in non-community-based settings.

Individuals receiving services with significant unmet needs and are at risk in being placed in a non-community base setting can contact DC Office on Aging Information and Assistance Department for a referral to the appropriate Aging Disability Resource Center ward social worker.

g. Individuals not receiving formalized services but who live with a family member unable to support them effectively.

Individuals not receiving formalized services, but who live with a family member unable to support them effectively are referred to an Options Counselor who works both with the client and caregiver on Long Term Care

options and in-home supports. The caregiver may also be referred to the Lifespan Respite Care program to receive caregiver support and services.

Interagency Collaboration

6. **Explain specifically how your agency works with other participating agencies, District residents, and community stakeholders. Please identify the agency/agencies (Government and Community-based) and consider the following:**

   a. Recommend community services and supports that allow an individual to select services and supports designed for their specific needs.

   b. Develop effective and timely transition plans for individuals who are placed in non-community-based settings.

   c. Conduct outreach on your services or other participating agencies' services specifically geared toward your service population.

DCOA has expanded access to community-based long-term supports for individuals through a memorandum of understanding (MOU) with the Department of Health Care Finance (DHCF) to provide a comprehensive interdisciplinary program that organizes, simplifies, and provides a "one-stop shop" for access to all public long-term care and support programs. Also DCOA has a memorandum of agreement (MOA) with DHCF and Department of Behavioral Health (DBH) to conduct a preliminary intake of all individuals. In addition DCOA has informal partnerships with Washington Hospital Center Mental Health and House Call Programs, Psychiatric Institute of Washington, DC Long term care Ombudsman office, Adult Protective Services, and Senior Service Network. DCOA has an outreach specialist who facilities meetings with individuals, and/or families interested in transitioning.

An ADRC Transition Care Specialist prescreens consumers for eligibility, informs individuals about the Elderly and Persons with Disabilities (EPD) Waiver, and provides transition assistance through options counseling individuals, creates a person centered action plan that maps out the services, and provides guidance on community resources to ensure a successful transition back into the community.

Addressing Barriers

7. **How does your agency address any or all of the following barriers to successful provision of community-based supports for individuals with**

disabilities? Note: address only those populations applicable to your agency's mission and vision.

a. Lack of comprehensive information on the supports and services available

b. Impacts of transitioning to life in the community: discrimination, fear, and stigma.

c. Unavailability of support services to assist with daily life for individuals with severe disabilities, such as education, transportation, and employment.

i. **Challenges** include locating affordable and suitable housing for homeless hospital patients who are medically stable for discharge, as well as obtaining services for non-Medicaid hospital patients in need of long-term in-home support care. Also, there is a challenge in locating affordable transportation services for the disabled population ages 18-59.

ii. **Solution:** The Hospital Discharge Planning Team and Nursing Home Transition Team continues to work closely with our Housing Coordinator to identify affordable housing options for our participants, as well as work with identified agencies to assist participants with obtaining necessary personal care aide services (in-home support) as quickly as possible. Participants with disabilities ages 18-59 needing transportation are referred to Metro Access.

d. Insufficient numbers of compensated, trained employees to work with the population of people with disabilities.

i. DCOA is working on improving partnership with the disability community and disability-focused organizations, and knowledge of disability services through training on the following topics:

Introduction to independent living and services; disability cultural competence; and person-first perspective; Services and resources for people with disabilities.

e. Post-discharge into community-based living with subsequent assessment that transition is not meeting the needs of the individual.

iii. **Challenge:** Due to the length of the Elderly & Persons with Physical Disabilities Waiver Program's application process, some participants do not receive adequate hours of in-home supportive services post-discharge.

iv. **Solution:** The Hospital Discharge and Nursing Home Transition Teams provide assistance and linkages to the participant and/or his/her family with in-home supportive resources and options counseling.

Department of Behavioral Health (DBH) FY 2015 Olmstead Planning Questions and Outline

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Setting Priorities

1. When does your agency consider an individual to be "institutionalized" under the auspices of the Olmstead mandate?

The Department of Behavioral Health defines "institutionalized" as 181 days or more.

2. **What policies/procedures does your Agency utilize for identifying individuals ready and invested for transition into the community?**

The Department of Behavioral Health has a number of policies to support a successful transition to the community. These policies include:

For youth in Psychiatric Residential Treatment Facilities (PRTFs), DBH Policy 200.7 requires a Continued Stay referral. The Continued Stay referral is a clinical packet submitted by the responsible District agency which describes the opinion of the treatment team (to include the youth with his/her parent(s)/guardian(s)) regarding whether or not the youth would benefit from continued treatment within the PRTF or discharge into the community. This policy supports the work of the DBH staff assigned to work with the youth while they are in a PRTF. The staff participates in monthly treatment team meetings for youth in the PRTF.

DBH Policy 525.4 details the practice guidelines for community integration of consumers in institutional settings. This policy provides guidance to community mental health providers who are required to participate in the discharge planning process for consumers who are in institutional settings.

DBH Policy 511.3A TL-174 describes the procedures by which consumers are screened for placement in a nursing facility (NF) using the Preadmission Screening and Resident Review (PASRR), the review of level of care and appropriateness of a NF for those already in a NF, and the discharge and transition process when NF is no longer indicated in the consumer's level of care.

DBH Policy 200.2B TL-178 establishes specific guidelines to ensure the continuity of care for adult consumers who seek or receive urgent or emergency mental health treatment and supports and/or transfer, as well as adults who are discharged to different levels of care within the mental health system.

3. **How do you communicate with your target population and their families/caregivers/advocates/providers about community-based options?**

   The Department operates a 24 hour/7 days a week Access Helpline which links individuals to community based services. The line receives over 60,000 calls per year and is able to link and/or inform callers about the range of community-based services available to them.

   In addition, the Department has the following activities:

   In FY09, the former Department of Mental health (DMH) through its Office of Consumer and Family Affairs developed a program to utilize individuals who self-identify as mental health clients to assist long term inpatients at Saint Elizabeths Hospital (SEH) transition into the community. The program involves peers in providing 1:1 support and intervention, teaching skills needed to live in the community and being active team members of the evidence-based Critical Time Intervention that assists consumers in their transitions to the community.

   Among the other supports, services, and resources offered by peers is working with consumers who have been admitted to psychiatric hospitals including community hospitals, e.g.Psychiatric Institute of Washington, Providence, United Medical Center, and SEH. Some of the key activities of these initiatives are as follows:

   - Working with the hospital, community providers, and families to facilitate a smooth transition to the community.
   - Providing the highly regarded Wellness Recovery Action Plan (WRAP) services for consumers hospitalized at SEH. WRAP helps individuals who are hospitalized manage their own recovery and health.
   - SEH uses trained peer specialists to facilitate recovery groups.SEH uses peer specialists on medication review panels.

For youth at PRTFs, DBH works with the youth and his/her parent(s)/guardian(s)/family within the PRTFs monthly treatment team meetings.

4. **What procedures or policies do you have in place to allow people with disabilities to assess the quality of the supports they receive?**

   The Peer Transition Specialist Program is designed to assist consumers who have been long term institutionalized at SEH consider and explore community

living and ultimately assist these consumers in leaving the institutional setting for community-based living.

DBH also has a codified grievance procedure available for individuals to use when they feel they have received inadequate or inappropriate treatment or care.

In addition, DBH funds a Peer-run organization, the Consumer Action Network. This organization is responsible for, among other things, conducting regular consumer surveys at the sites in Washington, D.C. where individuals receive care.

DBH clinical monitors continue to monitor Transition Age Youth (youth ages 18-25) discharged from PRTF into placements outside the District of Columbia when these youths continue to receive District services.

5. **What measures has your agency taken to address the needs of the following:**

   a. **Children who receive residential services from District agencies but live outside the District of Columbia.**

      DBH clinical monitors continue to monitor youth discharged from PRTF into placements outside of the District of Columbia when these youth continue to receive District services.

      Children/youth who live outside of the District of Columbia but who receive District services such as youth in the care and custody of Child and Family Services Administration (CFSA) are eligible for services offered through DBH.

   b. **Adults who receive residential services from District agencies but reside outside the District of Columbia.**

      If adults are being served by another District agency, they are eligible for all DBH services. For example, when consumers are transitioning to a nursing home and have been known to DBH, that provider may stay involved with that individual.

   c. **Individuals who are long-term homeless and seeking permanent housing.**

Individuals who are long-term homeless and seeking permanent housing are a priority for a DBH housing voucher.

d. Individuals who are soon to be released from jail/juvenile detention facilities.

DBH has a structure in place to coordinate service with the Department of Youth and Rehabilitation Services (DYRS).

e. Individuals who are receiving services, but still have significant unmet needs which put them at risk of placement in non-community-based settings.

DBH's Division of Integrated Care has responsibility for ensuring individuals discharged from psychiatric hospitalization are linked to a community provider within seven (7) to thirty (30) days.

DBH has implemented high utilizer meetings for both children and adults to ensure that community services are available to high risk individuals, as well as ensuring that services are well coordinated.

f. Individuals not receiving formalized services but who live with a family member unable to support them effectively.

DBH offers crisis services available to any District resident. These include mobile crisis services for adults and youth. These teams of mental health professionals and specialists are available to respond to an individual who is not currently involved with the treatment system. Since police officers are first responders to families that may have an individual experiencing a psychiatric crisis in many situations, DBH has worked with the Metropolitan Police Department (MPD) to develop the Crisis Intervention Officer (CIO) program. Since 2009 DBH and MPD have trained over 600 MPD officers.

In addition, the Department operates two mental health clinics that provide same day or urgent care service to any District resident.

Interagency Collaboration

6. Explain specifically how your agency works with other participating agencies, District residents, and community stakeholders. Please identify

the agency/agencies (Government and Community-based) and consider the following:

The DBH Child Division works with the Child and Family Services Agency (CFSA), Department of Youth Rehabilitation Services (DYRS), District of Columbia Public Schools (DCPS), Department of Disability Services (DDS), Health Services for Children with Special Needs (HSCSN), the Office of the State Superintendent of Education (OSSE), and the District of Columbia Superior Court (DCSC).

DBH Adult Services has collaborative relationships with Department of Human Services (DHS), Department of Housing and Community Development (DHCD), Department of Housing Authority (DCHA), Metropolitan Police Department (MPD), Department of Disabilities Administration (DDA), Office on Aging, and the Department of Health Care Finance (DHCF).

a. **Recommend community services and supports that allow an individual to select services and supports designed for their specific needs**.

   DBH's policies are based on choice and selection of providers according to each individual's desire and need.

b. **Develop effective and timely transition plans for individuals who are placed in non-community-based settings**.

   DBH policies require the community providers to be active participants in working with individuals who are in PRTFs, SEH, and nursing facilities.

c. Conduct outreach on your services or other participating agencies' services specifically geared toward your service population.

   DBH's policies require its provider network to provide outreach to individuals who are living in an institutional setting.

   In addition, DBH has worked with other agencies to offer a session called Family Talk which is intended to inform parents of PRTF treatment, discharge, and community-based services. This session has been supported by numerous agencies (including DCPS, DYRS, OSSE, CFSA,

DHCF, DCSC, and Health Services for Children with Special Needs (HSCN)).

Addressing Barriers

7. **How does your agency address any or all of the following barriers to successful provision of community-based supports for individuals with disabilities? Note: address only those populations applicable to your agency's mission and vision.**

   a. **Lack of comprehensive information on the supports and services available.**

      DBH keeps its webpage up-to-date to inform the community on its supports and services. In addition, we work with community groups such as Consumer Action Network National Alliance on Mental Illness-DC (NAMI), family groups, and peer operated services to provide information on services and supports available through DBH's network.

   b. **Scarcity of accessible, affordable, integrated housing.**

      DBH is committed to the availability of accessible, affordable, integrated housing. The agency provides over 800 housing subsidies a year to DBH consumers which are consumer-based, i.e. the consumer can use it for any appropriate housing they choose. Additionally the agency works aggressively to develop accessible, affordable, integrated housing. It has had a partnership with DHCD for the past five years and made more than $26 million available for the development of new or renovated housing units for the exclusive use of our consumers. More than 181 units have been built and are occupied and an additional 155 units are under development. This is an on-going initiative, and the agency requests additional funding for continued development in its annual budgets.

   c. **Unavailability of support services to assist with daily life for individuals with severe disabilities, such as education, transportation, and employment.**

      Through a program called Supported Employment, DBH helps people with mental illness find and keep full or part-time jobs in the community. The

jobs pay minimum wage or higher and are based on individual interests and abilities.

d. Insufficient numbers of compensated, trained employees to work with the population of people with disabilities.

The Department of Behavioral Health operates the most comprehensive behavioral health training program in the District, called the DBH Training Institute. The Training Institute produces over 150 training events annually. Topics relate to identified system needs determined by agency goals, compliance/audit data, and other sources including needs identified by mental health clients.

e. Post-discharge into community-based living with subsequent assessment that transition is not meeting the needs of the individual.

DBH has structure in place to provide support and assistance to providers who are working closely with individuals leaving institutional settings.

Depa rtme nt on Dis a bil it y S e r vic e s (DDS) FY ' 1 5 O lms tea d Pla nning O utli ne

Setting Priorities

1. **When does your agency consider an individual to be "institutionalized" under the auspices of the Olmstead mandate?**

   The Department on Disability Services ("DDS"), Developmental Disabilities Administration ("DDA") uses 91 days or more for the purposes of the Money Follows the Person ("MFP") program. However, through policy and procedure, discussed below, every nursing facility referral for a person who receives supports from DDS/ DDA is reviewed by the DDS Human Rights Advisory Committee ("HRAC"), and the agency begins to engage in transition planning for the person to return back to the community immediately, starting from the day of admission.

2. **What policies/procedures does your Agency utilize for identifying individuals ready and invested for transition into the community?**
   It is DDS's policy to ensure that all people who receive support from the DDA service system have access to and receive quality supports, services, and health care in the most integrated, least restrictive community-based setting appropriate to their needs. This is reflected in a range of policies and procedures including: Human Rights policy and Human Rights Advisory Committee (the Committee) procedure; Individual Support Plan ("ISP") policy and procedure; Most Integrated Community Based Setting policy; Out of State Placement policy; and the Nursing Facility Placement policy (all available on-line at http://dds.dc.gov/page/policies-and-procedures-dda.)

   As an example, the DDS Nursing Facility Placement policy defines acceptable uses for nursing facilities for people with intellectual disabilities who receive supports from DDA as follows:

   - The person has a need for a time-limited stay following hospitalization and his or her rehabilitation requires the availability of skilled nursing staff on a twenty-four (24) hour basis. The referral and placement must be directly related to a hospitalization discharge recommendation; or

   - The person has a need for medical supports that minimize deterioration in abilities and maximize quality of life and cannot be provided in the individual's current level of care, nor can it be met in a more intensive community-based alternative, such as an Intermediate Care Facility for Individuals with Intellectual Disabilities ("ICF/IID"); and facility and

community-based interventions are currently unavailable to address the person's medical support needs.

Additionally, the HRAC reviews each proposed nursing facility placement to determine whether it is the least restrictive and most appropriate setting to meet the person's needs. The Committee also establishes the schedule and recommendations for on-going review.

All placement decisions are determined based upon the person's assessed needs and preferences. Developmental Disabilities Administration (DDA) begins transition planning as soon as the person is admitted to a facility to ensure that he or she can return to an integrated, community-based setting, preferably his or her home, as soon as possible, given the person's health condition and need for ongoing medical treatment and therapies. At times, a person may be able to return to a more integrated community setting, but may not be able to return to his or her home because he or she needs an increased level of care, or, if given the length of stay in the nursing facility, the person's placement in a particular residential facility is no longer available. Federal Medicaid rules prohibit payment to the person's residential provider for any days when the person is in a nursing facility. To ensure that people are able to return to their homes, when appropriate, the Medicaid Home and Community-Based Services Waiver for Individuals with Intellectual and Developmental Disabilities ("HCBS IDD Waiver") rates do include a vacancy factor so that providers are able to hold a person's place in the home for short-term stays at a hospital, nursing facility, or other institution.

Finally, it is DDA's practice to use Person-Centered Thinking ("PCT") for all service and support planning. Michael Smull, one of the national experts on PCT, with whom DDS is working closely, describes PCT skills as follows: "At their core all of these skills are about how we can help people who traditionally have led isolated lives, lead ordinary, self-directed lives, within their own communities. The skills are about supporting people as ordinary citizens while recognizing (and accounting for) their unusual support needs." http://www.nasddds.org/pdf/importanceofpersoncenteredthinking5a.pdf.

DDA is engaged in implementing PCT throughout not only the agency, but the entire IDD support and service delivery system. DDA currently has five (5) certified PCT trainers on staff, and is training two (2) additional staff members; with additional trainers planned in FY 2015. These trainers offer

ongoing PCT training for DDA staff and provider agencies, both on site at DDS and at provider agencies to facilitate attendance. Once the new trainers are certified, they will assist with providing PCT training to providers, families, and people served by DDA.

3. **How do you communicate with your target population and their families/caregivers/advocates/providers about community-based options?**

   DDS communicates with the people we serve and other stakeholders in a variety of ways; including hosting community forums, attending community events, e-mails, the DDS website, and use of social media. We have a stakeholder outreach list that includes more than 700 people, many of whom are grass-top leaders who will help spread the word. As an example, in the spring, we hosted a series of forums to educate the community and receive feedback on proposed changes to the HCBS IDD waiver. We held a community forum at the Gateway Pavillion in Anacostia, accessible to where many of the families of the people we support live. We also presented at Project ACTION!, D.C.'s advocacy group for people with intellectual disabilities and the DC Coalition of Providers of Developmental Disabilities Services among other places. As a result, we received extensive comments on the proposed waiver amendments and made changes, accordingly, to reflect community input.

   For people who receive supports from DDA, PCT tools and skills are now an integral part of the ISP pre-planning process. The tools identify the interests, preferences, preferred environments, support requirements, and provide important information for the development of ISP goals and programmatic activities that are meaningful to the person and lead to support delivery in the most integrated, least restrictive setting appropriate to the person's needs. DDA also offers home and community-based services to persons who reside in ICF/IID settings during annual planning meetings and at any other time a person or their support team expresses an interest in home and community-based services.

4. **What procedures or policies do you have in place to allow people with disabilities to assess the quality of the supports they receive?**
   DDA has automated all of its performance metrics, and the data we collect is used to provide relevant information to assist consumers in choosing service providers. The system may also be used to evaluate our staff, providers, and

performance on a monthly basis for corrective action and quality improvement initiatives. Additionally, DDA posts the results of our Provider Certification Review process on our website, as well as provider reports cards, and listings of providers who are currently under sanctions. For District licensed facilities, the Department of Health, Health Regulation and Licensing Administration also posts results of its surveys and investigations on its website. In FY 2014, DDA re-joined the National Core Indicators (NCI) project. NCI is a voluntary effort by public developmental disabilities agencies to measure and track their own performance. The core indicators are standard measures used across states to assess the outcomes of services provided to individuals and families. Indicators address key areas of concern including employment, rights, service planning, community inclusion, choice, and health and safety. Results are drawn through interviews with people who receive services, and through responses from mailed surveys to families and guardians. The results are prepared by the Human Research Institute (HSRI) and the District will be able to compare its performance against forty (40) other participating states.

RSA provides people or, as appropriate, their representatives with information and support services to assist the person in exercising informed choice. Informed choice begins when the person first contacts RSA to apply for Vocational Rehabilitation ("VR") services and continues throughout the rehabilitation process. An applicant or a person eligible to receive VR services has the right to exercise informed choice in decisions related to the provision of VR services including: the provision of assessment services, choices among the methods used to procure VR services, the selection of the employment outcome, the specific services needed to achieve the employment outcome, and the entities that will provide the services to help them achieve their employment outcome.

To ensure that the availability and scope of informed choice is consistent, in accordance with 34 C.F.R. § 361.52 (c) (1), the information provided includes:

- Costs, accessibility, and duration of potential services;
- Consumer satisfaction with those services to the extent that information relating to consumer satisfaction is available;
- Qualifications of potential service providers;
- Degree to which services are provided in integrated settings; and
- Outcomes achieved by people working with services providers, to the extent that such information is available.

In FY 2013, DDS RSA added to the Office of Quality Assurance and Compliance two (2) new employees whose primary focus is to monitor the

quality and effectiveness of Supported Employment and Job Placement services provided by RSA's Community Rehabilitation Programs ("CRPs"). A robust monitoring tool was developed to better qualify each CRP's performance. Based on the data submitted to RSA by the CRPs, the Agency develops a Provider Profile showing each provider's performance for the covered time period. Data presented includes:

- Number of referrals per service area;
- Number of referred persons returned to the Agency;
- Number of people placed in employment;
- Number of employed people successfully employed for 90 days through DDS RSA;
- Average number of days between referral and employment;
- Average number of hours worked per week;
- Average hourly pay;

Currently, this information is provided to the VR supervisors and counselors for sharing with people receiving VR services. The agency is developing a CRP module through which this information will be available electronically.

5. What measures has your agency taken to address the needs of the following:

a. Children who receive residential services from District agencies but live outside the District of Columbia.

DDA works closely with the Child and Family Services Agency ("CFSA"), the Office of the State Superintendent of Education ("OSSE"), the District of Columbia Public Schools ("DCPS"), the Department of Youth Rehabilitation Services ("DYRS") and Health Services for Children with Special Needs ("HSCSN"). Our mission is to identify children who have been placed in out of state residential facilities at least two to three years prior to aging out of such services so that DDA can ensure timely submission and completion of applications for eligibility determinations for adult services. If eligible for adult services, DDA works with the sister agencies, families, guardians, and youth to prepare transitions back to the District for community-integrated supports as indicated based on person-centered planning. DDS is guided by statute, policy, and best practices; it ensures that transitioning youth receive services in Medicaid funded community-integrated services. *See* D.C. Official Code § 7-761.05(9).

RSA has worked with staff from DCPS, CFSA, and DBH to identify DC youth, receiving secondary education outside of the District, to give them the opportunity to apply to RSA. RSA also provided training to all DBH supervisory staff on the VR process to facilitate effective referral of cases when a youth is transition back to the District from an out-of-state facility. A presentation to provide an overview of the RSA process is planned for DBH staff. RSA has also invited representatives from DBH to provide input and feedback on the development of the RSA Youth in Transition Toolkit, which describes the RSA process and expectations for when a youth applies for RSA services.

b. Adults who receive residential services from District agencies but reside outside the District of Columbia.

Since 2007, DDA has returned 263 District residents to District based community-integrated services from out-of-state residential placements. Currently, eleven (11) people remain out-of-state in Medicaid funded home and community-based settings as the DDA worked to honor their preference to remain with long-standing friends and service providers. Four (4) people continue to be served in locally funded settings as a result of agreements with guardians to permit their family members to remain where they have lived, in some cases, for over thirty years. Three (3) people receive specialized, locally funded treatment services out-of-state that are currently unavailable in the District.

c. Individuals who are long-term homeless and seeking permanent housing.

For people who are homeless and seeking permanent housing, one of the most important issues is lack of steady and adequate income. RSA's focus is to help them obtain employment, but the reality is that the rehabilitation process can be long, and the need for housing/shelter is acute. Housing stability is a challenge for many of the people RSA serves because they have limited or no income. Currently, 1,874 RSA clients receive SSI or SSDI, while many of the other people served are already relying on family or friends for support.

RSA Counselors provide information at intake about housing and homeless services, which includes information about available programs; and if

necessary, help connect people by making the call and providing transportation to get to the shelter.

RSA also supports many of the related issues that homeless people confront, including access to health care, deficits/gaps in education/literacy, and transportation issues. RSA provides assistance with these services, *e.g.*, health services that are necessary to accomplish a vocational goal can be funded with VR funds. Transportation is provided as an adjunct service with any other service provided. RSA also works with OSSE and adult literacy programs to coordinate services.

For people who are homeless and applying to DDA for supports, DDA uses local funds to provide emergency respite for short-term housing until eligibility can be determined. Once determined, DDA uses person-centered planning to identify community-based residential and other supports that will meet the person's assessed needs. If the person is found ineligible, DDA will connect him or her with appropriate community resources. Occasionally, a person who already receives supports from DDA may become homeless due to illness, hospitalization, or death of his or her primary support person in the home, or because there is an allegation of abuse or neglect by the person's caregiver. In those instances, DDS also uses local or Medicaid funds to provide emergency respite and then uses person-centered planning for long term supports.

d. Individuals who are soon to be released from jail/juvenile detention facilities.

DDA supports people eligible for services who are pending release with a full range of housing and supportive services based on person-centered planning.

e. Individuals who are receiving services, but still have significant unmet needs which put them <u>at risk</u> of placement in non-community-based settings.

DDA currently does not experience challenges with meeting unmet needs that could place a person at risk of placement in non-community settings except as noted above. In cases where specialized services are not available, it seeks to recruit specialized providers from across the country to develop services in the District to avoid out-of-state placements.

f. Individuals who do not receive services but are known to have unmet needs that put them at risk for placement in non-community-based settings.

DDS recently applied for a grant for "Transforming State Long Term Services and Supports ("LTSS") Access Program and Functions into a No Wrong Door System for All Populations and All Payers. The proposal development process brought together over 20 partners who are committed to working together to create more streamlined and person-centered approaches for people with disabilities and others in need of LTSS. The proposal will also make it easier for people of all ages, disabilities and income levels to learn about and access the services and supports they need. If awarded, this grant will help facilitate access to community-based services and person-centered planning for people with unmet needs who are at risk for placement in non-community based services.

g. Individuals not receiving formalized services but who live with a family member unable to support them effectively.

In May 2013, DDA, in partnership with the Developmental Disabilities Council ("DD Council"), was awarded the "National Community of Practice: Supporting Families Throughout the Lifespan" grant. This grant is funded by the Administration on Intellectual and Developmental Disabilities ("AIDD") and is managed by a partnership between the National Association of State Directors of Developmental Disabilities Services ("NASDDDS"), University of Missouri Kansas City Institute for Human Development ("UMKC-IHD"), Human Services Research Institute ("HSRI"), and the National Association of Councils on Developmental Disabilities ("NACDD").

The National Community of Practice: Supporting Families Throughout the Lifespan grant provides funding and technical support to develop systems of support for families throughout the lifespan of their family member with an intellectual or developmental disability. "The overall goal of supporting families, with all of their complexity, strengths, and unique abilities is so they can best support, nurture, love, and facilitate opportunities for the achievement of self-determination, interdependence, productivity, integration, and inclusion in all facets of community life for their family members"— Building a National Agenda for Supports to Families with Member with I/DD, 2011.

Through this five (5) year grant, DDA, in collaboration with the DD Council, Project ACTION!, the Quality Trust for Individuals with Disabilities, and the Georgetown Center for Excellence in Developmental Disabilities, has convened a team of family members, people with IDD, and other government and community partners, to develop and implement an action plan that ultimately will shape policies and programs that support families. Through our work with the State Team, we have strengthened two-way communications with people with developmental disabilities and their families throughout the lifespan and have begun to identify and address gaps. As an example, a consistent message from families has been about the need for peer-support across disabilities and across the lifespan. The DC Core Team has been working closely with Health Services for Children with Special Needs and the National Parent to Parent to plan the launch of a DC Parent to Parent chapter. We have also identified many parent leaders in the community who participate in the Community of Practice and will share information back and forth within the community. We have seen increased participation by family members at community meetings.

Interagency Collaboration

6. **Explain specifically how your agency works with other participating agencies, District residents, and community stakeholders. Please identify the agency/agencies (Government and Community-based) and consider the following:**
   a. **Recommend community services and supports that allow an individual to select services and supports designed for their specific needs.**

      DDA has extensive and established policies, procedures, and practices that ensure people who apply for services are connected to government and community services. For persons who apply but are found ineligible for services, the DDA intake service coordinator provides information and referral resources based on the information and assessment materials gathered in the eligibility determination process to the person and their allies. These resources include, but are not limited to:

      - Department of Human Services, Economic Security Administration ("DHS/ESA") for Medicaid, Temporary Aid to Needy Families ("TANF"), Supplemental Nutrition Assistance Program ("SNAP") and other social service benefits;
      - RSA

- Office on Aging, Aging and Disabilities Resource Center ("DCOA/ADRC");
- Department of Behavioral Health (DBH);
- Department of Health Care Finance ("DHCF") for the Elderly and Person with Physical Disabilities ("EPD") waiver;
- Housing Authority ("DCHA");
- Mayors Liaison Services Center ;
- Center for Independent Living ("DCCIL");
- University Legal Services;
- The Quality Trust for Individuals with Disabilities;
- Mary's Center;
- Consumer Action Network;
- Health Services for Children with Special Needs ("HSCSN");
- Rachel's Women's Center;
- Bread for the City;
- Lifeline Partnership; and
- Columbia Heights/Shaw Family Support Collaborative: Parenting Program.

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For persons found eligible, DDA completes numerous assessments and subsequently person-centered planning with the person and their support team. Based on identified needs, the person is provided with an extensive list of formal, informal, government and community services and supports that can meet each need. For paid services, DDA has strict policies and procedures that govern choice of providers from an approved list of qualified providers under the Medicaid programs.

b. Develop effective and timely transition plans for individuals who are placed in non-community-based settings.

DDA participates in the MFP program and offers home and community-based services to persons who reside in ICF/IID settings during annual planning meetings and at any other time a person or their allies request home and community-based services. DDA works collaboratively with OSSE, DCPS, CFSA, and DBH to identify people with intellectual disabilities who are placed in non-community-based settings and are or may be seeking transition to community-based services and supports. Once identified, DDA works with the person and sister agencies to

complete eligibility determinations, assessments, person-centered planning, and a transition plan to community services.

DDA is also notified of all nursing home placements within the District for persons who are suspected to have an intellectual or developmental disability through the Preadmission Screening and Resident Review ("PASRR") process. Upon such notice, DDA conducts a PASRR evaluation and (a) determines if such placement is appropriate, (b) determines if supportive services are required to assist the person to assess the community or receive habilitative supports while in the nursing home, and/or (c) prepares to work on transitioning the person from the nursing home to community supports, if not already known to DDA. Lastly, DDA receives referrals from the ADRC and utilizes its intake service coordination team to assist eligible persons for DDA services to transition from nursing homes to community services.

c. Conduct outreach on your services or other participating agencies' services specifically geared toward your service population.

DDA regularly conducts outreach on services and supports available for people with intellectual disabilities. Outreach venues include, but are not limited to:

- RSA
- HSCSN, including at the June Fair and Family and Community Health Expo
- DC City Wide Transition Fair
- Mayors Disability Awareness Expo
- Public and charter school fairs
- OSSE events such as the Transition Professional Development Series and the OSSE CIRCLES Transition meeting
- DC Superior Court, Pretrial Services, Drug Court
- Seeking Equality Empowerment and Community ("SEEC")/ Smithsonian Project SEARCH
- Public Defender Service Re-entry Summit

RSA conducts outreach through a number of means:

- RSA has established Memoranda of Agreement with a number of District agencies and community based non-profit social services and health providers. Through these agreements, RSA currently accepts

referrals, conducts intakes, and sees clients at a variety of sites across the District. These include:

- 4 DOES sites
- 3 Unity Clinics
- Project Empowerment
- N Street Village, Inc.
- Mayor's Liaison Office DC Superior Court
- Ethiopian Community Center
- Office of Asian Affairs
- Salvation Army (Harbor Lights Treatment Program)
- Aging and Disability Services
- GW Acute Rehabilitation
- Washington Literacy Center
- Independent Living Services (Urban League)
- Columbia Lighthouse for the Blind
- Providence Hospital
- S.O.M.E. Veterans
- Langston Lane Apartments
- Community of Hope
- S.O.M.E
- Harvest House
- New Endeavor's for Women
- Central Union Mission.

- VR counselors from RSA's transition unit visit all District Public High Schools, all Public Charter Schools, the Model Secondary School (Gallaudet University) and all non-public schools that serve transition-aged District youth. The counselors conduct intakes and provide information about services to students, their families, and school staff.

- RSA developed a number of materials to improve outreach. A printed application for services is widely available in the community. The application is also available on the agency's website. In addition, as indicated above, the agency worked with SchoolTalk, Inc., OSSE, DCPS, DBH, and The Arc to develop a Transition Tool Kit for youth and their families. Lastly, the administration developed an orientation video regarding VR services that is shown at intake and is available on the agency's website.

The outreach efforts over the past year have been successful. RSA has seen continued growth in the number of new referrals. There was an increase from 2,380 referrals in FY 2012 to 3,141 in FY 2013. This increase continued in FY 2014.

Addressing Barriers

7. **How does your agency address any or all of the following barriers to successful provision of community-based supports for individuals with disabilities? Note: address only those populations applicable to your agency's mission and vision.**
   a. **Lack of comprehensive information on the supports and services available.**

      As part of the 2014-2016 State Plan for Independent Living, the DCCIL plans to create a How-to Information Guide for distribution to the community that will promote understanding of local housing requirements for persons with significant disabilities. The State Independent Living Council ("DCSILC") will advise the RSA and DCCIL in these efforts through community outreach and advocacy, with the end goal of ensuring that the guide bridges the knowledge gaps consumers have on the array of Independent Living services and supports available to them. The DCSILC will also advocate and provide testimony in reference to improved housing opportunities for people with disabilities before the Mayor and DC Council.

   b. **Impacts of transitioning to life in the community: discrimination, fear, and stigma.**

      DDS works closely with its service provider community to ensure community and neighborhood relations are developed and maintained to help mitigate stigma and negative perceptions among community members, especially as it pertains to NIMBY issues. DDS also presents at community meetings, ANC meetings, and hiring events, for example, to advance education about the rights and contributions of people with disabilities. DDS supports fully community-integrated services and through those efforts has significantly increased the opportunities of persons with disabilities to receive services in settings where people without disabilities live, work, and play, thus advancing the overall awareness and enrichment of our community at-large. DDS is now

working on other media campaigns that will continue to educate our community to embrace and value all members of our city.

c. Unavailability of support services to assist with daily life for individuals with severe disabilities, such as education, transportation, and employment.

The most significant deficit in the District's services and support for people with disabilities is for persons with developmental disabilities and brain injury who are not eligible for services from DDA or the EPD waiver program. These are constituents in the program operated by DHCF. Despite its name, DDA is only authorized to serve people with intellectual disabilities, narrowly defined as persons with an IQ of 70 or below and deficits in at least two areas of adaptive functioning such as communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work, established prior to the age of 18 years of age.[ii] Due to the nature of developmental disabilities and brain injuries, these persons require supports and may be at significant risk for institutionalization but are not eligible for any services in the District.

The District remains one of two jurisdictions in the nation to only provide services to people with ID and not DD. DDS has supported expanding its statute to serve people with DD within available appropriations and previously met opposition by the advocacy community as it may lead to waiting lists for services where none existed in the past. Despite this, it is imperative that the District again seek to expand its eligibility under DDA to serve this population to avoid unnecessary institutionalization of persons with DD.

A second under-served population is persons who experience brain trauma and the injury results in significant cognitive impairments. Again, those persons are not eligible for services from DDA if the injury occurred after age 18. Additionally, if they are not physically disabled, they are not eligible for services under the EPD program. The number of persons who experience brain injury is growing via service related injuries, vehicle accidents, and gun violence. As a result, this is another population that often must rely on nursing facilities for support.

Another significant barrier to community living is the absence of the Medicaid Buy-in Program for Working People with Disabilities ("MBI-WPD") in the District. The MBI-WPD is a program that allows individuals with disabilities to work and get or keep Medicaid. Many persons with significant disabilities are unable to obtain employer-funded private health insurance that provides coverage comparable to Medicaid. The fear of losing Medicaid and/or Medicare is one of the greatest barriers keeping individuals with disabilities from maximizing their employment, earnings potential, and independence. For many Social Security Disability Insurance ("SSDI") and Supplemental Security Income ("SSI") beneficiaries, the risk of losing health care through work activity can be a greater work disincentive than the risk of losing cash benefits through work activity.

For people who receive supports from DDA, the DDS HRAC has identified ventilator-use as a systemic barrier to community based living, albeit one that affects a small number of people DDA supports. The HRAC made a recommendation to the DDS Deputy Director for DDA to research barriers and propose solutions. DDS has begun discussions on this issue with DHCF and the Department of Health ("DOH").

Finally, the RSA Vocational Rehabilitation ("VR") program is able to provide time limited supports to help people with significant disabilities move to employment. When people need extended supports to maintain employment, RSA attempts to develop a plan including natural supports through its VR program. Long term employment supports are currently available for people with intellectual disabilities through the Home and Community Based Services waiver for People with Intellectual and Developmental Disabilities ("HCBS IDD") waiver. However, long term supports are more difficult to identify for people with physical or other disabilities, and the EPD waiver currently lacks long-term employment supports in its benefit package. Ticket to Work does provide some job retention support, but for a person who needs ongoing supported employment, this level of support is not adequate.

d. Insufficient numbers of compensated, trained employees to work with the population of people with disabilities.

Currently, DDS is not experiencing significant problems with the ability to retain trained employees to work with the population of people with

disabilities. Our current vacancy rate in key service positions working with individuals with intellectual disabilities (service coordination) is approximately 7%, which is a reasonable and expected rate allowing for normal turnover. The current vacancy rate for VR specialists is 13% and this is a bit higher than ideal, but during the recent year it has been very low and the 13% is not a long term rate. DDS keeps the vacancy rates low through active, targeted recruiting.

The ability of the disability service providers to recruit and retain trained individuals is a bit more of a concern particularly in regards to clinical staffing. DDS has taken steps to assist the providers in their staffing by retaining professional services to develop a series of advertisements to recruit clinical professionals into the disability field in the District of Columbia. At this time, we are waiting for service provider input prior to launching the advertising campaign. Additionally, working collaboratively with DHCF, DDS is submitting an amendment to the HCBS IDD waiver that would raise the rates for a number of clinical services in an effort to increase provider capacity in this critical area.

e. Post-discharge into community-based living with subsequent assessment that transition is not meeting the needs of the individual.

DDA provides ongoing service coordination for people with intellectual disabilities who transition into community-based services through the HCBS IDD waiver. Through our policy and procedure, there are required post-transition visits by a service coordinator to ensure the transition has gone smoothly. The service coordinator will assess how the person is doing in both their new residential and day/vocational setting and add additional supports or make changes in supports as needed, based upon the person's assessed needs and preferences. DDA has also retained a nurse via its quality assurance project contract with the Georgetown University Center for Excellence in Developmental Disabilities ("UCEDD") whose sole function is to monitor the course of care a person receives while hospitalized or in a nursing home. The nurse then conducts follow-up with the community home setting post-discharge to ensure that all health-related discharge orders are being followed.

As part of the State Plan for Independent Living, the DCSILC has taken on the charge of advocating for city-wide implementation and education to support and campaign to improve transition planning for people who are

on track for discharge from institutional or other restrictive settings. The DCSILC will monitor such planning to ensure that person-centered thinking is the focus of all such planning. The DCSILC will also advise RSA, other District government, and community agencies to achieve an Independent Living services and supports system that ensures planning for independence across the lifespan.

Additionally, the DCCIL provides advocacy and peer support services to people with disabilities.

Depa rtme nt of Hea lthc a re Fina nce (DHCF) FY ‘ 1 5 O lm s te a d Pla nning O utli ne

Setting Priorities

1. **When does your agency consider an individual to be “institutionalized” under the auspices of the Olmstead mandate?**

   Department of Healthcare Finance (DHCF) defines “institutionalized as 91 days or more.

2. **What policies/procedures does your Agency utilize for identifying individuals ready and invested for transition into the community?**

   DHCF works in partnership with the DC Office on Aging/Aging & Disability Resource Center (DCOA/ADRC) and DDS/DDA Department on Disability Services/Developmental Disabilities Administration (DDS/DDA) to identify individuals ready for and invested in transition. This is consistent with the agency’s Centers for Medicare and Medicaid Services approved Money Follows the Person (MFP) Rebalancing Demonstration Operational Protocol and Memoranda of Understanding between DHCF and DCOA/ADRC on MFP outreach to nursing facilities and operating as the intake and referral entity for the Elderly and Physical Disabilities (EPD) Home and Community-Based Services Waiver.

3. **How do you communicate with your target population and their families/caregivers/advocates/providers about community-based options?**

   Through its MFP Rebalancing Demonstration, DHCF conducts outreach to all District nursing facilities on a monthly basis in collaboration with the DCOA/ADRC. A monthly stakeholder meeting is convened by MFP as well. During FY 2015, the responsibility for convening the stakeholder meeting will be transitioned to DCOA/ADRC, the agency assuming the responsibility for MFP operations for DC residents transitioning from nursing facilities. The Demonstration also offers individualized consultation in service planning meetings about community-based options for residents of Intermediate Care Facilities for people with Intellectual and Developmental Disabilities (ICFs/IDD) at the request of residents and/or DDA service coordinators.

DHCF hosts monthly provider meetings for its EPD Waiver and Medicaid State Plan providers of home and community-based services.

DHCF's web site also features participant handbooks that include home and community-based options for its Medicaid Fee-for-Service beneficiaries and Elderly and Physical Disabilities Waiver Program participants.

4. What procedures or policies do you have in place to allow people with disabilities to assess the quality of the supports they receive?

The MFP Rebalancing Demonstration, through its operating agencies, DCOA/ADRC and DDS/DDA, administers a Quality of Life survey immediately before transition from a long term care facility and at 11 and 24 months after discharge from the long term care facility to home and community-based services.

DHCF solicits feedback from people with disabilities during planning and design for home and community-based services. This process provides people with disabilities the opportunity to comment on the quality of services.

5. What measures has your agency taken to address the needs of the following:

a. Children who receive residential services from District agencies but who live outside the District of Columbia.

b. Adults who receive residential services from District agencies but who reside outside the District of Columbia.

Through its MFP Rebalancing Demonstration, DHCF supports transition coordination for Medicaid beneficiaries who are placed in out-of-state nursing facilities and ICFs/IDDs. These referrals come directly or through the Demonstration's operating agencies (DCOA/ADRC, DDS/DDA).

c. Individuals who are long-term homeless and seeking permanent housing.

Through its MFP Rebalancing Demonstration, when housing financing is available (either through Housing Choice Voucher or other housing subsidies through the DC Housing Authority), DHCF supports transition coordination for

Medicaid beneficiaries who are long-term homeless and currently residing in a nursing facility, and remain there in large part because they do not have a home to return to.

d. Individuals who are soon to be released from jail/juvenile detention facilities.

e. Individuals who are receiving services, but who still have significant unmet needs which put them <u>at risk</u> of placement in non-community-based settings.

f. Individuals who do not receive services but are known to have unmet needs that put them at risk for placement in non-community-based settings.

g. Individuals not receiving formalized services but who live with a family member unable to support them effectively.

Through its MFP Rebalancing Demonstration, DHCF supports individualized consultation for these families when referred by DDS/DDA.

<u>Interagency Collaboration</u>

6. Explain specifically how your agency works with other participating agencies, District residents, and community stakeholders. Please identify the agency/agencies (Government and Community-based) and consider the following:

a. Recommend community services and supports that allow an individual to select services and supports designed for their specific needs.

See responses above regarding the MFP Rebalancing Demonstration. In addition, when it is identified that a participant has a serious and persistent mental illness, the compilation of documentation required for DBH services is initiated by MFP Transition Coordinators (TCs), and review and approval, if appropriate, is facilitated by the TCs.

DHCF has a Memorandum of Agreement with DCOA/ADRC and DBH that outlines roles and responsibilities specifically for the purpose of transitioning nursing facility residents.

b. Develop effective and timely transition plans for individuals who are placed in non-community-based settings.

See responses above for the MFP Rebalancing Demonstration.

DHCF has a Memorandum of Agreement with DCOA/ADRC and DBH that outlines roles and responsibilities specifically for the purpose of transitioning nursing facility residents.

c. Conduct outreach on your services or other participating agencies' services specifically geared toward your service population.

DCOA/ADRC, Department of Behavioral Health (DBH), DDS/DDA
See responses above for the MFP Rebalancing Demonstration.

DHCF has a Memorandum of Agreement with DCOA/ADRC and DBH that outlines roles and responsibilities specifically for the purpose of transitioning nursing facility residents.

Addressing Barriers

7. How does your agency address any or all of the following barriers to successful provision of community-based supports for individuals with disabilities? Note: address only those populations applicable to your agency's mission and vision.

a. Lack of comprehensive information on the supports and services available.

DCHF has developed accessible, easy-to-read handbooks on Medicaid home and community-based services as noted above, and they are posted on DHCF's Web site.

Monthly face-to-face outreach and meetings as noted above.

b. Impacts of transitioning to life in the community: discrimination, fear, and stigma.

Through the MFP Rebalancing Demonstration, in partnership with the DCOA/ADRC, DHCF delivers intensive case management services during the first year after discharge from a nursing facility.

DHCF anticipates that the operationalization of the Peer Counseling MFP Demonstration service through DC Medicaid in FY15 should also help to mitigate these impacts.

c. Unavailability of support services to assist with daily life for individuals with severe disabilities, such as education, transportation, and employment.

MFP Project Team members continue to actively participate in several systems change initiatives aimed at increasing community integration for people with disabilities. Among these are the Association of People Supporting EmploymentFirst (APSE) board and membership meetings, the EmploymentFirst Leadership meeting, and the EmploymentFirst Community of Practice meeting.

d. Insufficient numbers of compensated, trained employees to work with the population of people with disabilities.

Through its MFP Rebalancing Demonstration, DHCF is discussing partnership with DDS/DDA on person-centered thinking training for day program provider staff that focuses on community integration for FY 2015. DHCF rate setting, and mandatory training requirements for long term care home and community-based service providers addresses this factor on a large scale.

e. Post-discharge into community-based living with subsequent assessment that transition is not meeting the needs of the individual.

Through the MFP Rebalancing Demonstration, in partnership with the DCOA/ADRC, the delivery of intensive case management services during the first year after discharge from a nursing facility. These case managers often identify and work to resolve care coordination issues when the transition is not meeting the needs of the individual.

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[i] "District of Columbia Primary Service Agency Priorities," DC—One Community for All pp. 8-9 (April 2012). Available at: http://odr.dc.gov/sites/default/files/dc/sites/odr/publication/attachments/olmstead_community_integration_initiative.pdf.

[ii] There are estimated to be 10,000 persons in the District who have developmental disabilities including; autism spectrum disorders, Spina Bifida, cerebral palsy, Down's Syndrome, Prader Willi Syndrome, borderline intellectual deficits, epilepsy, and other neurological disabilities. *See* Assessment and Analysis of the Service Needs of Washington, D.C. Residents with Intellectual and Developmental Disabilities, June 2011; available online at http://ddc.dc.gov/sites/default/files/dc/sites/ddc/publication/attachments/FinalReportSupportNeedsDCResidents.pdf

Environmental Factors and Plan

18. Children and Adolescents Behavioral Health Services

Narrative Question:

MHBG funds are intended to support programs and activities for children with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults. 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 mental disorder that contributes to substantial impairment in their functioning at home, at school, or in the community.[90] Most mental health 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.[91] For youth between the ages of 10 and 24, suicide is the third leading cause of death.[92]

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.[93] 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 liaison 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 more than 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states. In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidence-based treatment for youth with substance use disorders.

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 substance use disorders and co-occurring disorders 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's, youth's and young adult's functioning in their home, school, and community. The system of care approach provides individualized services, is family driven and youth guided, and builds on the strengths of the child, youth or young adult and their family and promotes recovery and resilience. Services are delivered in the least restrictive environment possible, and using evidence-based practices while providing effective cross-system collaboration, including integrated management of service delivery and costs.[94]

According to data from the National Evaluation of the Children's Mental Health Initiative (2011), systems of care[95]:

- reach many children and youth typically underserved by the mental health system;
- improve emotional and behavioral outcomes for children and youth;
- enhance family outcomes, such as decreased caregiver stress;
- decrease suicidal ideation and gestures;
- expand the availability of effective supports and services; and
- 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 behavioral health 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, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification.

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

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with serious mental and substance use disorders?
2. What guidelines have and/or will the state establish for individualized care planning for children/youth with serious mental, substance

use, and co-occurring disorders?

3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?
4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?
5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?
6. Has the state identified a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse treatment and recovery support services? If so, what is that position (with contact information) and has it been communicated to the state's lead agency of education?
7. What age is considered to be the cut-off in the state for receiving behavioral health services in the child/adolescent system? Describe the process for transitioning children/adolescents receiving services to the adult behavioral health system, including transition plans in place for youth in foster care.

Please indicate areas of technical assistance needed related to this section.

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

[91] 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.

[92] 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.

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

[94] 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 http://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings/PEP12-CMHI2010.

[95] Department of Health and Human Services. (2013). Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions: Joint CMS and SAMHSA Informational Bulletin. Available from http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf.

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

Footnotes:

Environmental Factors and Plan

19. Pregnant Women and Women with Dependent Children

Narrative Question:

Substance-abusing pregnant women have always been the number one priority population in the SAMHSA block grant (Title XIX, Part B, Subpart II, Sec.1922 (c)). A formula based on the FY 1993 and FY 1994 block grants was established to increase the availability of treatment services designed for pregnant women and women with dependent children. The purpose of establishing a "set-aside" was to ensure the availability of comprehensive, substance use disorder treatment, and prevention and recovery support services for pregnant and postpartum women and their dependent children. This population continues to be a priority, given the importance of prenatal care and substance abuse treatment for pregnant, substance using women, and the importance of early development in children. For families involved in the child welfare system, successful participation in treatment for substance use disorders is the best predictor for children remaining with their mothers. Women with dependent children are also named as a priority for specialized treatment (as opposed to treatment as usual) in the SABG regulations. MOE provisions require that the state expend no less than an amount equal to that spent by the state in a base fiscal year for treatment services designed for pregnant women and women with dependent children.

For guidance on components of quality substance abuse treatment services for women, States and Territories can refer to the following documents, which can be accessed through the SAMHSA website at http://www.samhsa.gov/women-children-families: *Treatment Improvement Protocol (TIP) 51, Substance Abuse Treatment; Addressing the Specific Needs of Women; Guidance to States; Treatment Standards for Women with Substance Use Disorders; Family-Centered Treatment for Women with Substance Abuse Disorders: History, Key Elements and Challenges.*

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

1. The implementing regulation requires the availability of treatment and admission preference for pregnant women be made known and that pregnant women are prioritized for admission to treatment. Please discuss the strategies your state uses to accomplish this.
2. Discuss how the state currently ensures that pregnant women are admitted to treatment within 48 hours.
3. Discuss how the state currently ensures that interim services are provided to pregnant women in the event that a treatment facility has insufficient capacity to provide treatment services.
4. Discuss who within your state is responsible for monitoring the requirements in 1-3.
5. How many programs serve pregnant women and their infants? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP.)
    a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
    b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where pregnant women can receive MAT? If so, where are they?
6. How many programs serve women and their dependent children? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP)
    a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
    b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where women can receive MAT? If so, where are they?

Please indicate areas of technical assistance needed related to this section.

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

Footnotes:

Pregnant Women and Women with Dependent Children

The implementing regulation requires the availability of treatment and admission preference for pregnant women be made known and that pregnant women are prioritized for admission to treatment. Please discuss the strategies your state uses to accomplish this.

The Department of Behavioral Health's (DBH) SUD system in the District includes a comprehensive continuum ranging from more intense levels of care, such as Inpatient Withdrawal Management and Residential Treatment, to less intensive services such as Traditional Outpatient Programs and Intensive Outpatient Programs. During Fiscal Year 2014, the District provided comprehensive treatment and recovery services to over 8,600 individuals in care. Individuals seeking services are 67% male and 33% female. Over 48% of the individuals seeking SUD services report having at least 1 dependent child. According to Medical News Today (2005) the national age range for childbearing is 20-35 years old. Likewise, Data from the Birth Data File, National Vital Statistics System (2006) records that the average age of first time mothers increased 3.6 years from 1970 to 2006, from 21.4 to 25.0 years. Average age at first birth increased in all states and the District of Columbia. The District of Columbia increased by 5.5 years making the average age for first birth 26.9 years old. Approximately 273 women (20% of the women's population) in Department of Behavioral Health's treatment system are between the ages of 21-26 years of age. Another 28% of the DBH female population is between 27 – 35 years of age. The total female population between the ages of 21 – 35 is approximately 48%. The Assessment and Referral Center (ARC) is the main point of entry for adults seeking publicly funded treatment. The ARC is a walk-in and appointment-based facility which conducts nursing triages and comprehensive assessments for substance use disorders and other health disorders including HIV/AIDS and mental health. There are 5 other access points for any person seeking entry into treatment throughout the District. Pregnant women reporting to any intake site requesting treatment are assessed for the appropriate level of care and admitted immediately to receive services. Currently, DBH awards and monitors contracts for certified treatment and recovery support services that are on a fee for service basis, The contract allow immediate access to three levels of services: Levels I and II outpatient; Level III inpatient, detoxification, outpatient opioid treatment, and recovery support. These contracts include specialized services such as: adolescents aged 20 and under, pregnant women and women with dependent children; medication assisted therapy; culturally and racially appropriate services for other special populations including those who are HIV positive. Additionally, DBH, the Family treatment Court (FTC) and Child and Family Services Agency (CFSA) collaborate to improve the quality of services for parents in the child welfare system that are in danger of having their parental rights terminated that also require assessment and intensive treatment and case management for substance use issues. Through this collaboration, DBH, FTC and CFSA conduct subject matter trainings across agencies that promote a recovery focus for the parents and interagency partnerships that will ensure the systems interact as a recovery focused partnership.

Discuss how the state currently ensures that pregnant women are admitted to treatment within 48 hours.

Pregnant women reporting to any intake site requesting services are admitted to treatment on demand. Services are provided on the same day that includes; intake, assessment, screening, evaluations, interventions, counseling, HIV testing, pre and post-natal care and linkages to other social services.

Discuss how the state currently ensures that interim services are provided to pregnant women in the event that a treatment facility has insufficient capacity to provide treatment services.

The DBH provider network is providing women only programming in the currently co-ed programs so women have a choice. DBH has created a supportive fiscal structure to meet the needs of pregnant women by enabling providers

to provide specialized services that will promote intensive case management and integrated health care during pregnancy and postpartum until the infant is three years old. The District has “treatment on demand” for any resident seeking services. A person seeking treatment can access care at any of the Districts 5 access points. However, the District has recently implemented gender specific treatment programs that provide services to Pregnant and Post- Partum and Women with Dependent Children. The District is in the process of implementing direct access into those programs in an effort to link women with children into care without having to seek access at the traditional access points. The District also implemented a mobile access unit that provides interim care which includes HIV testing, counseling, TB and other infectious diseases service linkages for individuals who cannot immediately access care. Currently, the District has 32 residential treatment beds and 100 treatment slots specifically allocated for treating this special population. The District plans to expand outpatient services in FY 16-17 to 200 treatment slots.

Discuss who within your state is responsible for monitoring the requirements in 1-3. The Department of Behavior Health’s SUD system-Quality Assurance Office is responsible for ensuring that pregnant women have preference and priority admissions to the treatment program of their choice; pregnant women are admitted within 48 hours of intake; and interim services are provided immediately upon assessment for appropriate level of care. How many programs serve pregnant women and their infants? Please indicate the number by program level of care (i.e. hospital based, residential, IOP, OP.)

The treatment services provided to women and their dependent children (ages zero [0] to five [5] years will also provide services to pregnant women. There is one DBH certified program that provides residential treatment services to pregnant women and women and their children. This program uses a Cognitive Behavioral (CBT) approach along with Motivational Interviewing to treat Substance Use and Co-occurring disorders, with a focus on increasing cognition of compulsive behaviors and then modifying those behaviors. Foundational, the provider uses the stages of change theory and the client’s internal and external motivations for treatment to move the client along the treatment and recovery process. The provider believes in an interdisciplinary model of care. Members of the client’s treatment team include professionals from substance abuse, mental health, physical health, family and community members and other allied health services. The provider strives to also be trauma-informed. As such, there is a basic assumption that everyone who walks through the doors may have experienced at least one traumatic event that has affected his or her life. The provider strives to reduce potential triggers and trauma responses by attending to the environment of and providing supportive, respectful, strengths-based services that empower the client and is based on the client’s individual needs. Evidenced-based treatment models used are Cognitive Behavioral Therapy, Motivational Interviewing, Motivational Enhancement therapy, A Women’s Path to Recovery, and Trauma-Informed Care.

How many of the programs offer medication assisted treatment for pregnant women in their care?

There is one MAT program that provides medication to pregnant women. This provider has specialty services for pregnant women.

Are there geographic areas within the State that are not adequately served by the various levels of care and/or where pregnant women can receive MAT? If so, where are they?

Wards seven and eight are the geographic areas within the District that are not adequately served by various levels of care and/or where pregnant women can receive MAT services.

How many programs serve women and their dependent children? Please indicate the number by program level of

care (i.e. hospital based, residential, IOP, OP).

The DBH provider network provides women only programming in currently co-ed programs so that women have a choice. DBH has two residential providers certified to provide treatment services to pregnant women and their children. Each program provides services for up to 14 homeless and low- income mothers, each with one or two children 10 years old or younger and must have custody of their dependent children. This program uses a Cognitive Behavioral (CBT) approach along with Motivational Interviewing to treat Substance Use and Co-occurring disorders, with a focus on increasing cognition of compulsive behaviors and then modifying those behaviors. Foundational, the provider uses the stages of change theory and the client's internal and external motivations for treatment to move the client along the treatment and recovery process. The provider believes in an interdisciplinary model of care. Members of the client's treatment tem include professionals from substance abuse, mental health, physical health, family and community members and other allied health services. The provider strives to also be trauma-informed. As such, there is a basic assumption that everyone who walks through the doors may have experienced at least one traumatic event that has affected his or her life. The provider strives to reduce potential triggers and trauma responses by attending to the environment of acre and providing supportive, respectful, strengths-based services that empower the client and is based on the client's individual needs. Evidenced-based treatment models used are Cognitive Behavioral Therapy, Motivational Interviewing, Motivational Enhancement therapy, A Women's Path to Recovery, and Trauma-Informed Care.

The second program provides a comprehensive structured 30 day program for men and women treating substance abuse and mental health issues. The provider uses the Cognitive Behavioral Therapy model. Therapy includes; Addiction, Trauma, Co-occurring, family Therapy, Men's and Women's groups, Criminal Thinking and 12-step NA/AA meetings. The provider refers clients to DBH for mental health evaluations and follow-up services for psychiatric mediation and stabilization. The provider refers and escorts client for emergency appointments.

How many of the programs offer medication assisted treatment for the pregnant women in their care?

There is one MAT program that provides medication to pregnant women. The provider believes that opioid addiction is a chronic, progressive, and potentially fatal disease that sometimes requires long term outpatient methadone maintenance treatment. This program believes that appropriate and comprehensive outpatient addiction treatment services include the physical, mental, spiritual, and emotional stabilization of the clients through the use of medication, counseling, and peer self-help support groups and meetings. The provider also believes that it is very important to address each of the client's medial, psychiatric, vocational, and educational needs to provide comprehensive treatment and support, at the same time as treating their addiction. The provider believes that addiction is a disease, not a moral issue; and that recovery is a lengthy and time-consuming process, not a specific or immediate event, which occurs through education, family involvement, and peer self-help group support. Clients are held responsible and accountable for their behavior, actions, and obligations. The provider allows take home medication privileges as incentives. The provider uses empathy, respect, concreteness, and genuineness, Designs an appropriate maintenance period, comprehensive outpatient addiction treatment planning, short term and long term goal setting. Clients are provided with necessary support tools, services and challenges to attain and maintain their recovery. Clients are afforded the opportunity to continue treatment in what is called aftercare treatment and is another important part of the successful outpatient addiction treatment process for clients to maintain their recovery. Additionally, the provider recommends attendance to self-help support groups. It is important for clients to realize that addiction is a holistic process and not one individual entity.

Are there geographic areas within the State that are not adequately served by the various levels of care and /or where women can receive MAT? If so, where are they?

Wards seven and eight are the geographic areas within the District that are not adequately served by various levels of care and/or where women can receive MAT. Please indicate areas of technical assistance needed related to this section Approximately 273 women w/children will need residential treatment services.

Approximately 1,324 total women w/children will need these services across our continuum. The District estimates that we will have the capacity to treat approximately 120 women w/children in residential and 583 in outpatient services per year. For this need the District is requesting Technical Assistance from SAMHSA in the following areas: Engagement in alternate levels of care Waitlist management system and structure Expanding capacity Reducing treatment diversion Enhancing engagement and earlier interventions Integrating TANF and other resources Sustaining school aged children in school Prenatal and Integrated Health Care Developing a supportive care model versus 0 tolerance models Integrating Recovery Support System into existing treatment structure.

Environmental Factors and Plan

20. Suicide Prevention

Narrative Question:

In the FY 2016/2017 block grant application, SAMHSA asks states to:

1. Provide the most recent copy of your state's suicide prevention plan; describe when your state will create or update your plan, and how that update will incorporate recommendations from the revised National Strategy for Suicide Prevention (2012).
2. Describe how the state's plan specifically addresses populations for which the block grant dollars are required to be used.
3. Include a new plan (as an attachment to the block grant Application) that delineates the progress of the state suicide plan since the FY 2014-2015 Plan. Please follow the format outlined in the new SAMHSA document Guidance for State Suicide Prevention Leadership and Plans.[96]

Please indicate areas of technical assistance needed related to this section.

[96] http://www.samhsa.gov/sites/default/files/samhsa_state_suicide_prevention_plans_guide_final_508_compliant.pdf

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

Footnotes:

Suicide Prevention

APRA recognizes that many District youth experience risk factors associated with suicide that include exposure to violence, trauma, poverty and substance abuse. The DC Department of Health works to prevent youth suicide through its Capital CARES Program (Citywide Alliance to Reduce Risk for and Eliminate Youth Suicide) funded through SAMHSA. Capital CARES provides suicide and mental health screenings in schools and in the community with parental consent, trains adults to recognize when a youth is at risk, and funds community based suicide prevention programs for youth with demographic and/or behavioral risk factors for suicide. In addition, the Department of Mental Health (DMH) supports a 24/7 emergency crisis service for youth experiencing a psychiatric or emotional crisis. Teams of mental health clinicians respond to emergency calls whether in schools, the home or community. In addition, trained mental health counselors are available by phone 24/7 on the Suicide Prevention Hotline at 1-800-273-8255.

APRA prevention staff participated in the Capital CARES citywide in order to learn more about dispelling myths and encouraging care for youth and their families may be struggling with depression, thoughts of suicide and other mental health issues. APRA is in the process of merging with DMH to create the Department of Behavioral Health. During this juncture, the District plans to reassess the current suicide prevention plan and make revisions as ne

In addition, APRA has met with the DC General of the National Guard followed by meeting with Drug Demand Reduction Program staff. APRA Office of Prevention is identifying areas for long term partnerships including *Stay on Track Program*, Drug Awareness, DDR Lite All in higher risk geographic areas, Drug Education for Education (DEFY), *Plant the Promise*, and the DC National Guard Challenge Program. APRA is planning meeting with the DC National Guard, the new Army National Guard Program Manager based in the DC area, and the DC Prevention Centers.

Care Coordination: The Access Helpline (AHL) is the DBH call center. It is the major point of entry into the behavioral healthcare system. As of June 2015, there were 79,594 incoming and outbound calls. AHL activities include: 1) enrollment for Mental Health Rehabilitation Services (MHRS); 2) authorization for specialty services including Assertive Community Treatment, Community-based Intervention, Intensive Day Treatment, Rehabilitation Day Services and Crisis Stabilization (crisis beds); 3) authorization and review of involuntary hospitalization admissions; 4) crisis response and deployment of emergency response teams for adults (Mobile Crisis Services) and child/youth (Child and Adolescent Mobile Psychiatric Services); 5) discharge planning and disenrollment from MHRS; 6) coordination of services; and 7) 24-hour access to suicide prevention and intervention services. As of June 2015, there were 45,981 Crisis Line inbound calls, 3,265 DBH Suicide Lifeline calls, and 352 calls to the Washington Metropolitan Area Transit Authority Lifeline (through AHL) for citizens identified within Metro stations who are in need of support.

Suicide Prevention:

The District of Columbia suicide data from the Center for Disease Control (CDC) Fatal Injury Reports (1999-2013) shows that the District is ranked 51 in the nation for suicide deaths with a total of 38 deaths at a rate of 5.9 deaths per 100,000.

There is no current suicide plan. A plan was developed as part of a SAMHSA youth suicide grant that ended in FY 2013. A website was developed (I AM THE DIFFERENCE) along with marketing materials.

While there is no current suicide prevention plan, DBH implements a number of suicide prevention related activities. DBH provides training for the District Metropolitan Police Department at the Policy Academy. The Crisis Intervention Officer (CIO) training includes SafeTalk (suicide alertness) and is provided 5 times a year. Also, all new recruit training includes SafeTalk and is provided between 7-10 times a year.
The DBH Training Institute held six (6) SafeTalk trainings in calendar year 2014 with 103 trainees. In calendar year 2015 there were 3 classes with 65 trainees.

The DBH Access HelpLine is a certified suicide prevention Lifeline. The Washington Metropolitan Area Transit Authority (WMATA) workers have been trained in SafeTalk.

Also, the WMATA Suicide Line is housed in the DBH Access HelpLine.

Technical Assistance Needs: Development of a system-wide suicide prevention plan.

D.C. Suicide Prevention Plan

Goal 1: Promote awareness that suicide is a serious public health problem and that many suicides are preventable			
• **Objectives**	• **Activities**	• **Outcomes Expected**	• **Products/Outcomes as of October 2011**
• Create culturally competent social marketing campaign on risk factors for suicide and depression	• Create a series of multilingual (Spanish, English, Aramaic etc.) posters, brochures to be distributed to schools, recreation centers, collaborative centers, boys/girls' clubs, barber shops, shopping centers, churches, hospitals, detention centers, pediatrician's offices, health fairs, emergency rooms, workshop sites. • Distribute information about suicide prevention through an advertising campaign utilizing billboards, radio ads, television in Spanish and English	• By 2010, 10% of residents of D.C. will have been exposed to some suicide prevention materials • By 2011, 25% of residents of D.C. will have been exposed to suicide prevention materials • By 2015, all residents of D.C. will have been exposed to some suicide prevention materials • Increased # parents will consent for screening. • Increased # groups will request materials.	• Social Marketing Campaign created: I Am The Difference (posters depict youth of difference ethnicities) • Materials distributed widely • Chat and Chews in community planned for Fall • Radio Ads ran end of Aug thru September on WKYS • Radio to run again Thanksgiving thru Christmas • 750,000 people in DC – at least 10% reached via radio, materials •

• Provide information about suicide prevention and awareness to established groups	• Present DC suicide plan and information on suicide prevention to local working groups such as interfaith boards, Mayor's Reconnecting Disconnected Youth Board, School Health Work Group, relevant Boards and Commissions • Collaborate with local mental health associations to reach DC residents (NAMI DC, Mental Health America DC, Mental Health Association of DC)	• Present to established groups by 2010 • Present yearly to update groups and expand efforts	• Have worked with some groups – Children and Youth Directors, Children's Hospital planned in Oct, School nurses planned in Oct, • NAMI and Mental Health America attended our conference
• Collaborate with local conferences and forums and provide awareness and education about suicide prevention and intervention	• Present at local conferences or meetings • Seek out conferences that incorporate faith community as well as Latino, GLBT, school officials.	• Present at local events each year	• Held DC Youth Suicide Prevention conference • Two minigrant partners reaching out to faith community
• Collaborate and partner with other community health programs such as community outreach workers on substance abuse, HIV	• Present jointly at local forums • Train community outreach workers in signs and symptoms of suicide as well as risk factors	• Present at least three local forums or trainings each year	• DOH has a QPR Trainer
Goal 2: Develop broad based support for suicide prevention			
• **Objectives**	• **Activities**	• **Outcomes**	• **Outcomes/Products as of October 2011**
• Establish task force to address youth suicide and to initiate goals of this plan.	• Expand the STOP Suicide Advisory Board to include representatives from other agencies including: Mayor's Executive Group, DMH, DOH, DJJ, Chancellor's Office, MPD, DOES, DCPS, residential programs, Universities, primary care, suicide organizations such as AAS and SPAN, community providers, parents, youth.	• Task force will be created and meet at least quarterly	• Coalition meets bimonthly – well supported public/private

• Increase the number of professional, volunteer, faith community, and other groups that integrate suicide prevention activities into their ongoing activities and adopt policies to prevent suicide	• Develop community/neighborhood partnerships • Identify organizations who can outreach to parents, youth • Reach out to church groups (Health Ministries)	• # of groups who request materials, trainings • # groups who incorporate suicide prevention activities into their organizations	• Nine minigrant partners • At least 50 different agencies receiving materials • 58 trainings completed • Policy change at CFSA for foster care parents
Goal 3: Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse and suicide prevention services			
• **Objectives**	• **Activities**	• **Outcomes**	• **Outcomes/Products as of October 2011**
• Address belief systems of residents and consumers in D.C. to reduce stigma associated with receiving mental health and substance abuse services	• Develop outreach materials and social marketing campaign that is culturally competent • Create suicide prevention/health and wellness materials for distribution in physicians' offices, schools • Materials will be available in multiple languages • Emphasize neurobiological basis of many mental disorders and promote effective medicines and therapies	• 50% of DC youth referred for therapy by screening program will stay in treatment for at least two appointments • Materials will be distributed during all well visits. • There will be an increase in the percent of parental consents received for screening and education in suicide.	• 84% youth referred were linked within three months and went to at least one appointment • Materials to be given to school nurses in Oct 2011 • Materials to be disseminated to pediatricians • Of 60% of returned consent forms – 58% parents approved
• Provide education for families of youth involved in the mental health system for suicide, substance abuse or other mental health issues • Work with Medicaid Managed Care Organizations to increase identification of covered services for the Medicaid population	• Materials and support groups will be available for families • Work through the local Income Maintenance Administration to develop an MOU to increase oversight of interventions on behalf of the Medicaid population	• At least 2 new support groups will be established in different regions of the city through churches, hospitals, community based organizations or mental health agencies	•

• Increase the number of suicidal youth with underlying mental health disorders who receive appropriate mental health treatment	• Identify youth through screening and education and link to treatment	• 33% of schools will provide screening by 2013 • Schools will sustain screening year to year • Increased # of parents who provide consent for screening and treatment. • Increased # of youth referred for mental health services for depression and suicide. • Improved satisfaction with treatment services. • Referred youth will attend more appointments.	•
• Imbue cultural competence in all prevention strategies	• Identify differences in the ways unique communities in DC respond to suicide prevention and mental health promotion	• All suicide prevention programming will be culturally competent	•
• Promote resilience	• Incorporate wellness programs into DCPS health curriculum • Help promote use of youth external supports, inner-strengths, and interpersonal and problem-solving skills	• All schools will conduct health and wellness prevention programs as part of Health classes by 2011 • Families of youth with mental health needs will receive support	•
Goal 4: Identify, develop, implement and evaluate youth suicide prevention programs			
• **Objectives**	• **Activities**	• **Outcomes**	•
• Develop technical support activities to build the capacity across the District to implement and evaluate suicide prevention programs	• Establish collaborations with local stakeholders to share in training, education, and evaluation	• Key positions and coalition will be established	•

• Create policy changes to increase suicide prevention programming and education	• Work with DCPS to incorporate suicide prevention into health curriculum • Establish a policy that makes suicide prevention training mandatory for all school personnel • Make suicide prevention training available to police, recreation staff and other frontline workers	• Suicide prevention will be taught in all health classes for middle and high school youth • All school personnel will receive at least 2 hours annually in suicide prevention • Auxiliary personnel and frontline workers will receive training at least one time annually. • Screening will be incorporated into primary care settings.	•
• Develop public/private partnerships with local organizations who work with youth at risk for related risk factors for suicide.	• Develop partnership with National Campaign to Prevent Teen Pregnancy, Metro Teen AIDS, Latin American Youth Center	• # organizations who partner • Provide training and/or screening annually. • There will be an increase in help seeking behaviors by youth affiliated with these organizations.	•

• Identify youth at risk for suicide, suicidal behavior, and related risk factors	• Conduct universal screening of depression and suicide in middle and high schools. • Conduct screening through local organizations such as Health ministries • Conduct suicide screening for youth in juvenile detention centers • Conduct suicide screening for youth in CFSA • Conduct suicide screening for youth enrolled in substance abuse treatment through APRA	• Increased # of youth screened for depression and suicide annually. • # of settings conducting screening • # people trained to screen • # screenings held • At least 500 youth screened per year	•
• Train youth in signs and symptoms suicide and how to talk to friends at risk	•Conduct education based prevention program in schools, community, churches •Train staff of organizations with youth workers such as teen pregnancy, HIV prevention in signs of suicide and how to incorporate into their prevention programming	• There will be an increase in help seeking behaviors by youth for mental health services. • # youth who receive training • # sites conducting training	•
• Train medical providers to conduct suicide assessments	• Provide training to pediatricians, managed care organizations, school nurses, ER staff on suicide warning signs and risk factors	• All youth will be asked about thoughts of suicide and depression during well visits • # youth identified through screenings in primary care settings.	•

• Ensure availability of suicide hotlines	• Encourage Department of Mental Health Access Helpline to become a certified crisis line through AAS	• DMH will be a certified crisis hotline for 1800/273-TALK by 2009	•
Goal 5: Promote efforts to reduce access to lethal means and methods of self-harm			
• **Objectives**	• **Activities**	• **Outcomes**	•
• Reduce deaths by passive suicidal means	• Develop partnerships with organizations to reduce risk factors for passive suicidal behavior such as through violence, HIV exposure, substance abuse • Incorporate training on risk factors related to suicide such as exposure to violence, substance abuse when working with youth, families, schools, and community partners	• Increased # youth and families will recognize risk factors related to suicide behaviors • At least 500 youth annually participate in these activities	•
Goal 6: Implement training for recognition of at-risk behavior and delivery of effective treatment			
• **Objectives**	• **Activities**	• **Outcomes**	•

• Identify individuals to be trained as "Certified QPR Trainers"	• Establish group of individuals to be trained from diverse agencies within DC – including DCPS, DOH, DMH, DJJ, DOES, MPD, DCPS, CFSA, DYRS, organizations that serve charter schools, church representatives, parents, school nurses, neighborhood/community groups • Identify staff in programs who work with high risk youth to receive training through programs such as Metro TeenAIDS, Campaign to Prevent Teen Pregnancy, GLBT programs, Latino community	• 50 individuals will be trained as certified QPR trainers • Pre/Post-tests by trainees will show increase in knowledge and skills acquisition • Within 5 years, 75% of staff at each of these agencies will have received QPR training. • 1000 people annually will receive QPR gatekeeper training	•
• Train medical professionals in signs and symptoms of suicide and depression	• Train pediatricians in signs and symptoms of suicide • Train hospital emergency room workers in signs and symptoms of suicide • Train mobile outreach groups (dental, pediatrics, maternal/child) in signs and symptoms of suicide	• Train at least 100 individuals yearly involved in well visits	•
Goal 7: Develop and promote effective clinical and professional practices			
• **Objectives**	• **Activities**	• **Outcomes**	•
• Enhance the abilities of providers to provide culturally competent, evidence-based management of youth in crisis	• Provide training to DMH, CFSA, DJJ, CSAs and private providers, physicians, nurses • Provide training to all providers of mental health services in the management youth in a suicidal crisis • All training will be based on culturally competent principles	• At least 500 individuals will receive training per year	•
• Establish group of individuals who have received training in suicide prevention and identification in schools	• Encourage schools to apply for school-based accreditation through AAS	• At least 5 schools per year will receive accreditation in suicide prevention	•

• Promote therapeutic support for victims of violence and sexual abuse as risk factor for suicidal behavior	• Identify youth who are victims of violence or sexual abuse • Promote linkage between violence and suicide • Youth with histories of violence or sexual abuse will be identified and providers working with these youth will incorporate screening for suicide and depression	• 10% more youth yearly will be identified to mental health providers or receive prevention programming from community based organizations with histories of exposure to violence or sexual abuse	•
Goal 8: Improve access to and community linkages with mental health and substance abuse services			
• **Objectives**	• **Activities**	• **Outcomes**	•
• Ensure timely and accurate compliance with referrals of all youth referred to local mental health providers.	• Create database and reporting mechanisms for data regarding screening, referral, and compliance with recommendations • Monitor and track length of time from referral to first appointment	• 50% of youth will be linked to services within one month of screen • 75% of youth will be linked to service within six months of screen	•
• Determine length of treatment	• Assess whether youth stays in treatment for at least two appointments	• Collaborate with treatment providers to obtain follow-up data on at least 50% of youth referred for treatment	•

• Ensure satisfaction of services rendered	• Conduct parent satisfaction surveys.	• 50% of parents with youth referred for treatment will complete Satisfaction Survey	•
• Compile and update a guide to DC suicide prevention resources and services	• Update resource list to include local, state, and national organizations with a focus on suicide awareness, prevention, intervention, and aftercare. • Distribute list widely.	• Guide will be available at schools, mental health centers, local organizations, pediatricians by 2012	•
Goal 9: Improve reporting and portrayals of suicidal behavior, mental illness, and substance abuse in the entertainment and news media			
• **Objectives**	• **Activities**	• **Outcomes**	•
• Increase the number of local television programs and news reports that observe recommended guidelines in the depiction of suicide and mental illness	• Provide guidelines from AAS to local media outlets	• Local news agencies will make changes to their reporting	•
Goal 10: Promote and support research on suicide and suicide prevention			
• **Objectives**	• **Activities**	• **Outcomes**	•
• Promote youth suicide prevention research	• Develop partnerships with universities to collect, analyze, and disseminate data on youth suicide prevention and training	• Data and activities of the DC Suicide Prevention Coalition will be analyzed annually and distributed	•

• Evaluate prevention programs	• Gather data on universal suicide prevention programs on numbers of youth identified with suicidality, depression, substance abuse • Gather data on numbers of youth linked effectively to treatment for mental health services following screening • Gather data on numbers of youth identified as suicidal as a result of gatekeeper training • Gather data on numbers of youth identified through classroom-based peer prevention programs	• Data and activities of the DC Suicide Prevention Coalition will be analyzed annually and distributed • Data will be presented at national and local conferences	•
Goal 11: Improve and expand surveillance systems			
• **Objectives**	• **Activities**	• **Outcomes**	•
• Synthesize suicide data for the District	• Obtain data from all relevant stakeholders (hospitals, Child Fatality Review Committee, police, schools, crisis response teams, Access Helpline) with regard to youth suicide (completions, attempts, hotline calls) in the District • Determine STIPDA representative for District • Encourage DC to establish National Violent Death Reporting System	• Stakeholders will provide data to central repository • DC will contribute to NVDRS	•
• Increase the number of hospitals and local service providers that code for external cause of injuries	• Encourage hospitals to code for suicidal behaviors • Encourage police to report on transporting suicide victim	• Hospitals will use codes for external causes of injury	•
• Produce an annual report on youth suicide	• Present findings to District leaders (Mayor, City Council) and recommend changes	• Annual report will be distributed yearly	•

Environmental Factors and Plan

21. Support of State Partners

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 mental and substance use disorders 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 actors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and substance use disorders, 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 emergency management/homeland security and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

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

1. Identify any existing partners and describe how the partners will support the state in implementing the priorities identified in the planning process.
2. Attach any letters of support indicating agreement with the description of roles and collaboration with the SSA/SMHA, including the state education authorities, the SMAs, entity(ies) responsible for health insurance and the health information Marketplace, adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency, etc.

Please indicate areas of technical assistance needed related to this section.

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

Footnotes:

Support of State Partners

The Department of Behavioral Health (DBH) partners with other District agencies to provide mental health and substance use disorder treatment services and supports for children, youth, families, and adults. Some of the partnerships are described below.

- Child and Family Services Agency (CFSA):
  - Trauma screenings and assessments for CFSA involved children.
  - Assessment Center evaluations.
  - Collaborative co-located staff for In-home Mental Health Coordinators.
  - Behavioral health services solicitation for children placed in foster homes in Maryland.
  - Wraparound services provided by a care management entity for children and youth in the custody of CFSA.
  - Choice Providers program services for children and youth in the custody of CFSA.

- Department of Health Care Finance (DHCF):
  - DHCF and DBH are working on the implementation of several initiatives that include Health Homes and Medicaid billing for Adult Substance Abuse Rehabilitative Services (ASARS).
  - Medicaid reimbursement for mental health rehabilitation services (MHRS).
  - Transfer of fee for service (FFS) Day Treatment to the MHRS Day or Intensive Day Treatment.
  - Medicaid reimbursement for services to individuals in care at Saint Elizabeths Hospital and the disproportionate share payment from DHCF.

- Department of Health (DOH):
  - Maternal mental health case management services for women in Wards 5-8.
  - Health Emergency Preparedness and Response Administration- Mental health preparedness training.

- Office of the State Superintendent of Education (OSSE): Wraparound Project services.

- Office of Justice Grants Administration (OJGA)- Deputy Mayor for Public Safety: Co- occurring (mental health and substance use disorder) pilot at a Department of Corrections adult women correctional treatment facility.

- Department of Human Services (DHS): Treatment services for Temporary Assistance for Needy Families (TANF) eligible clients.

State Behavioral Health Planning/ Advisory Council and Input on the Mental Health/ Substance Abuse Block Grant Application
Department of Behavioral Health Behavioral Health Council
Comments on the District Behavioral Health Assessment and Plan

The Department of Behavioral Health (DBH), formerly the Department of Mental Health, planning process to transition from a mental health planning and advisory council to a behavioral health planning council was supported by three (3) SAMHSA technical assistance (TA) initiatives. They included: 1) receiving general TA provided to state planning councils that included an on-site TA meeting with the existing planning council (FY 2012-2013 cycle); 2) participating in the state planning council intensive TA National Learning Community that involved monthly conference calls and individual state calls, and an on-site TA meeting with the mental health advisory councils, consumers/clients, family members, advocates, mental health and substance use disorder staff and providers (FY 2013-2014 cycle); and 3) participating in the Leadership Academy and on-site TA (FY 2014-2015 cycle) for the newly created Behavioral Health Council.

On August 19, 2015 the DBH Behavioral Health Council orientation meeting was held. In addition to the council members, the new DBH Acting Director, Dr. Tanya A. Royster, M.D., and the DBH grant program staff participated in the meeting. The co-facilitators were Phillip Lubitz, M.S.W. and Angela Halvorson, M.P., M.S. The

presentations generated thoughtful questions, comments and discussion.
DBH Behavioral Health Council Comments

The DBH Behavioral Health Council reviewed and provided comments about the District of Columbia Behavioral Health Assessment and Plan. To facilitate their review, they were given a Behavioral Health Assessment and Plan Review Comment Guide. The comments below are organized by the document review sections.

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, 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. Other performance indicators the Behavioral Health Council would like DBH to consider in the future:
- 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.

Public Awareness of Plan and Public Comment

It is the DBH custom to post the District of Columbia FY 2016-FY 2017 Mental Health Block Grant Application on the Department's website. This allows for ongoing review and comment. Also, if there are any major changes the revised document can be posted.

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:

Department of Behavioral Health Behavioral Health Council
Comments on the District Behavioral Health Assessment and Plan

The Department of Behavioral Health (DBH), formerly the Department of Mental Health, planning process to transition from a mental health planning and advisory council to a behavioral health planning council was supported by three (3) SAMHSA technical assistance (TA) initiatives. They included: 1) receiving general TA provided to state planning councils that included an on-site TA meeting with the existing planning council (FY 2012-2013 cycle); 2) participating in the state planning council intensive TA National Learning Community that involved monthly conference calls and individual state calls, and an on-site TA meeting with the mental health advisory councils, consumers/clients, family members, advocates, mental health and substance use disorder staff and providers (FY 2013-2014 cycle); and 3) participating in the Leadership Academy and on-site TA (FY 2014-2015 cycle) for the newly created Behavioral Health Council. The Department notified the public that the SAPT Block grant was available for comment for 30 days by Public View via the DBH website.

On August 19, 2015 the DBH Behavioral Health Council orientation meeting was held. In addition to the council members, the new DBH Acting Director, Dr. Tanya A. Royster, M.D., and the DBH grant program staff participated in the meeting. The co-facilitators were Phillip Lubitz, M.S.W. and Angela Halvorson, M.P., M.S. The presentations generated thoughtful questions, comments and discussion.

DBH Behavioral Health Council Comments

The DBH Behavioral Health Council reviewed and provided comments about the District of Columbia Behavioral Health Assessment and Plan. To facilitate their review, they were given a *Behavioral Health Assessment and Plan Review Comment Guide*. The comments below are organized by the document review sections.

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- 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.
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- 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>
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- The percentage of supported housing units that are integrated and accessible.
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- 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.

Public Awareness of Plan and Public Comment

It is the DBH custom to post the District of Columbia FY 2016-FY 2017 Substance Abuse Prevention and Treatment Block Grant Application on the Department's website for a 30 day review period. Also, if there are any major changes the revised document is reposted for an additional 30 day review.

Environmental Factors and Plan

Behavioral Health Advisory Council Members

Start Year: 2016

End Year: 2017

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Marie Morilus -Black	State Employees	Child and Family Services Agency	200 I Street, SE Washington, DC 20003 PH: 202-442-6002	marie.morilus-black@dc.gov
Michen Tah	State Employees	Criminal Justice Coordinating Council	441 4th Street, NW Washington, DC 20001 PH: 202-442-9283	Michen.Tah@dc.gov
Diane Lewis	State Employees	District of Columbia Health Benefit Exchange Authority	1225 I Street, NW 4TH FLOOR Washington, DC 20005 PH: 202-966-7516	dlewis@acg-cos.com
Claudia Schlosberg	State Employees	Department of Health Care Finance	441 Fourth Street, NW 900 South Washington, DC 20001 PH: 202-442-9075	Claudia.schlosberg@dc.gov
Sakina Thompson	State Employees	Department of Human Services	64 New York Avenue, NE 6th Floor Washington, DC 20002 PH: 202-671-4451	Sakina.thompson@dc.gov
Adrienne Todman	State Employees	District of Columbia Housing Authority	1133 North Capitol Street, NE Washington, DC 20002 PH: 202-535-1513	ATodman@dchousing.org
Sara Tribe Clark	State Employees	District of Columbia Office on Aging	500 K Street, NE Washington, DC 20002 PH: 202-535-1367	Sara.tribe@dc.gov
Misha Kessler	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		3355 16th Street, NW, Unit 510 Washington, DC 20010 PH: 513-520-1346	misha.kessler@gmail.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 1000 Washington, DC 20005 PH: 202-842-0001	esmith@can-dc.org
Doris Carter	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		915 Allison Street, NW #201 Washington, DC 20011 PH: 202-832-8336	DCarter@calvaryhealthcare.org
Timothy Robinson	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1511 E Street, SE Washington, DC 20003 PH: 202-569-0151	Timrobinsonskate64@gmail.com
			1125 15th Street,	

Andrew Reese	State Employees	Department on Disability Services	NW, 4th Floor Washington, DC 20005 PH: 202-442-8606	andrew.reese@dc.gov
Barbara Bazron	State Employees	DC Department of Behavioral Health	64 New York Avenue, NE Washington, DC 20002 PH: 202-271-2992	barbara.bazron@dc.gov
Yuliana Del Arroyo	State Employees	Office of the State Superintendent of Education	810 First Street NE, 9th Floor Washington, DC 20002 PH: 202-741-0478	Yuliana.delarroyo@dc.gov
Evelyn Sands	Parents of children with SED		4030 Livingston Road, SE #301 Washington, DC 20032 PH: 202-271-6032	esands231@gmail.com
Donna Flenory	Parents of children with SED		510 Division Avenue, NE Washington, DC 20019 PH: 202-497-3097	dlflenory@gmail.com
Senora Simpson	Family Members of Individuals in Recovery (to include family members of adults with SMI)		323 Quackenbos, NE Washington, DC 20001 PH: 202-529-2134	Ssmimp2100@aol.com
Maria Newman	Family Members of Individuals in Recovery (to include family members of adults with SMI)		1363 Spring Road NW Washington, DC 20010 PH: 202-865-3796	m_newman@howard.edu
Miya Wiseman	Family Members of Individuals in Recovery (to include family members of adults with SMI)		3105 18th Street, NE Washington, DC 20018 PH: 202-270-6173	Miya714@yahoo.com
Samantha Stevens	Others (Not State employees or providers)		4520 MacArthur Blvd., NW, Apt. 305 Washington, DC 20007 PH: 202-716-1201	samanthastevens86@gmail.com
Lynne Person	Others (Not State employees or providers)		601 E Street, NW T3-314 Washington, DC 20049 PH: 202-434-2140	lperson@aarp.org
Evan Langholt	Providers		2100 New York Avenue, NE Washington, DC 20002 PH: 202-269-6333	evan_langholt@uss.salvationarmy.org
Julie Kozminski	Providers		1220 12th Street, SE, Suite 120 Washington, DC 20003 PH: 202-715-7966	jkozminski@unityhealthcare.org
Tamara Weissman	Providers		1104 Allison Street NW Washington, DC 20011 PH: 202-722-1815	tweissman@gafsc-dc.org
			1001 Lawrence	

Shannon Hall	Others (Not State employees or providers)	Street, NE Washington, DC 20017 PH: 202-481-1419	dcbehavioralhealth@gmail.com
Jennifer Lav	Others (Not State employees or providers)	220 I Street, NE, Suite 130 Washington, DC 20002 PH: 202-547-0198	jlav@uls-dc.org
Tammi Lambert	Others (Not State employees or providers)	905 6th Street, SW, Apt. 708B Washington, DC 20024 PH: 202-724-5454	Lambert.tammi@gmail.com
Cheryl Doby-Copeland	State Employees	821 Howard Road, SE Washington, DC 20032 PH: 202-698-1836	Cheryl.copeland@dc.gov
Nicole Denny	State Employees	2435 Alabama Avenue, SE Washington, DC 20020 PH: 202-671-6140	Nicole.denny@dc.gov

Footnotes:

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year: 2016

End Year: 2017

Type of Membership	Number	Percentage
Total Membership	31	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	4	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	3	
Parents of children with SED*	2	
Vacancies (Individuals and Family Members)	2	
Others (Not State employees or providers)	5	
Total Individuals in Recovery, Family Members & Others	16	51.61%
State Employees	12	
Providers	3	
Federally Recognized Tribe Representatives	0	
Vacancies	0	
Total State Employees & Providers	15	48.39%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	9	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	3	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	12	
Persons in recovery from or providing treatment for or advocating for substance abuse services	7	

* 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?

The DBH Behavioral Health Council has two (2) vacancies related to individuals and family members. DBH has identified two (2) candidates to fill these vacancies. Their membership has not yet been confirmed.

Footnotes: