District of Columbia

UNIFORM APPLICATION
FY 2018/2019 - STATE BEHAVIORAL HEALTH ASSESSMENT AND PLAN

COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

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

State Information

State Information

Plan Year

Start Year 2018

End Year 2019

State DUNS Number

Number 14384031

Expiration Date

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

Agency Name District of Columbia Department of Behavioral Health

Organizational Unit Office of Strategic Planning, Policy and Evaluation

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

City Washington, D.C.

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 64 New York Avenue, N.E., 3rd Floor

City Washington, D.C.

Zip Code 20002

Telephone (202) 673-2200

Fax (202) 673-3433

Email Address tanya.royster@dc.gov

III. Third Party Administrator of Mental Health Services

First Name

Last Name

Agency Name

Mailing Address

City

Zip Code

Telephone

Fax

Email Address

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

From

To

V. Date Submitted

Submission Date 9/1/2017 5:12:28 PM

Revision Date 12/4/2017 12:20:36 PM

VI. Contact Person Responsible for Application Submission

First Name JUANITA

Last Name REAVES

Telephone (202) 671-4080

Fax (202) 673-7053

Email Address juanita.reaves@dc.gov

Footnotes:

The DUNS number does not have an expiration date.

State Information

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

Fiscal Year 2018

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
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Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	**42 USC § 300x-1**
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Section 1915	Additional Provisions	**42 USC § 300x-4**
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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: _____

Signature of CEO or Designee[1]: _____

Title: _____   Date Signed: _____

mm/dd/yyyy

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

Footnotes:

CHIEF EXECUTIVE OFFICER FUNDING AGREEMENT

Certifications and Assurances

Letter Designating Signatory Authority

State Information

Fiscal Year 2018

<div align="center">

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
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I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: _Tanya A. Royster_

Signature of CEO or Designee: _[signature]_

Title: _Director_   Date Signed: _08/30/2017_

                                        mm/dd/yyyy

Footnotes:

GOVERNMENT OF THE DISTRICT OF COLUMBIA

ADMINISTRATIVE ISSUANCE SYSTEM

Mayor's Order 2015-146
May 27, 2015

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

ORIGINATING AGENCY: Office of the Mayor

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

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

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

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

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

MURIEL E. BOWSER
MAYOR

ATTEST:

LAUREN C. VAUGHAN
SECRETARY OF THE DISTRICT OF COLUMBIA

GOVERNMENT OF THE DISTRICT OF COLUMBIA

ADMINISTRATIVE ISSUANCE SYSTEM

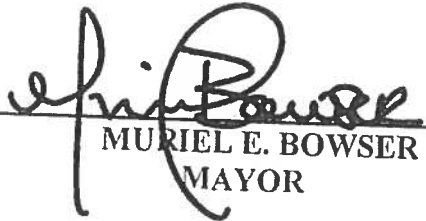Mayor's Order 2015-146
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MURIEL E. BOWSER
MAYOR

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

State Information

Disclosure of Lobbying Activities

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

Name

Title

Organization

Signature: Date:

Footnotes:

The Disclosure of Lobbying Activities form is not applicable.

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:

<center>**Planning Steps**</center>

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

- **Overview of State Behavioral Health Prevention, Early Identification, Treatment, and Recovery Support Systems**

  The District of Columbia Department of Behavioral Health (DBH) serves as the State Mental Health Authority (SMHA) and the District of Columba Single State Agency (SSA) for substance use disorders. The DBH organizational structure under the new realignment includes the following: 1) Behavioral Health Authority; 2) Accountability Administration; 3) Administrative Operations; 4) Clinical Services Administration; 5) Community Services Administration; 6) Consumer and Family Affairs Administration; 7) Systems Transformation Administration; and 8) Saint Elizabeths Hospital. The DBH leadership team includes the leaders of the administrations, divisions and branches.

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

    The Child System is described in great detail under Criterion 3- Children's Services. An abbreviated summary is provided here. The child/youth services include: 1) Mental Health Rehabilitation Services; 2) Early Childhood Interventions (Early Childhood Mental Health Consultation-Healthy Futures, D.C. Social Emotional and Early Development Project, Parent Infant Early Childhood Enhancement Program, Primary Project, Physicians' Practice Group, Child Urgent Same Day Services, and Co-Located Programs); 3) School Mental Health Program- Primary and Secondary Prevention Programs; 4) Youth Suicide Prevention and School Climate Survey Amendment Act of 2016 (Law 21-120); 5) Children and Adolescent Mobile Psychiatric Services; 6) Psychiatric Residential Treatment Facilities; 7) Functional Assessment Scales; and 8) Evidence-Based Practices.

    The transition age youth initiatives include: 1) Transformation Transfer Initiative; 2) Now Is The Time-Healthy Transitions; 3) It's Time to Let Help In; 4) FY 2017 First Episode Psychosis Transition Age Youth Pilot Project; 5) Trauma, Intellectual Developmental Disabilities/Mental Illness; 6) Proposed Projects (services, training, resources); and 7) Transition Age Youth Housing Initiative.

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

    The prevention activities also include the SUD social marketing campaigns that are presented from the perspective of youth and related adults. They include: 1) "*The Blunt*

Truth" (addresses marijuana use); 2) *There's a Reason"* (addresses underage drinking); and 3) *"K2 Zombie"* (addresses fake weed and other synthetic drug use among youth).

Evidenced Based and Evidence Informed Curriculum- The DBH School Mental Health Program (SMHP) implements primary and secondary prevention programs that include evidenced-based or evidence informed programs. These activities include: 1) Violence Prevention; 2) Sexual Abuse Prevention; 3) Suicide Prevention; 4) Anger Management; 5) Ask 4 Help-K-5; 6) Parenting Program; and 7) Substance Abuse Prevention.

Early Identification- The early childhood interventions were previously referenced. An additional early identification project is the DC Mental Health Access Project (DC MAP). It supports the integration of health and mental health by providing pediatricians with immediate access to mental health and/or psychiatric consultation as children/youth are identified as potentially needing behavioral health services.

Treatment- DBH currently offers nine (9) evidence-based practices as part of the treatment process that include: 1) Child Parent Psychotherapy for Family Violence; 2) Trauma Systems Therapy; 3) Parent Child Interaction Therapy; 4) Trauma Focused Cognitive Behavioral Therapy; 5) Multi-Systemic Therapy; 6) Multi-Systemic Therapy for Youth with Problem Sexual Behavior; 7) Adolescent Community Reinforcement Approach (SUD); 8) Transition to Independence Process (an evidenced supported model); and 9) Cognitive Behavioral Therapy for Psychosis (CBTp).

The substance use disorder treatment services include a variety of strategies for adolescents and adults: 1) assessment (comprehensive, ongoing, brief), 2) drug screening; 3) clinical care coordination; 4) case management; 5) case management HIV; 6) crisis intervention; 7) counseling (individual, family, group, psycho-educational, and psycho-educational HIV); 8) medication management; 9) recovery support; 10) residential room and board; 11) recovery support evaluation; 12) recovery support management; 13) recovery mentoring and coaching; 14) life skills support; 15) spiritual support; 16) education services; 17) transportation services; 21) recovery social activities; and 22) environmental stability.

Recovery Support Services- In the District of Columbia non-clinical services are provided to an individual by a certified Recovery Support Services (RSS) provider to assist him or her in achieving or sustaining recovery from a SUD. There are eight (8) billable recovery support services: 1) Recovery Support Evaluation; 2) Recovery Support Management; 3) Recovery Coaching (Recovery Mentoring and Coaching); 4) Recovery Support Service (Life Skills Support Services); 5) Spiritual Support Services; 6) Education Support Services; 7) Recovery Social Activities; and 8) Environmental Stability.

- **Juvenile Justice Initiatives**

  - *Juvenile Behavioral Diversion Program (JBDP)-* Operated within the D.C. Superior Court Juvenile Division this program is intended for children and youth who are often

served within multiple systems who are at risk of re-offending without linkage to mental health services and other important supports.

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

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

- **Behavioral Health Service Partners**

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

- **Diverse Racial and Ethnic Initiatives**

   - *My Brother's Keeper Initiative (MBK-DC)*- On January 16, 2017 Mayor Muriel Bowser launched the District of Columbia My Brother's Keeper initiative to provide programming targeting boys and young men of color in four (4) key areas: 1) education, 2) justice, 3) health, and 5) job opportunities. Seeking to develop coalitions with public and private sector leaders, My Brother's Keeper DC is part of President Obama's MBK Community Challenge to implement evidence-based strategies that create equal opportunities for boys and young men of color. To represent and implement the values of the program, Mayor Bowser also designated Martin Luther King, Jr. Commissioners as My Brother's Keeper Ambassadors.

     Mayor Bowser stated that "*from establishing the Ron Brown College Preparatory High School, to creating more opportunities for summer jobs through the expansion of the Marion Barry Summer Youth Employment Program, we have seen tremendous progress in reaching our boys and young men of color.*" She noted that "*we are doubling down on strategies that are making a difference in the lives of boys and young men of color, and through this initiative my Administration will continue to press forward in closing the gaps that still remain for far too many young men in our city.*"

     The Bowser Administration plans to bridge the opportunity gap in the following ways:

     1. **Justice** - Elevate efforts to foster healthy and inclusive relationships between District youth and law enforcement officers.

2. **Education** - Renew urgency surrounding education reform and making the needed investments to prepare the next generation of Washingtonians for today's economy.

3. **Health** - Shape positive health identities by targeting all life circumstances and acknowledging that mental health is a fundamental element of well-being for positive development.

4. **Job Opportunities** - Invest in initiatives that connect the city's youth to jobs and opportunities to develop skills needed in the workplace

My Brother's Keeper DC will target three (3) types of partnerships: 1) **Fund**- leadership will contact private institutions, venture capital firms, and family philanthropists to provide capital; 2) **Grow**- Academic institutions and non-profits will provide technical assistance, data processing, and impact evaluation; and 3) **Support**- Community leaders, advisory board members, and other key partners will offer resources that allows initial successes to advance over time.

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

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

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

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

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

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

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

  The adult clinical services include: 1) DBH directs and manages mental health services at two (2) locations (35 K Street Northeast and 821 Howard Road Southeast); 2) the Adult Services Branch provides clinical assessment and treatment; 3) the Pharmacy Branch provides psychiatric medications for residents enrolled in the public behavioral health system who are uninsured and unable to pay for medications; 4) the Comprehensive Psychiatric Emergency Program Division provides emergency mental health services;
  5) the Psychiatric Emergency Services Branch provides immediate access to multi-disciplinary emergency psychiatric services 24/7; 6) the Mobile Crisis/Homeless Outreach Branch responds to individuals in the community in psychiatric crisis and provides homeless outreach service visits; 7) the Access HelpLine enrolls consumers into services and ensures District residents receive crisis services, as well as provides telephonic suicide prevention and other counseling as appropriate; 8) the Forensics Division provides and oversees behavioral health and other services for justice-involved individuals from pre-arrest to post-incarceration to ensure their successful return to the community; 9) the Assessment and Referral Center Division assess and refer adults seeking treatment for SUD to appropriate services and the Mobile Assessment and Referral Center visits communities throughout the District to conduct assessment, referral, and HEP-C and HIV testing; 10) the Consumer and Family Affairs Administration promotes the involvement of consumers, including family members and young adults, across the behavioral health system including a Peer Operated Drop-In Center and D.C. Certified Peer Academy; 11) the adult evidence-based programs include Assertive Community Treatment and the Supported Employment Program (partners include Department of Human Services, Rehabilitation Services Administration, and Department on Disability Services).

- **Prevention Activities**

  - *National Capital Region Compact to Combat Opioid Addiction-* The Mayor of the District of Columbia and the Governors of Maryland and Virginia have pledged to work collaboratively to help stop the damaging effects of opioid addiction on the lives of those addicted, their families, law enforcement, health care providers, and the broader community.

  - *Prevention Centers-* The DBH funds four (4) D.C. Prevention Centers (DCPCs) that are designed to strengthen the community's capacity to reduce substance use and prevent risk factors. The services include community education, community leadership, and community change.

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

- ***Prevention Symposium-*** This activity was implemented in October 2016. The participants included DBH substance use disorder staff, prevention center staff, and other participants. The goal is to continue to build prevention related activities to address workforce, data, and expertise in the field issues.

- ***D.C. Epidemiological Outcomes Workgroup (DC EOW)-*** The DC EOW goals will be sustained through local and Strategic Prevention Framework Partnership for Success funds. 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.

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

- **Recovery Coaching Training**

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

- **Adults, Young Adults and Youth Substance Use Campaigns**

  - ***The Blunt Truth (addresses marijuana use)-*** While health effects associated with marijuana use can be equally applicable to adults, the *Blunt Truth* adult focus centers on the laws governing marijuana consumption in the District of Columbia. Materials point out the "cans" and "can nots," so that individuals can make informed decisions and stay within the realm of the law.

  - ***"Adult Synthetics" (addresses synthetic drug use among adults)-*** The Adult Synthetics campaign clarifies that the purchase, sell, and use of synthetic drugs are illegal in the

District of Columbia. The campaign addressed designer drugs such as "Molly" and other drugs found to be popular among adults. The associated laws were made available through brochures, palm cards, and a website in order to inform as many adults as possible.

- ▪ *__"Opioid Awareness Campaign" (addresses opioid use among adults, young adults and youth)-__* DBH is developing this campaign to raise awareness about the risks associated with opioid use and to direct individuals to help. Phase 1 targets adults, specifically older African American male heroin users age 40-69. Phase 2 targets youth and young adults to shed light on how the misuse of prescribed opioids can lead to addiction, be a gateway to more potent variations of opioids, or result in death.

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

  This is a permanent, cabinet-level office within the Office of Community Affairs in the Executive Office of the Mayor, established by statute in 2006 to address important concerns of the District's LGBTQ) residents. The District has one of the highest concentrations of LGBTQ residents in the country with an estimated 7 to 10% of the population being LGBTQ. The Office of LGBTQ Affairs works collaboratively with an Advisory Committee, appointed by the Mayor, to define issues of concern to the LGBTQ community and find innovative ways of utilizing government resources to help address these issues. This includes: 1) services are available for grant funding and business opportunities from the District Department of Small and Local Business Development; 2) community resources with links and publications including a directory of LGBTQ community organizations; 3) LGBTQ education and training; and 4) improving the treatment of LGBTQ residents by providing technical assistance.

- **Report on the Health of the Lesbian, Gay, Bisexual and Transgender (LGBT) Community in the District of Columbia 2011-2013**

  Some of the highlights from this District Department of Health report include:
  - ▪ 12.3% of high school youth identified as either lesbian, gay or bisexual;
  - ▪ LGBT adults were more likely than their non-LGBT counterparts to report 15-30 days of mental health not being good, which includes stress, depression and problems with emotions;
  - ▪ Non-LGBT adults were more likely than their LGBT counterparts to have a disability that required the use of special equipment;
  - ▪ 4.5% of adults who identified as non-LGBT reported that they have had sexual intercourse with someone of the same sex;
  - ▪ Non-LGBT adults were more likely than their LGBT counterparts to be physically inactive and obese;
  - ▪ LGBT adults were more likely than their non-LGBT counterparts to be binge drinkers and reporting that they have used either cocaine or heroin;
  - ▪ LGBT adults were more likely than their non-LGBT counterparts to be tested for HIV;

- LGBT adults were more likely than their non-LGBT counterparts to have engaged in high risk behaviors such as unprotected anal sex, therefore increasing their risk for HIV infection;
- LGBT adults were more likely than non LGBT adults to be treated for a STD within the past 12 months, use street/party drugs in the past 12 months and had sex with a partner other than a primary partner within the past 12 months; and
- LGBT adults were more likely than their non-LGBT counterparts to be diagnosed with asthma and depressive disorder.

- **Health Homes Initiative**

  The District Health Homes (HH) initiative is a joint effort by DBH and the Department of Health Care Finance. HH1 was launched in January 2016. HH2/ *MyHealth GPS* was launched in July 2017. The HH services include: 1) comprehensive care management; 2) care coordination; 3) health promotion; 4) comprehensive transitional care/follow-up; 5) patient and family support; and 6) referral to community and social support services.

- **Community Residential Facilities (CRFs)**

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

- **Crisis Stabilization Beds**

  Provides a short-term, safe supportive living environment for consumers who do not require inpatient treatment for stabilization. DBH contracts with two (2) community providers for 15 crisis beds, 8 at Jordan House and 7 at Crossing Place.

- **Housing Programs**

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

DISTRICT OF COLUMBIA

FY 2018-2019 MENTAL HEALTH BLOCK GRANT BEHAVORIAL HEALTH ASSESSMENT AND PLAN

Table of Contents

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1. Executive Summary

A major accomplishment for the District of Columbia Department of Behavioral Health (DBH) during FY 2017 was the development and implementation of an organizational realignment process. The newly realigned behavioral health system will be officially launched in fiscal year 2018 on October 1, 2017. The guiding principles include the following:

- Openness- an open and transparent system that listens, engages, understands, and responds appropriately to staff and community concerns;
- Consumer and Client Focused- provide opportunities for consumer and client participation and engage them as partners;
- Accountability- staff meet commitments that creates a culture of success, mutual accountability and respect;
- Empowerment- encourage staff to actively participate in creating a common organizational culture; and
- Communication- maintain an environment that encourages participation, and shares information in various ways including individual, group, and mass media platforms.

The new DBH organizational structure under the realignment consists of the Behavioral Health Authority, six (6) administrations, and Saint Elizabeths Hospital. Each administration is divided into divisions that may breakdown into smaller units called branches. The six (6) administrations are: 1) Accountability Administration, 2) Administrative Operations, 3) Clinical Services Administration, 4) Community Services Administration, 5) Consumer and Family Affairs Administration, and 6) Systems Transformation Administration. The DBH leadership team includes the leaders of the administrations, divisions and branches.

The narrative section of the District of Columbia FY 2018-2019 Mental Health Block Grant Behavioral Health Assessment and Plan includes the: 1) District of Columbia Population Overview, 2) Department of Behavioral Health New Organizational Structure, and 3) Mental Health Block Grant Five Statutory Reporting Criteria.

The Substance Abuse and Mental Health Services Administration (SAMHSA) webBGAS Forms Overview includes: 1) State Information, 2) Chief Executive Officer's Funding Agreement - Certifications and Assurances /Letter Designating Signatory Authority and Disclosure of Lobbying Activities, 3) Environmental Factors and Plan (Required and Requested). The District of Columbia Department of Behavioral Health is responding to the Environmental Factors and Plan required factors only.

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2. District of Columbia Population Overview

Population: The U.S. Census Bureau 2015 estimate for the District of Columbia population is 672,228. The gender, age, and race/ethnicity data source is the U.S. Census Bureau 2015 American Community Survey (ACS) 1-Year Estimates.

- *Gender:* There are 352,523 females representing 52.4% of the population, and 319,705 males representing 47.6% of the population

- *Age:* The majority of the residents are age 25-64 (396,293) followed by those 18-24 (81,506).

Age	Number of People	Percent of Population
Total	672,228	100.0
Under 5 years	43,230	6.4
5 to 9 years	32,562	4.8
10 to 14 years	26,490	3.9
15 to 17 years	15,556	2.3
18 to 24 years	81,506	12.1
25 to 64 years	396,293	59.0
65 years and over	76,591	11.4

- *Race/Ethnicity:* The majority of the residents are African American (318,831) followed by White alone (269,143).

Race/Ethnicity	Number of People	Percent of Population
Total	672,228	100.0
White alone	269,143	40.0
Black or African American alone	318,831	47.4
American Indian and Alaska Native alone	1,661	0.2
Asian alone	25,944	3.9
Native Hawaiian and Other Pacific Islander alone	475	0.1
Some other race alone	34,797	5.2
Two or more races	21,377	3.2

- *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 educational attainment data is in the table that follows.

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Educational Level	Number of People	Percent of Population
Population 25 years and over	472,884	100.0
Less than 9th grade	20,227	4.3
9th to 12th grade, no diploma	28,022	5.9
High school graduate (includes equivalency)	82,181	17.4
Some college, no degree	60,107	12.7
Associate's degree	14,002	3.0
Bachelor's degree	112,629	23.8
Graduate or professional degree	155,716	32.9

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

Household Characteristics	Number/Rate/Median
Total Housing Units	309,596
Occupied Housing Units	281,787
Homeownership Rate	39.9%
Housing Units in Multi-Unit Structure	62.9%
Median Value Home Owner Occupied Units	$551,300
Median Household Income	$75,628

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

Households by Type	Number	%
Total households	281,787	100%
Family households (families):	125,178	44.4%
With own children of the householder under 18 years	54,494	19.3%
Married-couple family	71,857	25.5%
With own children of the householder under 18 years	27,840	9.9%
Male householder, no wife present, family	10,834	3.8%
With own children of the householder under 18 years	4,640	1.6%
Female householder, no husband present, family	42,487	15.1%
With own children of the householder under 18 years	22,014	7.8%
Non-family households	156,609	55.6%
Householder living alone	118,347	42.0%
65 years and over	28,849	10.2%

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3. Department of Behavioral Health New Organizational Structure

A major accomplishment for the District of Columbia Department of Behavioral Health (DBH) during FY 2017 was the development and implementation of an organizational realignment process. The newly realigned behavioral health system will be officially launched in fiscal year 2018 on October 1, 2017. The guiding principles include: 1) *Openness*- an open and transparent system that listens, engages, understands, and responds appropriately to staff and community concerns; 2) *Consumer and Client Focused*- provide opportunities for consumer and client participation and engage them as partners; 3) *Accountability*- staff meet commitments that creates a culture of success, mutual accountability and respect; 4) *Empowerment*- encourage staff to actively participate in creating a common organizational culture; and 5) *Communication*- maintain an environment that encourages participation, and shares information in various ways including individual, group, and mass media platforms.

Behavioral Health Authority

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

- *Office of the Director-* leads management and oversight of the public behavioral health system; directs the design, development, communication, and delivery of behavioral health services and supports; and identifies approaches to enhance access to services that support recovery and resilience. The Office of the Director includes the Chief of Staff who oversees risk management and compliance with Language Access requirements and the Americans with Disability Act.

- *Office of the Ombudsman-* identifies and helps consumers and clients resolve problems, complaints and grievances through existing processes; educates on available services and helps to maximize outreach; refers individuals when appropriate to other District agencies for assistance; and comments on behalf of residents on District behavioral health policy, regulations and legislation.

- *Legal Services-* provides legal advice to the Director on all aspects of DBH operations and activities; drafts, researches and/or reviews legislation, regulations, and policies that affect the DBH mission and programs; and formulates strategic advice on DBH program development, compliance and oversight activities.

- *Legislative and Public Affairs-* develops, leads and coordinates the agency's public education, internal and external communications, and public engagement and outreach initiatives; manages legislative initiatives and acts as the liaison to the Executive Office of the Mayor and the District Council; facilitates responses to constituent complaints and service requests; and provides information and support for special projects.

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Accountability Administration

The Accountability Administration oversees provider certification; mental health community residence facility licensure; program integrity; quality improvement; incident management; major investigations; claims audits; and compliance monitoring. It issues the annual Provider Scorecard. The Accountability Administration includes a new division called Program Integrity that strengthens provider oversight and overall system performance review. The Administration components are described below.

- *Office of Accountability-* leads the Accountability Administration by providing oversight and management of DBH certification, licensure, incident management, and program integrity activities.

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

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

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

- *Program Integrity Division-* provides oversight of certified providers through audits and reviews to ensure they meet service delivery and documentation standards for mental health and substance use disorder services.

Administrative Operations Administration

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

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

- *Claims and Billing Division-* manages the services revenue cycle for Saint Elizabeths, the Comprehensive Psychiatric Emergency Program (CPEP), and DBH operated adult and

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child/youth outpatient clinics; processes claims for the certified community based behavioral health providers; and responsible for billing and claim adjudications including local payments, claim accounts receivable, customer service for provider claims, claim reporting, and eligibility file management.

- *Fiscal Services Division-* coordinates, in conjunction with the Director and senior management, financial plans to fulfill ongoing program requirements; leads operational and capital budget preparation, execution, and administration; coordinates budget loading and tracking activities; provides guidance on strategic financial planning and fiscal soundness of spending plans; develops options to achieve budget objectives; conduct fiscal monitoring for compliance, audits, risk assessments, fiscal orientations, site visits and closeout reports for all sub grants; and monitors spending for Human Care Agreements and Contracts.

- *Records Management Division-* manages the medical records program and maintains official medical records for DBH consumers and clients; oversees the development, implementation, maintenance, and adherence to DBH policies and procedures covering the privacy of and access to patient health information; in compliance with federal and state laws and the provider's information privacy practices.

- *Human Resources Division-* develops and administers human resource services including management advisory services; human resources policy development; position classification/ position management; staffing and recruitment; employee and labor relations; performance management; benefits administration;, records management; human resources information systems and human rights; and equal employment.

- *Revenue Management Division-* plans, implements and manages finance and revenue generating sources for DBH directly provided services and Saint Elizabeths Hospital.

Clinical Services Administration

Led by the Chief Clinical Officer, the Clinical Services Administration supervises the operation of all clinical programs and sets standards for the provision of clinical care throughout the public behavioral health system. It includes all DBH directly provided assessment, referral, and clinical services; forensic services; the comprehensive emergency psychiatric program; and the disaster behavioral health program. The Administration oversees involuntary commitment at community hospitals, and coordinates services that assist individuals transitioning from psychiatric hospitals and nursing homes to community based behavioral health services. The Administration components are described below.

- *Office of the Chief Clinical Officer-* supervises and sets standards for the provision of clinical care throughout the agency and public behavioral health system for children, youth, and adults; oversees community hospitals that treat consumers on an involuntary basis; serves as the petitioner in guardianship cases; and oversees the agency's disaster response for the District.

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

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

- ▪ ***Children's Services Branch-*** provides urgent same-day service and clinical assessment and treatment for children up to 7 years old who present with challenging social, emotional and disruptive behaviors that cause impairment in functioning at home, school, daycare and the community.

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

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

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

  - ▪ ***Mobile Crisis/Homeless Services Outreach Branch-*** Mobile Crisis provides crisis intervention and stabilization services to residents and visitors who are experiencing psychiatric crises in the community or at home. Services include linkage to DBH, psychoeducation, treatment compliance support, and grief and loss services to individuals after a traumatic event. Homeless Outreach connects homeless individuals and families with behavioral health services and assists in the District's encampment protocol.

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

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

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

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Community Services Administration

The Community Services Administration develops, implements and monitors a comprehensive array of prevention, early intervention and community-based behavioral health services and supports for adults, children, youth, and their families that are culturally and linguistically competent and supports resiliency and recovery. This Administration includes services and supports in the former Adult Services, Children/Youth Services, Substance Use Disorder Prevention Services, and Treatment and Recovery Services. The Administration components are described below.

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

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

  - *Early Childhood Branch-* provides school-based and center-based early childhood mental health supports and child and family-centered consultation to staff and families to build their capacity to promote social and emotional development, respond to mental health issues and prevent escalation of challenging behaviors, and increase referrals for additional services.

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

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

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

  - *Community-Based Services Branch-* oversees development, implementation and monitoring of community-based mental health and substance use disorders services including evidenced-based and promising practices, to address the needs of adults, children, youth and their families.

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- ▪ *New Initiatives Branch-* provides overall technical direction and administration of a broad range of grant-funded projects and other new initiatives, tracks and monitors their progress and outcomes, and makes recommendations on their integration into the agency and full-scale implementation.

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

  - ▪ *Assessment Center Branch-* provides the Superior Court of the District of Columbia with court-ordered, high-quality, comprehensive, culturally competent mental health consultation, and psychological and psychiatric evaluations for children and related adults with involvement in child welfare, juvenile justice and family court.

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

  - ▪ *Psychiatric Residential Treatment Facility Branch-* provides centralized coordination and monitoring of placement, continued stay, and post-discharge of children and youth in psychiatric residential treatment facilities (PRTF), and oversees the coordination of the PRTF medical necessity review process.

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

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

Consumer and Family Affairs Administration

The Consumer and Family Affairs Administration promotes and protects the rights of individuals with behavioral health disorders; encourages and facilitates consumer and client and family leadership of treatment and recovery plans, and ensures consumer and client voice in the development of the behavioral health system. The Administration also promotes consumer and client leadership, manages the peer certification training, and provides expertise on the consumer

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and client perspective. This Administration is made up of the following teams: Peer Support, Consumer Engagement, Consumer Rights, Quality Improvement and Saint Elizabeths Hospital.

Systems Transformation Administration

The Systems Transformation Administration conducts research, analysis, planning and evaluation leading to defined individual, service and system outcomes; works to improve efficiency and collaboration among internal and external partners; develops and implements learning opportunities to advance system change, and greater effectiveness of the service delivery system.

The Systems Transformation Administration uses information systems and data to develop a transformational strategic plan as well as programmatic regulations, policies, and procedures to support the DBH mission. The Administration includes functions of the former Provider Relations, Information Technology and Applied Research and Evaluation, and the Office of Strategic Planning, Policy and Evaluation. The Administration components are described below.

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

- *Information Systems Innovation and Data Analytics Division (ISIDA)-* provides and maintains high-quality hardware and software applications that support the provision and monitoring of consumer and client services. It also produces and analyzes data for decision-making. This division is made up of the Data and Performance Management Branch, Information Systems Support Branch, and Technology Infrastructure Branch.

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

  - *Information Systems Support Branch-* ensures continuity of operations and continual improvement of existing practice management, billing software applications, electronic health record applications and other systems, and provides business analysis support for new systems.

  - *Technology Infrastructure Branch-* manages the agency's technical support systems, including server maintenance; maintains asset inventory, and provides multi-functional device support and management.

- *Strategic Management and Policy Division-* develops programmatic regulations, policies and procedures to support the agency's mission and manages the Performance Plan and Performance Accountability Report.

- *Network Development Division-* monitors and provides technical assistance to individual providers and the provider network on emerging clinical, care coordination, administrative

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and organizational issues to ensure and enhance the provision of services. Supports the development of new providers interested in certification.

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

Saint Elizabeths Hospital

Saint Elizabeths Hospital provides inpatient psychiatric, medical, and psycho-social person-centered treatment to adults to support their recovery and return to the community. The Hospital's goal is to maintain an active treatment program that fosters individual recovery and independence as much as possible. The Hospital is licensed by the District's Department of Health and meets all the conditions of participation promulgated by the federal Centers for Medicare and Medicaid Services. The Saint Elizabeths Hospital components are described below.

- *Office of the Chief Executive-* provides overall executive management and leadership for all services and departments of Saint Elizabeths.

- *Office of the Director of Medical Affairs-* provides the clinical, operational, strategic, and cultural leadership necessary to deliver care that is high- value (in terms of cost, quality and patient experience) to support their recovery and reintegration into the community.

- *Chief Clinical Officer-* provides clinical leadership and interdisciplinary treatment teams; ensures the provision of social work services; treatment programs; rehabilitation services; utilization review; and volunteer services.

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

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

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

- *Office of the Chief Operating Officer-* provides the operational, strategic, and cultural leadership necessary to plan, direct and manage major administrative functions. This ensures the provision of high quality services while also meeting the needs of individuals in care and

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external stakeholders. The Chief Operating Officer regularly interacts and coordinates with finance, information systems, human resources, performance improvement, and risk management.

- *Engineering and Maintenance-* provides maintenance and repairs to ensure a functional, safe, and secure facility to maximize the benefits of the therapeutic environment.

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

- *Housekeeping-* maintains a clean and sanitized environment to enhance the therapeutic environment and level of clinical performance.

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

- *Nutritional Services-* provides optimum nutrition and food services, medical nutrition therapy and nutrition education services in a safe and sanitary environment.

- *Security and Safety-* provides a safe and secure facility for patients, visitors, and staff to support a therapeutic environment.

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

4. Mental Health Block Grant Five Statutory Reporting Criteria

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

The Mental Health Block Grant statutory reporting requirement **Criterion 1** addresses **Comprehensive Community-Based Mental Health Service Systems** defined as: *provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental health/substance use disorders (M/SUD). States must have available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities.*

The Department of Behavioral Health (DBH) system realignment will be fully implemented October 1, 2017. The system is not population based. It is based on services, functions, initiatives, projects and activities that cross several broad administrations that include various populations. *Criterion 1- Comprehensive Community-Based Mental Health Service Systems* will

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address the adult system of care and *Criterion 3-Children's Services* addresses the system of care for children, youth, transition age, young adults and their families.

Definition Adults with Serious Mental Illness (SMI): SAMHSA defines adults with SMI as persons age 18 and over who: 1*) currently meet or at any time during the past year has met criteria for a mental disorder – including within developmental and cultural contexts – as specified within a recognized diagnostic classification system (e.g., most recent editions of DSM, ICD, etc.), and 2) display functional impairment, as determined by a standardized measure that impedes progress towards recovery and substantially interferes with or limits the person's role or functioning in family, school, employment, relationships, or community activities.*

Goal of Adult Services: The primary goal for the adult service system is to develop and provide an integrated system of care for adults with serious mental illness and/or co-occurring substance use disorders (SUD). This includes DBH providing mental health and SUD services. It also includes DBH contracting with community providers for mental health and SUD services and supports.

Overview of Adult Services System

- **Mental Health Rehabilitation Services Providers**

  The District of Columbia Department of Behavioral Health (DBH) serves the State Mental Health Authority (SMHA) providing services and contracting with community providers for mental health services and supports. The adult mental health rehabilitation services (MHRS) include: 1) diagnostic-assessment; 2) medication/somatic treatment; 3) counseling; 4) community support; 5) crisis/emergency; 6) rehabilitation/day; 7) intensive day treatment; 8) assertive community treatment; 9) supported employment; and 10) health homes. As of August 18, 2017, there were 14 adult only providers and 12 adult and child//youth serving providers. It should be noted that DBH has opened the system for new providers to seek certification. The goal is to increase access and choice for consumers.

  The adults served include the following:

Fiscal Year	Adults Ages 21 and over
2015	22,122
2016	13,547
2017 YTD	19,024

- **Substance Use Disorder Services Providers**

  The DBH also serves as the District of Columbia Single State Agency (SSA) for substance use disorders providing services and contracting with community providers for substance use disorder services and supports. The level of care for the substance use disorder services include: 1) 0.5-early intervention services; 2) I-outpatient services; 3) II.1-intensive outpatient; 4) II.5- partial hospitalization; 5) III.1-clinically-managed low-intensity residential; 6) III.3-clinically-managed medium-intensity residential; 7) III.5-clinically-managed high-intensity residential; 8) III.7- medically-monitored intensive-inpatient services; and 9) IV-medically-managed intensive inpatient services.

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The SUD service providers include: 1) parents with children provider (1); 2) child and youth providers (6); 3) adult providers some with multiple locations (30); and SUD providers who are also MHRS providers (6).

- **Clinical Services Administration**

The Clinical Services Administration is a newly expanded part of the agency. The programs and services associated with this Administration include the outpatient direct care services of the Department.

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

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

  The number of adults served include the following:

Fiscal Year	Number Served
FY 2015	5,398
FY 2016	5,568
FY 2017 YTD	4,366

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

  Although this Division serves children, the description of the Children's Services Branch is included under Criterion 3- Children's Services.

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

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

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

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loss counseling; 9) coordinate visits with other District agencies; 10) FD12 completion in likelihood of injury; and 11) consultations.

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

Fiscal Year	Mobile Crisis Service Visits
FY 2015	1,274
FY 2016	1,007
FY 2017 YTD	776

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

The number of homeless outreach service visits include the following:

Fiscal Year	Homeless Outreach Service Visits
FY 2015	2,897
FY 2016	2,009
FY 2017 YTD	3,070

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

The number of Access HelpLine calls include the following:

Fiscal Year	Access HelpLine Incoming Calls	Access HelpLine Suicide Calls	Access HelpLine/Washington Metropolitan Area Transit Authority Suicide Line Calls
FY 2015	82,420	3, 891	379
FY 2016	53,908	2,264	89
FY 2017 YTD	47,450	1,555	51

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

Forensic Outpatient Services- This service provides: 1) court ordered outpatient competency restoration and evaluations for pre-trial defendants at the adult clinic; 2) court ordered evaluations at the D.C. Superior Court for both pre-trial and post-trial defendants; 3) medication monitoring and management for Not Guilty By Reason of Insanity (NGRI) individuals who have been discharged from Saint Elizabeths Hospital and reside in the community with an order of conditions; and 4) mental health liaisons to

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the D.C. Superior Court, jails and prisons to link justice involved individuals to services and coordinate care on their behalf.

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

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

Court Urgent Care Clinic Services (D.C. Superior Court)- Serves individuals in the criminal justice system who 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.

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

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

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

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Saint Elizabeths Hospital- Within the hospital, the forensic consult service provides pre-trial and post-trial forensic evaluations for inpatients who are involved in the criminal justice system. The forensic division also oversees the management of NGRI individuals to ensure that court ordered updates and directives are executed in a timely manner.

- **Assessment and Referral Center Division-** Assess and refer adults seeking treatment for substance use disorders to appropriate services including detoxification, inpatient, Medication Assisted Treatment (MAT), outpatient substance use disorder treatment programs, or recovery support services. The Mobile Assessment and Referral Center (MARC), a mobile outreach vehicle, visits communities throughout the District to conduct assessment, referral, and HEP-C and HIV testing.

  The MARC visits include the following:

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

- **Adult Community Services Reviews**

  The adult Community Services process is under review. During FY 2018 there will be either an adult or child community services review.

- **Consumer and Family Affairs Administration (CFAA)**

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

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

  During the FY 2017 Winter Peer Specialists Training 13 individuals completed the course. The Certified Peer Specialists (CPS) included: 3 Family Peers, 1 Youth Peer, and 9 Adult Peers. Also, during FY 2017 CFAA reported the number of CPS engaged in meaningful work (quarter 1= 79, quarter 2= 85, and quarter 3= 85).

  Projects: Some of the current projects are described below.

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

- ▪ ***D.C. Certified Peer Academy (DCCPA)-*** The DCCPA was launched in late FY 2017. It offers access to subject matter experts and support to help expand certified peer run organization's knowledge, expertise, sustainability, and capacity to carry out their mission. It also provides opportunities to connect with and learn from other Certified Peer Run Organizations (CPRO)/Recovery Community Organizations (RCO)/Youth Run Organizations (YRO)/Family Run Organizations (FRO) facing similar challenges. The intensive Technical Assistance (TA) will: 1) support the implementation and sustainment of activities to engage peer leaders from mental health and substance use communities, and 2) assist DBH in achieving implementation plans to expand recovery support efforts.

- ▪ ***Purple Wave Festival-*** This annual celebratory event launched in 2016 led by DBH during the national recovery month to promote healthy lifestyles and the positive impact of mental health and substance use recovery. The purpose is to inform people that recovery is possible and help is available. The event is intended for anyone who has or is currently recovering from mental health and/or substance use disorders, as well as everyone who supports recovery as a journey to a healthy lifestyle and wellness. The 2017 Festival planning is underway and will occur in September 2017.

- • **Evidence-Based Practices**

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

    The services include: 1) mental health-related medication administration and monitoring; 2) crisis assessment and intervention; 3) symptom assessment, management and individual supportive therapy; 4) substance use treatment for consumers with co-occurring addictive disorders; 5) psychosocial rehabilitation and skill development; 6) interpersonal, social, and interpersonal skill training; and 7) education, support and consultation to consumers' families and their support system, which is directed exclusively to the well-being and benefit of the consumer.

    There are 6 ACT providers that include: 1) Anchor Mental Health, 2) Community Connections, Inc., 3) Family Preservation, 4) Hillcrest Children and Family Center,

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5) MBI, and 6) Pathways To Housing. These providers collectively have 20 teams. The Dartmouth Assertive Community Treatment Fidelity Scale is used annually to review each team. DBH also developed an ACT Review Tool to assess the quality of services provided. DBH has two (2) combined Transition to Independence Process (TIP) Model and ACT teams, known as TACT, that target transition age youth ages 18-29.

The data for consumers served through the ACT program include the following:

Fiscal Year	Number Served
FY 2015	1,450
FY 2016	1,502
FY 2017 YTD	1,643

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

  DBH currently has eight (8) certified Supported Employment providers that include: 1) Anchor Mental Health, 2) Community Connections, 3) Contemporary Family Services, 4) Deaf- Reach, 5) MBI, 6) Pathways To Housing, 7) PRS, and 8) Psychiatric Center Chartered. Each provider has a total of 1-7 Employment Specialists (depending on the size of the program) carrying a maximum caseload of 20 clients per Employment Specialist. The current maximum DBH capacity is 800, however, capacity can grow with demand. DBH uses a 14-point fidelity scale to annually review and rate the quality of supported employment services.

  The data for the number of consumers served across the eight (8) certified Supported Employment providers include the following:

Fiscal Year	Number Served
FY 2015	1,326
FY 2016	1,025
FY 2017 YTD	670

  There were approximately 763 consumers employed over this 3-year period. The average hourly salary was approximately $10.13 - $12.74. The types of jobs the consumers performed included but were not limited to**:** Peer Specialist, Child Care, Custodial, Food Services, Geriatrics, Home Health Aide, Banking, Stocking, Medical Assistant, Security Guard, Management, Customer Service, Hospitality, various government and other positions.

  The Supported Employment partners are listed below.

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

  In FY 2016, there were 263 individuals screened and referred to providers for ongoing behavioral health services. In FY 2017 year-to-date, 108 individuals have been screened and referred.

- **_Department on Disability Services (DDS)-_** DBH is an active partner in the "Employment First Initiative" that is centered on the belief that all individuals, including individuals with significant disabilities, are capable of full participation in integrated paid competitive employment. DBH evidence-based Supported Employment fits perfectly with Employment First principles and practices. In FY 2016, two (2) DBH provider agencies piloted Customized Employment Strategies promoted by this Initiative and are geared toward assisting individuals who have experienced multiple barriers to gain and maintain employment.

  The Rehabilitation Services Administration (RSA is a component of DDS. DBH and RSA have a memorandum of agreement (MOA) where RSA jointly supports DBH certified Supported Employment providers. The funds from RSA are directed toward job development, job placement and job retention services. In FY 2016 DBH Supported Employment providers received purchase orders totaling $907,231.00 for the provision of these three (3) services. In FY 2017 all DBH certified Supported Employment providers are using a milestone payment system to pay for these services for all eligible referred consumers. A total of $1.7M is available from RSA for job development, placement and retention services.

- **Prevention Activities**

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

  - **_Prevention Centers-_** The DBH funds four (4) D.C. Prevention Centers (DCPCs) that are designed to strengthen the community's capacity to reduce substance use and prevent risk

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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.

- ***Combating Opioid Misuse within the HEP-C/HIV Population-*** DBH substance use disorder staff attended this training event in September 2016. The purpose was to define and summarize the overwhelming opioid epidemic occurring in the Metropolitan Washington, D.C. area and nationwide. The presentations addressed the challenges in screening, treating and managing patient populations co-infected with Hepatitis-C, HIV, mental illness and opioid misuse.

- ***Prevention Symposium-*** This activity was implemented in October 2016. The participants included DBH substance use disorder staff, prevention center staff, and other participants. The session discussions included: 1) Under Age Drinking, 2) Use of Social Media for Prevention Messaging, and 3) Marijuana Use. It is anticipated that another symposium will occur by the end of 2017. It will add Prescription Use and Misuse to the other topics related to Under Age Drinking and Marijuana Use. The goal is to continue to build prevention related activities to address workforce, data, and expertise in the field issues.

- ***D.C. Epidemiological Outcomes Workgroup (DC EOW)-*** The DC EOW goals will be sustained through local and Strategic Prevention Framework Partnership for Success funds. They include: 1) continue updating District and Ward alcohol, tobacco and other drug data that includes consumption, consequences, risk and protective factors, demographics and health disparities; 2) develop a collaborative effort to build a common, systematic methodology for conducting prevention needs assessment based upon a risk assessment system to guide prevention policy, program planning, and resource allocation.; 3) utilize risk and protective factor data, incidence and prevalence data to estimate service needs, target prevention resources, select appropriate preventive interventions, and evaluate the effects of the prevention system; and 4) develop District and Ward reports and resources for policy and program planners and community stakeholders.

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The emphasis on risk and protective factors increases an understanding that substance use and other aspects of behavioral health share many of the same risk and protective factors. Common risk factors predict diverse behavior problems including substance use, anxiety and depression, delinquency, violence, school dropout, and teen pregnancy. Because common risk factors predict diverse behavior problems, it is important to ensure that prevention efforts reach those young people exposed to many risk factors during their development.

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

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

- **Adults, Young Adults and Youth Substance Use Campaigns**

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

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

  - **"Opioid Awareness Campaign" (addresses opioid use among adults, young adults and youth)-** DBH Substance Use Disorder Services Prevention Division is developing this campaign to raise awareness about the risks associated with opioid use and to direct individuals to help. Phase 1 targets adults, specifically older African American male heroin users age 40-69. It highlights increased health risks of using heroin especially batches laced with other synthetic opioids such as fentanyl and carfentanil. It also

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promotes the use of Naloxone that can reverse an overdose resulting from heroin use. The emphasis will be on seeking medical attention following administration of the Naloxone.

Phase 2 targets youth and young adults to shed light on how the misuse of prescribed opioids can lead to addiction, be a gateway to more potent variations of opioids, or result in death. It will also address the notion that many individuals who are misusing prescription opioids are not knowledgeable of the risks and/or the class of drugs they are using (e.g., same family as heroin).

- **Recovery Coaching Training**

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

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

- **District of Columbia Olmstead Plan 2017-2020**

  Since 2007, the District's Office of Disability Rights (ODR) has had the responsibility of developing and submitting the city's Olmstead Compliance Plan to the Mayor for approval. In August 2015, Mayor Muriel Bowser created an Olmstead Working Group charged with making recommendations for revisions to future iterations of the District's Olmstead Plan to support this effort, and to include a broad array of voices in the process. In 2016, during its first full year of existence, the Olmstead Working Group focused its efforts on determining what data the District should track to allow for a comprehensive picture of what transition looks like for individuals leaving institutionalized care and attempting to access long-term services and supports in the District. The Group concentrated its efforts and discussion around data collection that would aid the District in its effort to create a seamless system across agencies that tracks a person's progress toward independence in a meaningful, understandable way.

  - *Improving Long-Term Care in the District-* The District is engaged in a multi-year effort to design and implement a seamless process for accessing Long Term Services and Supports. The new system embraces the principles of No Wrong Door and will ensure that individuals receive accurate information regardless of where they enter the system. Efforts are underway to streamline and simplify the eligibility process. These efforts are supported by federal grants including a three year, No Wrong Door Implementation Grant awarded by the Administration on Community Living and CMS, as well as a major grant awarded to the Department of Health Care Finance to support the procurement of a new, multi-agency case management system. These system improvements will reduce

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fragmentation and the time it takes to connect to needed services.

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

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

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

G*overnment Agencies-* The primary District agencies are described below.

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

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

Department of Health Care Finance (DHCF)- The DHCF is the District's Medicaid agency and the primary payer for all long term services and supports (LTSS) the city provides. In FY 2016, the District spent a total of $796 million in Medicaid funds on these services; $241 million (or 30%) were local dollars. These funds pay for care in

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institutional settings including nursing facilities and Intermediate Care Facilities for individuals with Intellectual and Developmental Disabilities (ICF/IDDs), as well as a variety of home and community-based services (HCBS). Approximately 44% of total Medicaid funds spent on LTSS were spent on institutional care while 56% were spent on home and community-based services.

Department of Human Services (DHS)- The DHS routinely serves people with disabilities. For example, in FY 2014 approximately 17% of applicants were assessed as likely to have a mental disorder of some magnitude, and 4% to have a learning disability in income-based programs such as TANF, SNAP, and Medicaid. In the homeless services program, 40% of singles and 16% of adult head of families entering shelters were assessed to have a disability in at least one of eight (8) categories. In the Adult Protective Services program (investigates reports of abuse, neglect, exploitation and self-neglect and provides temporary services and supports) and in some cases an estimated 45% of those served were assessed to have a disability.

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

Department on Disability Services (DDS)- The DDS oversees and coordinates services for District residents with disabilities through a network of community-based, service providers. Within DDS, the Developmental Disabilities Administration (DDA) coordinates person-centered home and community services so each person can live and work in the neighborhood of his or her choice. DDA promotes health, wellness and a high quality of life through service coordination and monitoring, clinical supports, and a robust quality management program. In FY 2016, DDA served 2,363 people.

DDS's Rehabilitation Services Administration (RSA) provides comprehensive, person-centered employment services and supports for people with disabilities, pre-employment and transition services for youth with disabilities, independent living services and services for people with visual impairments. In FY 2016 RSA served 7,309 people.

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

Office of the State Superintendent for Education (OSSE)- The OSSE is the District's

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state education agency. OSSE is responsible for ensuring that all education-related public agencies identify and evaluate children who may have a disability and provide an education that meets the children's individualized needs alongside peers without disabilities to the maximum extent appropriate. OSSE also has oversight of non-public special education schools -- the most restrictive educational placements for children with disabilities. In FY 2015, 12,173 children with qualifying disabilities ages 3- 21 were served. In addition, OSSE oversaw IDEA Part C early intervention services for approximately 700 infants and toddlers. Finally, OSSE operated hundreds of buses that traveled 34,000 miles per day to transport more than 3,000 students with disabilities to their schools across the region.

Other Agencies- Many other District agencies serve and support people with disabilities. In doing so, they interface on a regular basis with the agencies listed above. The other government agencies include: 1) D.C. Housing Authority (independent agency), 2) D.C. Public Libraries, 3) D.C. Public Schools, 4) Department of Child and Family Services Agency, 5) Department of Corrections, 6) Department of Housing and Community Development, 7) Department of Employment Services, 8) Department of Parks and Recreation, 9) Department of Youth Rehabilitation Services, and 10) D.C. Department of Transportation.

- **Health Homes Initiatives**

    - *Health Home 1-* The District of Columbia Health Homes (HH) initiative launched in January 2016 is a joint effort by DBH and the Department of Health Care Finance (DHCF). The primary goals include: 1) improve care coordination; 2) prevent avoidable hospital and emergency room visits; 3) improve the overall health status of persons with serious mental illnesses; and 4) reduce health care costs.

      The HH are for people with Medicaid who have: 1) 2 or more chronic conditions; 2) one chronic condition and are at risk for a second; 3) one serious and persistent mental health condition; 4) chronic conditions listed in the statute that include mental health, substance abuse, asthma, diabetes, heart disease and being overweight; and 5) other chronic conditions such as HIV/AIDS may be considered by the Centers for Medicare and Medicaid (CMS) for approval. Also, states can target health home services geographically but cannot exclude people with both Medicaid and Medicare from health home services.

      The health home services include: 1) comprehensive care management; 2) care coordination; 3) health promotion; 4) comprehensive transitional care/follow-up; 5) patient and family support; and 6) referral to community and social support services. At the end of the FY 2017 third quarter, there were 1,711 adults receiving HH1 services.

    - *Health Homes 2/ MyHealth GPS-* HH2 was launched in July 2017. The **model** includes: 1) providers integrate and coordinate all primary, acute, behavioral health, and long-term services and supports; 2) must include fee-for-service (FFS) and managed care organization (MCO) beneficiaries; and 3) Centers for Medicare and

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Medicaid Services (CMS) provides 90/10 match for the first 8 quarters. The **eligibility requirements** include: 1) have 2 or more chronic conditions; 2) have one chronic condition and are at risk for a second; and 3) have one serious mental illness (SMI). The **required services** are the same as the 6 services described under **Health Home 1**. The goals include: 1) improve the integration of physical and behavioral health care; 2) reduce healthcare costs (lower rates of avoidable Emergency Department use and reduce preventable hospital admissions and re-admissions); 3) improve the experience of care and quality of services delivered; and 4) improve health outcomes.

- **Community Residential Facilities (CRFs)**

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

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

    Supportive Rehabilitation Residence (SRR): Provides 24- hour, structured housing support for consumers with severe and persistent mental illnesses who need an intense level of support to live within the community. The specific services offered include: 24-hour awake supervision; assisting the consumer to obtain medical care; providing training and support to assist consumers in mastering activities of daily living; maintaining a medication intake log to 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. DBH licenses these facilities.

    Intensive Rehabilitative Residence (IRR): Provides 24- hour intensive level of care for individuals enrolled in the DBH behavioral health system that have medical issues that put them at risk for needing nursing home care if they do not receive physical health care nursing supports along with the appropriate mental health rehabilitation services. DBH licenses these facilities.

    Transitional Residence (TR): Provides 24- hour beds specifically for persons with a principal diagnosis of mental illness and who are homeless. They may also be used

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for persons with dual diagnoses of mental illness and substance abuse and who may need extensive medical and psychiatric evaluation, or require intermittent or limited nursing care. DBH licenses these facilities.

In FY 2017, there were 104 MHCRF licensed by DBH. They include: 1) 69 SRs, 2) 34 SRRs, 3) 2 IRRs, and 4) 1TR.

- **Crisis Stabilization Beds**

  This DBH service provides a short-term, safe supportive living environment for consumers who do not require inpatient treatment for stabilization. The Department contracts with two (2) community providers for 15 crisis beds, 8 at Jordan House and 7 at Crossing Place.

- **Housing Programs**

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

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

  - *D.C. Local Rent Supplement Program (LRSP)-* The LRSP, in effect since 2007, is 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.

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

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- *Persons Receiving Housing:* In FY 2016 a total of 2,708 persons received housing. At the end of the FY 2017 third quarter 2,730 people had received housing.

- **Mental Health Statistics Improvement Program Survey (MHSIP) for Adults**

The MHSIP survey has been designed for the adult mental health population. The Department of Behavioral Health (DBH) served 19,599 adult consumers in FY 2016. From this general population, a random sample of 2,600 adult consumers who received at least two (2) mental health services within the past 6-months was selected to participate in the survey. These consumers were extracted from the DBH claims database with 390 consumers completing the MHSIP survey.

The MHSIP survey presents statements about services within 7 domains and asks respondents to state to what degree they agree or disagree with them. The domains include: 1) Access, 2) Participation in Treatment Planning, 3) Quality and Appropriateness, 4) Social Connectedness, 5) Functioning, 6) Outcomes, and 7) General Satisfaction.

Focusing on the 2016 findings, adults were most satisfied with Quality and Appropriateness (82%) and General Satisfaction (79%). Adults, however, were least satisfied with their Social Connectedness (63%) and Outcomes (67%).

- **Adult FY 2017 Mental Health Block Grant (MHBG) Funded Projects**

  - **MBI Health Services, LLC-** *Wellness Recovery Action Plan (WRAP) At Our Door* offers WRAP workshops, support groups and educational experiences. The trainees include persons in recovery from substance use disorders and/or serious mental illnesses, community participants and others.

  - **Miriam's Kitchen-** *Critical Conversation and Connections* provides services by the contract psychiatrist that include some combination of medication management, assessments and evaluations, short-term crisis management and/or referrals to mental health providers for longer term treatment or other resources. Also, training sessions conducted with Case Management staff on how to work effectively with homeless populations. An estimated 75 adults will be engaged in mental health treatment providing 150 sessions of 1:1 psychiatric support services (2 sessions per individual). Recipients are adults with substance use and/or mental health issues, who are struggling with homelessness.

  - **Mary's Center-** *Tele-Behavioral Health Senior Wellness Program* provides depression screening and treatment to District resident senior citizens who use the Bernice Fonteneau Senior Wellness Center in Ward 1. The goal is to screen 50% of the wellness center participants using the PHQ-9 (national standardized instrument) and provide tele-behavioral health for up to 40 of those who screen positively for depression.

  - **Thrive DC-** *Substance Abuse and Recovery Counseling Program (SARC)* consists of group treatment sessions, substance use assessments, 1:1 counseling, and case management services. SARC will serve approximately 40 unduplicated individuals in 90

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group sessions, with 10 participants being intensively case managed by the Substance Abuse Counselor.

- **So Others Might Eat (SOME, Inc.)-** *Integrated Treatment for Co-Occurring Disorders: Enhancing SOME's Addiction Recovery Services and Beyond* by providing more integrated services with mental health care. The project targets the addiction continuum treatment staff primarily whose clients include homeless adults and older adults with serious mental illnesses, persons at risk of contracting communicable diseases, and the LGBT community.

- **The Women's Collective (TWC)-** *Trauma Recovery Empowerment Model (TREM) @ TWC and Reinforcement-Based Treatment (RBT)) @ TWC* designed to facilitate trauma recovery among women with histories of exposure to sexual and physical abuse and those involved with illicit substance abuse. TWC will target 20 urban, low income African American women 18+ living with HIV/AIDS, co-occurring substance use and childhood sexual trauma for TREM. Also, 10 women with the same histories will participate in the RBT intervention. The total participants across the two (2) interventions is 30.

Criterion 2: Mental Health System Data Epidemiology

The Department of Behavioral Health (DBH) does not generate data on prevalence. The information DBH receives is provided by SAMHSA from the Center for Behavioral Health Statistics and Quality (CBHSQ). They fill in the prevalence information on the relevant Uniform Reporting System (URS) tables.

The most recent data that the Department of Behavioral Health (DBH) has is 2015 data provided by the National Association of State Mental Health Directors/National Research Institute (NASMHPD/NRI) for adults with SMI and children/youth with SED.

2015 District of Columbia Adults with Serious Mental Illness (SMI)

2015	Civilian+ Population Age 18+	Civilian+ Population Age 18+ with SMI (5.4%)	Lower Limit of Estimate (3.7%)	Upper Limit of Estimate (7.1%)
	550,598	29,732	20,372	39,092

2015 District of Columbia Children/Youth with Serious Emotional Disturbances (SED)

2015	Civilian Population Youth Age 9-17	Age 5-17 % In Poverty	D.C. Tier % in Poverty	LOF Score=50 Lower Limit/Upper Limit	LOF Score=60 Lower Limit/Upper Limit
	47,681	26.3%	High	3,338 / 4,291	5,245 / 6,199

- **Behavioral Health Data Summary**

  The *Behavioral Health Barometer: District of Columbia, 2015* is one of a series of national and state reports that provide a snapshot of behavioral health in the United States. The reports present a set of substance use and mental health indicators as measured through data

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collection efforts sponsored by SAMHSA, including the National Survey on Drug Use and Health and the Uniform Reporting System.

1. *Youth Mental Health and Treatment-Depression*

   ▪ <u>Past Year Major Depressive Episode (MDE) Among Adolescents Aged 12–17 in the District of Columbia and the United States (2010–2011 to 2013–2014)</u>- The District of Columbia percentage of MDE among adolescents aged 12–17 was lower than the national percentage in 2013–2014. The District was 8.7% and the nation was 11.0%.

     In the District of Columbia about 3,000 adolescents aged 12–17 (8.7% of all adolescents) per year in 2013–2014 had at least one MDE within the year prior to being surveyed. The percentage increased from 2010–2011 to 2013–2014.

2. *Youth Mental Health and Treatment- Treatment for Depression*

   ▪ <u>Past Year Treatment for Depression Among Adolescents Aged 12–17 with Major Depressive Episode (MDE) in the District of Columbia (Annual Average, 2007–2014)</u>- The District of Columbia annual average of treatment for depression among adolescents aged 12–17 with MDE was similar to the annual average for the nation from 2007 to 2014. The District was 37.7% and the nation was 38.1%.

     In the District of Columbia about 1,000 adolescents aged 12–17 with MDE (37.7% of all adolescents with MDE) per year from 2007 to 2014 received treatment for their depression within the year prior to being surveyed.

3. *Mental Health and Treatment- Thoughts of Suicide*

   ▪ <u>Past Year Serious Thoughts of Suicide Among Adults Aged 18 or Older in the District of Columbia and the United States (2010–2011 to 2013–2014)</u>- The District of Columbia percentage of adults aged 18 or older with suicidal thoughts was similar to the national percentage in 2013–2014. The District was 3.9% and the nation was 3.9%.

     In the District of Columbia about 21,000 adults aged 18 or older (3.9% of all adults) per year in 2013–2014 had serious thoughts of suicide within the year prior to being surveyed. The percentage did not change significantly from 2010–2011 to 2013–2014.

4. *Mental Health and Treatment- Serious Mental Illness*

   ▪ <u>Past Year Serious Mental Illness (SMI) Among Adults Aged 18 or Older in the District of Columbia and the United States (2010–2011 to 2013–2014)</u>- The District of Columbia percentage of serious mental illness (SMI) among adults aged 18 or older was similar to the national percentage in 2013–2014. The District was 3.9% and the nation was 4.2%.

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In the District of Columbia about 21,000 adults aged 18 or older (3.9% of all adults) per year in 2013–2014 had SMI within the year prior to being surveyed. The percentage did not change significantly from 2010–2011 to 2013–2014.

5. *Mental Health and Treatment- Treatment for Any Mental Illness*

- Past Year Mental Health Treatment/Counseling Among Adults Aged 18 or Older with Any Mental Illness (AMI) in the District of Columbia (Annual Average, 2010–2014)- The District of Columbia annual average of mental health treatment or counseling among adults aged 18 or older with any mental illness (AMI) was similar to the annual average for the nation from 2010 to 2014. The District was 41.6% and the nation was 42.7%.

  In the District of Columbia about 43,000 adults aged 18 or older with AMI (41.6% of all adults with AMI) per year from 2010 to 2014 received mental health treatment/counseling within the year prior to being surveyed.

6. *Mental Health and Treatment- Mental Health Consumers*

- Mental Health Consumers in the District of Columbia and the United States Reporting Improved Functioning from Treatment Received in the Public Mental Health System (2014)- In 2014, 4,943 children and adolescents (aged 17 or younger) were served in the District of Columbia public mental health system. The percentage of children and adolescents (aged 17 or younger) reporting improved functioning from treatment received in the public mental health system was lower in the District of Columbia than in the nation as a whole. The District was 64.1% and the nation was 69.5%.

  The percentage for adults (aged 18 or older) was higher in the District of Columbia than in the nation as a whole. The nation was 70.9% and the District was 72.5%.

7. *Youth Substance Use- Illicit Drug Use*

- Past Month Illicit Drug Use Among Adolescents Aged 12–17 in the District of Columbia and the United States (2010–2011 to 2013–2014)- The District of Columbia percentage of illicit drug use among adolescents aged 12–17 was higher than the national percentage in 2013–2014. The nation was 9.1% and the District was 13.7 %.

  In the District of Columbia about 4,000 adolescents aged 12–17 (13.7% of all adolescents) per year in 2013–2014 reported using illicit drugs within the month prior to being surveyed. The percentage did not change significantly from 2010– 2011 to 2013–2014.

8. *Youth Substance Use- Cigarette Use*

- Past Month Cigarette Use Among Adolescents Aged 12–17 in the District of Columbia and the United States (2010–2011 to 2013–2014)- The District of

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Columbia percentage of cigarette use among adolescents aged 12–17 was similar to the national percentage in 2013–2014. The District was 4.1% and the nation was 5.2%.

In the District of Columbia about 1,000 adolescents aged 12–17 (4.1% of all adolescents) per year in 2013–2014 reported using cigarettes within the month prior to being surveyed. The percentage decreased from 2010–2011 to 2013– 2014.

9. *Youth Substance Use- Binge Alcohol Use*

- <u>Past Month Binge Alcohol Use Among Individuals Aged 12–20 in the District of Columbia and the United States (2010–2011 to 2013–2014)</u>- The District of Columbia percentage of binge alcohol use among individuals aged 12–20 was similar to the national percentage in 2013–2014. The nation was 14.0% and the District was 16.2%.

  In the District of Columbia about 9,000 individuals aged 12–20 (16.2% of all individuals in this age group) per year in 2013–2014 reported binge alcohol use within the month prior to being surveyed. The percentage decreased from 2010– 2011 to 2013–2014.

10. *Youth Substance Use- Substance Use Initiation and Risk Perceptions*

- <u>Past Year Initiation (First Use) of Selected Substances Among Adolescents Aged 12– 17 in the District of Columbia, by Substance Type (Annual Averages, 2010–2014)</u>- Among adolescents aged 12–17 in the District of Columbia from 2010 to 2014, an annual average of 9.8% initiated alcohol use (i.e., used it for the first time) within the year prior to being surveyed, and an annual average of 6.5% initiated marijuana use within the year prior to being surveyed.

- <u>Adolescents Aged 12–17 in the District of Columbia and the United States Who Perceived No Great Risk from Smoking One or More Packs of Cigarettes a Day (2010–2011 to 2013– 2014)</u>- The percentage of adolescents aged 12–17 in the District of Columbia who perceived no great risk from smoking one or more packs of cigarettes a day did not change significantly from 2010–2011 to 2013–2014.

  In the District of Columbia about 4 in 10 (41.9%) adolescents aged 12–17 in 2013– 2014 perceived no great risk from smoking one or more packs of cigarettes a day, a percentage higher than the national percentage (34.7%).

- <u>Adolescents Aged 12–17 in the District of Columbia and the United States Who Perceived No Great Risk from Having Five or More Drinks Once or Twice a Week (2010–2011 to 2013–2014)</u>- Adolescents Aged 12–17 in the District of Columbia and the United States Who Perceived No Great Risk from Having Five or More Drinks Once or Twice a Week (2010–2011 to 2013–2014).

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In the District of Columbia about 1 in 2 (53.3%) adolescents aged 12–17 in 2013–2014 perceived no great risk from having five or more drinks once or twice a week, a percentage lower than the national percentage (60.9%).

- Adolescents Aged 12–17 in the District of Columbia and the United States Who Perceived No Great Risk from Smoking Marijuana Once a Month (2010–2011 to 2013–2014)- The percentage of adolescents aged 12–17 in the District of Columbia who perceived no great risk from smoking marijuana once a month increased from 2010–2011 to 2013–2014.

  In the District of Columbia about 8 in 10 (84.3%) adolescents aged 12–17 in 2013–2014 perceived no great risk from smoking marijuana once a month, a percentage higher than the national percentage (76.5%).

11. *Youth Substance Use- Non-Medical Use of Pain Relievers*

- Past Year Nonmedical Use of Pain Relievers Among Adolescents Aged 12–17 in the District of Columbia and the United States (2010–2011 to 2013–2014)- The District of Columbia percentage of nonmedical use of pain relievers among adolescents aged 12–17 was similar to the national percentage in 2013–2014.

  In the District of Columbia about 1,000 adolescents aged 12–17 (4.6% of all adolescents) per year in 2013–2014 reported non-medical use of pain relievers within the year prior to being surveyed. The percentage did not change significantly from 2010–2011 to 2013–2014.

- **District of Columbia Health Profile Overview**

The information about the District of Columbia Health Profile is developed by the D.C. Department of Health. It includes: 1) life expectancy at birth, 2) mortality, 3) maternal and child health outcomes, 4) chronic health indicators, and 5) health disparities.

- *Life Expectancy at Birth* (*District of Columbia and the United States, 2011-2015*)

	2011	2012	2013	2014	2015
DC	78.3	78.4	78.6	78.5	78.4
US	78.7	78.8	78.8	78.9	78.8

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- *Mortality* (*- District is higher than United States)

Health Indicator	District of Columbia (2015)	United States (2015)
Leading Causes of Death (age adjusted death rate per 100,000 population)		
Heart Disease	186.4	197.2
Cancer	166.5	185.4
Accidents	39.4	45.6
Cerebrovascular Disease (Stroke)	37.9	43.7
Diabetes	25.6*	24.7
Chronic Lower Respiratory Disease	23.1	48.2
Alzheimer's Disease	19.2	34.4
Homicide/Assault	17.5*	5.5
Influenza and Pneumonia	16.2	17.8
Septicemia	13.4*	12.7

- *Maternal and Child Health Outcomes* (*- District is higher than United States)

Health Indicator	District of Columbia (2015)	United States (2015)
Infant Mortality (per 1,000 births)	7.6* (2014)	5.8
Low Birth Weight (percent of births)	10.0*	8.1
Pre-term Birth (percent of births)	10.2*	9.6
Teen Birth Rate (per 1,000 women ages 15-19)	25.6*	22.3
Fertility Rate (births per 1,000 women ages 15-44)	52.8	62.5

Sources for D.C. Life Expectancy, Mortality, and Maternal and Child Health Outcomes: Vital Records, Center for Policy, Planning and Evaluation, D.C. Department of Health. Sources for U.S. data: Centers for Disease Control and Prevention.

- *Chronic Health Indicators* (*- District is higher than United States)

Health Indicator	District of Columbia (2014)	United States (2014)
Overweight and Obesity (BMI):		
Overweight (BMI 25.0-29.9, percent adults 18 and older)	33.2	35.4
Obese (BMI 30.0-99.8, percent adults 18 and older)	21.7	29.6
Cardiovascular Diseases:		
Heart Attack or Myocardial Infarction (percent adults 18 and older)	2.6	4.4
Angina or Coronary Heart Disease (percent adults 18 and older)	2.4	4.2
Stroke (percent adults 18 and older)	3.3*	3.0
Diabetes:		
Diagnosed with Diabetes (percent adults 18 and older)	8.4	10.0
Asthma:		
Current Asthma (percent adults 18 and older)	11.5*	9.2

Source for Chronic Health Indicators: Behavioral Risk Factor Surveillance System, Center for Policy, Planning and Evaluation, D.C. Department of Health; National data source: Centers for Disease Control and Prevention, all states and D.C. included.

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- **Health Disparities**

  - Non-Hispanic Black infants account for a disproportionate percentage of all infant deaths and the disparity between Non-Hispanic Black infant deaths and Non-Hispanic White is growing (Vital Records, 2015).

  - Blacks/African Americans have the highest obesity rates and are least likely to exercise. (Behavioral Risk Factor Surveillance System, 2014).

  - Hispanics make up the highest percentage of overweight residents (Behavioral Risk Factor Surveillance System, 2014).

  - Ward 8 had the highest age-adjusted death rate from heart disease at 369.4 per 100,000 population (Vital Records, 2014).

  - Life expectancy in the District has mirrored the U.S. trend and decreased from 2014 to 2015. The geographic disparity within the District is more than 20 years, with life expectancies topping 90 years in parts of northwest D.C. and, in neighborhoods east of the Anacostia River, dropping as low as 70 years (Vital Records, 2010-2014 for neighborhood-level data).

Criterion 3*: *Children's Services

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

The Department of Behavioral Health (DBH) system realignment will be fully implemented October 1, 2017. The system is not population based. It is based on services, functions, initiatives, projects and activities that cross several broad administrations that include various populations.

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

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

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develops with the youth and family an individualized plan that focuses on the provision of services within the community.

Overview of Child and Youth Services

- *Mental Health Rehabilitation Services*

  The Department contracts with community providers for mental health services and supports. The child/youth mental health rehabilitation services (MHRS) include: 1) diagnostic-assessment; 2) medication/somatic treatment; 3) counseling; 4) community support; 5) crisis/emergency; and 6) community-based intervention. As of August 18, 2017, there were 5 child only providers and 10 child and youth providers. It is noted that the moratorium on new service providers was lifted so additional providers will be able to seek certification.

  The number of children/youth served includes the following:

Fiscal Year	Children/Youth Ages 0-20
2015	3,301
2016	4,471
2017 YTD	4,232

- *Early Childhood Interventions*

  In the DBH realignment these services are located in the Community Services Administration and the Clinical Services Administration.

  - *Early Childhood Mental Health Consultation (ECMHC)-Healthy Futures:* This evidence-informed mental health consultation project provides early childhood consultation to parents, children and their families, teachers, and providers about mental health and early identification of young children at risk of or displaying signs and symptoms of mental health disorders. ECMHC-Healthy Futures promotes social and emotional development in children and transforms their challenging behaviors. The children range in age from birth-5.

    In FY 2017, the ECMHC- Healthy Futures program operated in several sites that included child development centers and the new expansion-sites. The expansion-sites are showing a demonstrable positive level of change in child behaviors and classroom environments.

    The number of project sites by type includes the following:

Project Site Type	Number of Sites
Child Development Centers	43
Home-Based Providers	3
Pre-Kindergarten Incentive	17
Quality Improvement Network	12

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

- ***Parent Infant Early Childhood Enhancement Program (PIECE):*** This maternal and child mental health program serves pre- and postnatal women, children birth-7.6 years and their families who present with challenging social-emotional behaviors that are disruptive at home, school, and the community. The 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 (e.g., Parent Child Interaction Therapy and Child Parent Psychotherapy).

  The PIECE program data includes the following:

Fiscal Year	Mothers Only Served	Mothers and Children Served	Children Birth -7.6 Served
2015	63	120	120
2016	5	108	108
2017 YTD	6	132	132

- ***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 third grade who have mild problems with social-emotional adjustment in the classroom. The Primary Project services are provided to children attending District of Columbia public and public charter schools, and child development centers 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.

  The Primary Project data is included in the table that follows.

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Fiscal Year	Primary Project Locations	Participants	Screened Positive More Intensive Mental Health Intervention	Screened Positive for Early Intervention/ Prevention Services
2015	45	441	2,456	1,067
2016	46	419	1,348	2,269
2017 YTD	42	329	1,136	802

- *Physicians' Practice Group (PPG):* The PPG provides services to children and youth ages 6-21 with complex emotional and behavioral needs, and mental health challenges. The services provided are available to eligible children and adolescents who are: 1) residents of the District of Columbia, 2) receive services within the DBH provider network, and 3) linked to child servicing agencies such as Child and Family Services Agency, Department of Youth Rehabilitation Services, District of Columbia Public Schools, and children who are court involved. The majority of the PPG services (medication assessments, medication management and court evaluations) are scheduled by the PPG Triage Team.

  The PPG data includes the following:

Fiscal Year	Total Served
FY 2015	1,489
FY 2016	1,449
FY 2017 YTD	741

- *Child Urgent Same Day Services:* Provides urgent same day service, clinical assessment and treatment for children up to age 7 who present with challenging social, emotional, and disruptive behaviors that cause impairment in functioning at home, school/daycare and the community. The same day urgent care services are also triaged to determine urgency/need.

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

- *School Mental Health Program*

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

In FY 2017, DBH clinicians were assigned to 43 D.C. Public Schools and 22 D.C. Public Charter schools. The SMHP utilization data is presented in the table that follows.

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School Mental Health Program (SMHP) Utilization		
Student Information	School Year 15-16 (FY16)	School Year 15-16 (FY17)
Students referred to SMHP clinician	2,198	1,054
Students referred and seen by SMHP clinician	1,884	1,025
Students on caseload	800	598
Students referred to outside services (housing, food, etc.)	236	89
Students referred to outside mental health services (core service agency, Managed Care Organization)	191	161

- **SMHP Primary Prevention and Secondary Prevention Programs:** This includes evidenced-based or evidence informed programs.

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

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

Suicide Prevention: 1) *Signs of Suicide (SOS)-*(SAMHSA approved, evidence-based depression and suicide prevention program), and 2) *Question, Persuade, and Refer (QPR)* - (SAMHSA approved, evidence-based Gatekeeper Training for suicide prevention).

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

Ask 4 Help-K-5: *Yellow Ribbon's Elementary* evidence-informed curriculum that specializes in the ongoing development and reinforcement of protective factors in children and youth.

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

Substance Abuse Prevention: 1) *Teen Intervene-* Helps youth identify the reasons they have chosen to use alcohol or other drugs, examine the effects of substance abuse in their lives, and learn to make healthier choices. *Teen Intervene* now includes updated information on the stages of change theory, motivational interviewing techniques, and cognitive-behavioral therapy, all incorporated into a practical, ready-to-use model. 2) *Botvins Life Skills Training Program-* D.C. Public Schools (elementary only) and

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D.C. Public Charter Schools (elementary, middle, and high schools). A SAMHSA approved evidence-based substance abuse prevention program that addresses the most important factors leading children and adolescents to use drugs. The program teaches a combination of drug resistance skills, self-management skills, and general social skills, and can be implemented with children in 3rd -12th grades.

- *Youth Suicide Prevention and School Climate Survey Amendment Act of 2016 (Law 21-120)*

  This law requires the Office of the State Superintendent for Education (OSSE) to adopt a rule requiring all District teachers and principals in public and charter schools to undergo training on suicide prevention, intervention, and postvention every 2 years. It also requires OSSE to develop and publish online written guidance to assist local education agencies (LEAs) in developing policies and procedures for handling various aspects of student mental and behavioral health. OSSE must examine and evaluate its guidance every 5 years, at a minimum, and notify LEAs within 30 days of updating the guidance. The law also requires OSSE to establish and implement a pilot program to collect school climate data (data regarding engagement, safety, and environment) through school climate surveys, and report school climate data to the Mayor and Council annually.

- *Children and Adolescent Mobile Psychiatric Service (ChAMPS)*

  FY 2017 is year 9 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, 7 days a week for children and youth ages 6 to 18, except for youth who are committed to the Child and Family Services Agency 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.

  The ChAMPS data includes the following:

Fiscal Year	Total Children Served-Unduplicated	Total Calls Received	Total Deployments	Child & Family Service Agency Youth (calls)	Total FD-12s	Total Cases Resulting in Acute Care Admissions
FY 2015	817	1,409	828	179	56	88
FY 2016	748	1,348	930	238	102	162
FY 2017 YTD	455	902	578	110	95	91
TOTAL	2,020	3,659	2,336	527	253	341

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- *Psychiatric Residential Treatment Facilities (PRTFs)*

  DBH provides centralized coordination and monitoring of placement, continued stay, and post-discharge for children and youth receiving services in PRTFs. The Department also oversees the coordination of the PRTFs medical necessity review process.
  During 2017 DBH acquired a new vendor to provide High Fidelity Wraparound services since it is an important component of diverting children/youth from PRTFs. The PTRF data includes the following:

Fiscal Year	Children/Youth in PRTFs	Average Length of Stay	Children/Youth Diverted from PRTFs
2015	113	9.4 months	295
2016	122	8.7 months	250
2017 YTD	78	9.2 months	130

- *Functional Assessment Scales*

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

  The child/youth serving agencies' utilizing the CAFAS and/or PECFAS includes the following:

  - **Child and Family Services Agency (CFSA)-** implemented the CAFAS/PECFAS for all children/youth. 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.
  - **Department of Youth Rehabilitation Services (DYRS)-** administers the CAFAS when a Notice of Intent to Commit is filed and then administers it every 90 days for all committed youth. It is used in the quarterly Team Decision Making (TDM) meeting to identify needs for the plan of care and illustrate change and improvement over time.
  - **Department of Human Services (DHS)-** utilizes the CAFAS for all youth actively enrolled in the Parent and Adolescent Support Services (PASS) in the Alternatives to Court Experience (ACE) diversion program, and in the Teen Parent Assessment Program (TPAP). DHS utilizes the CAFAS data to measure outcomes in these short-term programs.
  - **Department of Behavioral Health (DBH)-** continues to utilize the CAFAS/PECFAS across the child serving providers. The CAFAS/PECFAS total score is used to inform the types and quantity of services that are automatically approved for inclusion in the child/youth's plan of care.
  - **Office of State Superintendent of Education (OSSE)-** is leading a pilot in 13 D.C. Public Schools and D.C. Public Charter schools for youth identified as needing

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counseling to support their learning and functioning in the school environment. These children are administered the CAFAS every 90 days to assess current functioning and change or improvement over time. Plans are underway for expansion of the project in the School Year FY 17-18.

- **Evidence-Based Practices (EBPs)**

  The DBH is committed to improving the lives of children, youth, transition age youth, and families through the use of evidence-based practices. DBH contracts with Evidence Based Associates (EBA) to provide training, quality and fidelity reviews, and monitors EBPs. EBA also provides technical support to all District agencies implementing a DBH sponsored EBP and supports the DBH annual summit held on evidence-based and innovative programs for children, youth and families.

  There are currently nine (9) EBPs that include the following:
  - *Child Parent Psychotherapy for Family Violence-* For ages 0-6 with a history of trauma exposure or maltreatment and their caregivers.
  - *Trauma Systems Therapy-* For ages 0-19 who have experienced traumatic events and/or who live in environments with ongoing traumatic stress.
  - *Parent Child Interaction Therapy-* For ages 2-6 who experience extreme behavioral difficulties with 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.
  - *Cognitive Behavioral Therapy for Psychosis (CBTp)-* An evidence-based treatment primarily designed to target psychotic symptoms such as delusions and hallucinations that persist despite appropriate treatment with antipsychotic medication.

- **Child Community Services Reviews (CSR)**
  The child Community Services process is under review. During FY 2018 there will be either a child or an adult community services review.

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- **Transition Age Youth Initiatives**

  - *Transformation Transfer Initiative (TTI):* In November 2016 DBH was 1 of 6 states/territories awarded a grant by the SAMHSA/ Center for Mental Health Services for projects related to developing, strengthening, or sustaining innovative projects or programs focusing on co-occurring intellectual/developmental disabilities and mental health. DBH in partnership with the D.C. Department on Disability Services (DDS), Child and Family Services Agency (CFSA), and community providers propose to identify individuals between the ages of 16 -25 years who are:1) transitioning from youth services to adult care, 2) diagnosed with an intellectual disability, 3) a co-occurring mental health disorder, and 4) have experienced trauma. A cross-agency team will coordinate the development of a comprehensive support plan.

    The overall goal of this project is to shift the culture of the District's system of care (SOC) supporting people living with dual diagnosis to reflect a more inclusive responsiveness to the holistic needs of the client. The culture shift will also allow agencies to take ownership and believe that they can treat persons living with dual diagnosis through the current system and services available in the community. This shift in culture will be reflected through intervention, treatment planning, and a joint teaming approach and will inform the future of practice for the District.

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

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

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

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

Reports and Outcome Evaluations- A 2016 Year End Progress Report was developed. Also, an independent evaluation will be completed at the end of 2017.

▪ *It's Time to Let Help In-* On April 26, 2016, DBH launched a campaign called *It's Time to Let Help In* to build awareness about youth mental health in the District. It allows youth to shape the conversation about identifying mental health concerns, addressing stigma, and finding resources for help. During the early stages of the project a number of activities occurred including: 1) developing a website to provide facts about the impact of mental illnesses on learning, family and social life and featuring stories in youth voices; 2) creating a strong social media presence via Instagram, Twitter, and Facebook; 3) deploying a colorful mobile unit to help increase mental health awareness; 4) engaging the community directly through flyers, direct mail, and multiple events; 5) forming partnerships with local radio stations (WKYS 93.9, MAJIC102.3, PRAISE 104.1) to communicate with the community on-air and through key co-sponsored events; and 6) devising strategies for DBH outreach.

During FY 2017, the DBH Let Help In anti-stigma campaign targeted vulnerable youth and young adults ages 15-21 in District wards 5, 7 and 8. It also continued to participate in public outreach events. DBH staff will engage in planning strategies to determine the focus and activities that will occur during FY 2018.

▪ *Mental Health Awareness Day Event-* On May 20, 2017 the Department of Behavioral Health hosted a Mental Health Awareness Day to promote available treatment services and to increase understanding and awareness of mental illness. DBH also promoted a new *"It's OK 2 Let Help In"* campaign to combat stereotypes and stigma that keep too many people from getting the treatment they need. This community event included: workshops, health information, family fun, entertainment, games, and refreshments.

▪ *FY 2017 First Episode Psychosis Transition Age Youth (FEP/TAY) Pilot Project-* The goal of the District of Columbia FEP early intervention pilot program is to change the long-term prognosis for young people coping with schizophrenia. The project is being implemented by Community Connections one of the Department of Behavioral Health (DBH) provider agencies.

The project has two (2) primary components: 1) training in Cognitive Behavioral Therapy for Psychosis (CBTp), and 2) implementing a FEP pilot project.

CBTp Training- The training is provided by the Institute of Cognitive Therapy for Psychosis. It consists of four (4) days of didactic presentation followed by 30 weeks of supervised practice, which occurs in skype sessions in groups of 4-5.

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FEP Pilot Project- The District FEP pilot project uses the NAVIGATE Model. The NAVIGATE- inspired team model includes a psychiatrist, program consultant, program director, program evaluator, resiliency trainer, and supported employment and education specialist. The NAVIGATE-inspired services include recovery focus, employment, family education, psychiatric screening, and psychotherapy (referrals).

Referrals- The number of referrals to date includes 24 consumers.
- 25% of referrals were walk-in referrals.
- 20% of referrals originated from the District DBH and the Department of Corrections.
- 1% of referrals were from MedStar Washington Hospital Center Behavioral Health and Psychiatry, 1 individual was referred from Children's National Behavioral Health and Psychiatry.
- 17% of referrals were intra-agency program referrals from within Community Connections.
- 13% of referrals were referred from the Half-Way Back program.
- 8% of referrals were from two (2) public charter schools, Maya Angelou Public Charter School and Idea Public Charter school both located in Washington, D.C.

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

- *Age of TAY Served:* All of the 24 referred individuals fall within the 12-26 age range. The breakdown of each age group includes the following:

Age	Individuals
16	2
17	3
18	3
19	3
21	4
22	4
24	3
25	1
26	1

- *Race and Ethnicity of TAY Served:* Of the 24 TAY in FEP, 75% of identified as Black or African American, 13% of TAY served identify as Hispanic or Latino, 8% of TAY served identify at Caucasian, and 4% of TAY served identify as Other.

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

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Race/Ethnicity	Percentage of Individuals
Black/African-American	75%
Hispanic or Latino	13%
Caucasian	8%
Other	4%

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

Living Arrangement	Residential Setting	Percentage of Individuals
Correctional facility	Jail	13%
Family	House	38%
Family	Apartment	4%
Family	Unknown	4%
Friend/Other	Apartment	4%
Homeless	Shelter	8%
Homeless	House	4%
Homeless	No fixed address	8%
Transitional housing	Shelter	4%
Transitional housing	No fixed address	8%
Section 8 Housing	N/A	0%

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

Employment Status	Percentage of Individuals
Unemployed-Seeking	58%
Full-Time Student	21%
Unemployed-Not Seeking	13%
Employed-Part Time	4%
Unknown	4%

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

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Education Level	Percentage of Individuals
High School Graduate/GED	29%
11th Grade	21%
10th Grade	13%
Some College	13%
12th Grade	8%
8th Grade	8%
9th Grade	4%
Unknown	4%

- *Service Outcomes:* The referrals to date include 24 consumers. Of the 24 consumers referred, 54% continue to receive services from the FEP pilot program while the other 46% were referred to outside resources within Community Connections or to neighboring agencies within the D.C. Metropolitan area.

- *Psychiatric Services and Medication Management:* All FEP enrolled consumers (100%) are receiving medication management services and continued psychiatric care from the FEP pilot program psychiatrist. Fifteen percent (15%) of FEP consumers are linked to psychotherapeutic services delivered by the FEP Resiliency Trainer. In addition, all FEP consumers (100%) continue to receive continued support in addressing clinical and socioenvironmental consumer needs from a NAVIGATE inspired model provided by the FEP Resiliency Trainer.

- *Education and Employment Services:* Forty-six percent *(*46%) of enrolled FEP consumers are connected and receiving services from the FEP Supported Employment and Education Specialist. Services provided include addressing vocational and educational consumer needs within the NAVIGATE inspired model.

- *Pending Status/Referred to Other Programs:* Per program protocol, each consumer enrolled in FEP has to meet program criteria prior to their full enrollment in FEP and this is completed by the FEP team psychiatrist. Furthermore, an initial assessment is administered to ensure that FEP is the best program fit for the individual's needs in addition to identifying whether each individual referred to FEP meets program criteria. Due to this reason, 29% are pending approval to date. Seventeen percent (17%) of referred individuals were referred to Community Connections sister program, TAY-SOC, while one (1) individual is pending a complete referral to the TAY-SOC program.

As FEP becomes more established as a program, the amount of the referrals continues to increase on a monthly basis and Community Connections has created a robust system of care from referral to program enrollment and engagement. It is noted that during July 2017 the number of TAY served increased from 24 to 26.

- *Trauma, Intellectual Developmental Disabilities/Mental Illness (IDD/MI)-* This is a collaboration between the Department of Behavioral Health, Department on Disability Services, Child and Family Services Agency, community based programs,

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and the Georgetown University Center for Excellence in Developmental Disabilities. The focus is on trauma informed care and dual diagnosis (IDD/MI) for transition age youth 16-25.

- *Proposed TAY/ Young Adult Projects:* The proposed projects include: 1) services, 2) training, and 3) resources.

Services

Family Run Organization Partnership: A partnership with a Family Run and/or Young Adult focused organization will be developed via a contract. A Youth Development Specialist will: 1) facilitate outreach to youth and young adults (YA) of transition age across the District with a focus on Wards 7 & 8; 2) support the DC Youth Move chapter; 3) further develop the Youth Council and facilitate the Youth Council meetings; and 4) recruit and engage a diverse group of youth and YA who will actively participate in all aspects of the Our Time project.

Training

- *Youth Leadership Academy:* Transition age youth (TAY) will support the development of a Leadership Academy focused on training youth advocates to become effective leaders within the community. This Academy will create a District-wide speakers bureau for TAY and YA who can advocate and speak to the needs of the young adult population.

- *Trauma Informed Plus/Sexually Exploited Children:* TAY will support the funding of a sub-grant for the creation of a TAY/YA focused train-the-trainer trauma curriculum. Funding will also train the first cohort of young adult trainers who will deliver trauma training to TAY/YA peer-to-peer and Transition to Independence Process/Assertive Community Treatment (TACT) trainees, other District professionals and informal supports working with the TAY/YA population.

- *TAY/YA Parenting Skill Building and Support:* TAY will support funding of a sub-grant that will allow *a 25-30 week* parenting skill-building program for up to 20 TAY/YA to be created specifically for parents of African-American children in the District. Funds include curriculum creation and/or adjustment and training of a cadre of District trainers.

Resources

- *Transition to Adulthood Program Impact Data Collection:* TAY will support the funding of a sub-grant that allows creation, training and implementation of a tracking mechanism that will be used as a transition assessment tool for TIP/TACT providers. Since TIP is at the core of the TAY system of care (SOC) it is necessary that all providers track information and data as prescribed by the model and that the information addresses individual consumer and aggregate data of the model's impact.

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- **Web-Based TAY/YA App:** DBH will secure a contract that allows the building and/or modification of a Web-Based TAY/YA App that will identify District resources and empower youth to become more self-sufficient.

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

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

Fiscal Year	Total Served
FY 2015	38
FY 2016	43
FY 2017 YTD	67

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

  Wanda Alston Foundation (WAF)- is dedicated to ensuring that LGBTQ (ages 16-24) youth have access to services that improve their overall quality of life. This is achieved through advocacy and programming. The WAF advocates for increased resources for youth while providing programs including: housing, life skills training, linkages to other social services, and capacity building assistance for other community allies. The ***Wanda Alston House*** is named after a D.C. LGBT activist whose goal of empowering the LGBT community was cut short by her tragic death. This temporary transitional housing program provides a safe place for youth and young adults to live up to 18 months. It also provides life skills training and links to other social services. The ***Capacity Building Assistance Program*** helps community allies better understand and work with LGBTQ youth. It focuses on four (4) key areas to improve the lives of LGBTQ youth and young adults: 1) working with LGBTQ youth and young adults of color, 2) understanding the transgender community, 3) utilizing and understanding interventions and public health strategies for LGBTQ youth and young adults, and 4) working with LGBTQ youth, young adults and their families.

  Supporting and Mentoring Youth Advocates and Leaders (SMYAL)- supports and empowers LGBTQ youth in the Washington, D.C. metropolitan region. Through youth leadership, SMYAL creates opportunities for LGBTQ youth to build self-confidence, develop critical life skills, and engage their peers and community through service and advocacy. Committed to social change, SMYAL builds, sustains, and advocates for

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programs, policies, and services that LGBTQ youth need as they grow into adulthood. The new SMYAL transitional housing program for LGBTQ youth is designed to house, empower, and equip the homeless LGBTQ youth community will include wrap-around services to support the youth in residence. Some of these services include: 1) case management (development of personal action plan, weekly check-in meetings, and crisis navigation); 2) supportive services (medical care, mental health services, and self-care support); 3) skill development (education, job readiness, and life skills such as cooking, budgeting, etc.); 4) social support (community outings and access to LGBTQ youth networking); and 5) after-care (open line of post-program communication between the youth and their case manager for up to 12 months).

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

Different Avenues- Provides services to youth and young adults, ages 12-30, who are homeless or living in unstable housing. Many of their clients are transgender, gay, lesbian or bisexual. It also assists youth who are parents and their families. The services include a drop-in center, HIV/AIDS prevention education, sexual health education, access to drug prevention and mental health services, peer-based leadership training and legal referrals.

- **Office of the Ombudsman**

The initial Office of the Ombudsman was called the DBH Child and Youth Services Ombudsman Program. It began in FY 2015 with full implementation beginning in FY 2016.

FY 2016 Accomplishments- Several goals were achieved that supported the infrastructure for the Ombudsman's office and the consumers who utilize DBH services. This included: 1) established an Ombudsman Advisory Council that provides feedback and support whose members include stakeholders from the community (e.g., consumer groups, legal advocates, and District agency staff from the Human Service Cluster; 2) coordinated a small work group to address complaint resolution within DBH; and 3) established a centralized database to track complaint resolution with consumers. The database logs and tracks individual complaints and eventually will provide limited access to other DBH staff to support problem resolution. Once the data is gathered the complaint is categorized, and service gaps and needs identified.

The available data during FY 2016 includes the following:

Contacts	Complaints	Inquiries
69	59 (86%)	10 (14%)

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

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

Contacts	Complaints	Inquiries
144	127 (88%)	17 (12%)

**FY 2018 Office of the Ombudsman**- In FY 2018 this Office will become part of the DBH Behavioral Health Authority due to the Department's realignment. The newly created Office will provide services for children/youth and families, transition age youth, and adults. It will also provide support to individuals who receive services through the DBH network and/or individuals who have questions about the public behavioral health system.

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 to access and navigate behavioral health care services; and 3) support the resolution of problems associated with accessing behavioral health services.

In responding to consumer/stakeholder inquiries and complaints the Ombudsman's office 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.

- **Social Services**

  These services are provided by a number of District agencies. Some examples include: 1) _**Department of Behavioral Health**_- provides a system of care for children/youth and their families that includes prevention, intervention, treatment services for mental health and/or substance use disorders in community-based, outpatient and residential, and emergency psychiatric care settings; 2) _**Child and Family Services Agency**_- protects child victims and those at risk of abuse and neglect and assists their families; 3) _**Department on Disability Services**_- provides innovative high quality services that enable people with disabilities to lead meaningful and productive lives as vital members of their families, schools, workplaces and communities; and 4) _**Department of Human Services**_-1) Parent and Adolescent Support Services (PASS)- serves youth who commit status offenses and works cooperatively with families and service providers to reduce these challenging behaviors before child welfare and/or juvenile justice intervention is needed; 2) Teen Parent Assessment Program(TPAP)- a volunteer program that provides case management services for teen parents ages 14-17 with teen parents under the age of 18 participating in a living arrangement assessment; and 3)

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Violence in Dating Relationships- addresses issues related to non-healthy relationships (abusive-physically violent, controlling, verbally abusive) emphasizes physical and psychological abuse are not normal or acceptable even among teenage lovers.

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

  The educational services are described earlier in this section. The focus here is on the Individuals with Disabilities Education Act.

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

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

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

- **Child Welfare**

  The Child and Family Services Agency (CFSA) is the public child welfare agency in the District of Columbia that is responsible for protecting child victims, those at risk of abuse and neglect, and assisting their families. There are four (4) primary functions:

  Take and Investigate Reports: CFSA Child Protective Services take and investigate reports of known or suspected child abuse and neglect of children/youth up to age 18. When a report indicates a child may have suffered abuse or neglect as defined in law, CPS must investigate to determine whether the report is true or false. Investigative social workers look into reports of child abuse and neglect by parents, guardians, or others acting in a parental capacity wherever they occur in the District.

  Assist Families: In child welfare, serving the primary clients (children) means helping their parents or caretakers. When child victims of abuse or neglected are identified, trained social

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workers from CFSA and private organizations under contract to CFSA step in to keep children safe while working with their families. Social workers connect families to services that can help them overcome long-standing difficulties that endanger their children.

Provide Safe Out-of-Home Care: When a home presents too much danger, CFSA temporarily removes children to safe settings and promptly seeks agreement with the removal from Family Court. Relatives take some children. CFSA also recruits, trains, and licenses foster parents and also licenses, monitors, and maintains contracts with group homes and other safe places for children and youth.

Re-establish Permanent Homes: Young people grow up best in a family. CFSA works to ensure every child and youth leaves the system to return safely to parents, to go to a permanent home with relatives or others through guardianship, or to join a new forever family through adoption.

- **Juvenile Justice Services**

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

  - *Assessment Center:* Provides the Superior Court of the District of Columbia with court-ordered, high-quality, comprehensive, culturally competent mental health consultation, and psychological and psychiatric evaluations for children and related adults with involvement in child welfare, juvenile justice and family court.

  - *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 6- months to 1-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.

    The JBDP enrollment data includes the following:

Fiscal Year	Enrollment
2015	46
2016	61
2017 YTD	30

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

  The referrals and competency evaluation outcomes includes the following:

Fiscal Year	Referrals	Competent	Not Competent	Refused	Incomplete
2015	14	5	8	1	
2016	16	10	6	N/A	
2017 YTD	17	9	6	N/A	2

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

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

- **Substance Use Disorder Services:** The substance use disorder treatment services include a variety of strategies: 1) assessment (comprehensive, ongoing, brief), 2) drug screening; 3) clinical care coordination; 4) case management; 5) case management HIV; 6) crisis intervention; 7) counseling (individual, family, group, psycho-educational, and psycho-educational HIV); 8) medication management; 9) recovery support; 10) residential room and board; 11) recovery support evaluation; 12) recovery support management; 13) recovery mentoring and coaching; 14) life skills support; 15) spiritual support; 16) education services; 17) transportation services; 21) recovery social activities; and 22) environmental stability.

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

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use and mental disorders, and 3) enhance services that adolescent and TAY and their families/primary caregivers receive.

The Adolescent Community Reinforcement Approach (A-CRA), an evidence-based practice is the main clinical model. It is used for a variety of SUD and includes family members/primary caregivers as an integral part of the therapeutic process. Clinicians who have extensive training in A-CRA are currently located at the four (4) Adolescent Substance Abuse Treatment Expansion Program (ASTEP) sites: 1) Federal City Recovery Services (SYT funded), 2) Hillcrest Children and Family Center (SYT funded), 3) Latin American Youth Center, and 4) Riverside Treatment Services. Adolescents and TAY receive direct services through the ASTEP providers for substance use treatment by contacting the core service agencies (CSAs) for an intake to determine eligibility. The ASTEP providers have seen approximately 400 youth ages 12-21 to date.

- *State Youth Treatment (SYT) Adolescent Community Reinforcement Approach (A-CRA) Program:* SYT funding will expand the infrastructure and service capacity of DBH-certified adult SUD treatment programs to provide A-CRA services for District TAY ages 21-24. Specifically, available funds will be used to supplement salaries of an existing clinician and supervisor who have been identified by the SUD provider to receive A-CRA training. The funding period is 1-year from the date of award ending in 2018.

- *Adolescent Community Reinforcement Approach (A-CRA)-* Infused with Level 1 Outpatient Treatment to provide a more targeted approach to treatment for youth and TAY (12-24) with co-occurring mental health and substance use disorders.

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

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

- *Substance Use Disorder Social Marketing Strategies-* These strategies are presented from the perspective of youth and related adults.

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

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

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

- *Community Engagement-* The substance use disorder prevention services team participates in community and health events, gives presentations to organizations and agencies, and responds to requests for training and technical assistance.

- *Photovoice Project-* Cameras were put in the hands of young people who live in the District of Columbia in order to document the drug issues that surround them, as well as advocate for change to make it an even better place to live. The goal is to reduce the abuse and use of substances among youth. The Project was conducted by youth members of the D.C. Youth Prevention Leadership Corps (DCYPLC). It was established and funded by the D.C. Department of Behavioral Health (DBH) through its four (4) Prevention Centers. In addition to providing the resources to produce the Photovoice Project, that is both a digital and physical exhibit, DBH also made it possible for all DCYPLC members to receive youth development training in community problem-solving, substance abuse prevention and Photovoice through the Community Anti-Drug Coalitions of America (CADCA) National Youth Leadership Initiative (NYLI). The aim is to equip youth with the knowledge and skills to make population-level change.

  The Photovoice Project received local attention when it was displayed at a park in the center of the District and national recognition when displayed at CADCA's National Leadership Forum before thousands of community-based coalitions, public officials, legislatures and private organizations.

- **Health and Mental Health Services**

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

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second; and 3) have one serious mental illness (SMI). The **required services** include: 1) comprehensive care management; 2) care coordination; 3) health promotion; 4) comprehensive transitional care/follow-up; 5) patient and family support; and 6) referral to community and social support. The goals include: 1) improve the integration of physical and behavioral health care; 2) reduce healthcare costs (lower rates of avoidable Emergency Department use and reduce preventable hospital admissions and re-admissions); 3) improve the experience of care and quality of services delivered; and 4) improve health outcomes.

▪ *DC Mental Health Access Project (DC MAP):* This project supports the integration of health and mental health. 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. This Committee has not yet been initiated.

The number of behavioral health screenings includes the following:

Fiscal Year	Behavioral Health Screenings
2015	22,762
2016	26,608
2017 YTD	27,342

Serious Emotionally Disturbed (SED) Youth with Aggressive Behavior in Community and Other Settings: In FY 2017, DBH received technical assistance via a SAMHSA contractor (National Association of State Mental Health Program Directors) to address an increase in acts of physical aggression among youth with SED. Physically aggressive acts have been exhibited in a variety of community and secure settings. The consultant report reviews findings from the literature on local and national efforts to prevent and manage physical aggression in youth with SED. It includes information on effective screening, evidences-based approaches to intervention/ treatment, outcomes, and limitations. The consultant conducted initial planning calls with representatives of the impacted agencies, followed by an on-site visit to present materials, discuss options, and provide guidance to meet the District's needs. Follow-up consultation will be provided remotely as needed to help ensure successful the implementation of recommendations. The on-site technical assistance occurred in July 2017 and the report has been forwarded to SAMHSA and the project team for review.

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- **Youth Services Survey for Families (YSS-F)**

  The YSS-F survey gives parents and/or guardians an opportunity to share their perception of services provided to their children and/or adolescents. The information reported is summarized from the DBH FY 2016 YSS-F survey. There were 4,404 child and adolescent consumers served in FY 2016. From this general population, a random sample of 2,600 consumers who received at least two (2) mental health services within the past 6-months in the District was selected to participate in the survey. There were 410 caregivers who completed the YSS-F survey.

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

  The FY 2016 findings show that the caregivers were most satisfied with Cultural Sensitivity (92%) and Participation in Treatment Planning (85%). Caregivers, however, were least satisfied with their child's Functioning (55%) and Outcomes (55%). The latter findings are areas for improvement.

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

- **Child and Youth FY 2017 Mental Health Block Grant (MHBG) Funded Projects**

  - **Bridging Resources In Communities, Inc.-** *Promoting Mental Health/Wellness and Drug Free Living East of the River* focuses on preventing the co-occurrence of mental health issues and drug use. The target population is 120 youth ages 8-18 and 30 adults including parents/caregivers.

  - **Fihankra Akoma Ntoasa (FAN)-** *FAN Positive Youth Development Alumni and Caregiver Support Programs* provides support towards emotional health for current and former youth in foster care. The target population is 10 alumni and 15 caregivers of teens in foster care who have been diagnosed with or who are at risk for mental health and substance abuse disorders.

  - **One Common Unity-** *The Fly By Light: Discover Your True Nature Program* focuses on the needs of youth with conduct disorder, chronic depression, recurring issues with substance abuse, previously incarcerated, foster care, victims of domestic violence, and experiencing discrimination based on sexual orientation. The target population and clientele is high risk youth ages 13-18 and their parents, guardians and families. The program serves 80 youth per year with 15-20 served at five (5) different high schools.

  - **Teens Run DC-** *Teens Run This School* engages at-risk youth in a targeted mental health and substance abuse prevention program that provides integrated social emotional learning and physical health programming. The target population includes 400 youth in the new school initiative, 80-120 youth in intensive weekday programming and 320

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youth in the twice yearly health promotion, community building events at each of the partner schools.

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

The Mental Health Block Grant statutory reporting requirement **Criterion 4** addresses **Targeted Services to Rural and Homeless Populations and to Older Adults** defined as: *Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.*

- **Targeted Services to Rural Populations**

  The District of Columbia is an urban area.

- **Targeted Services to Homeless Populations**

  - **District of Columbia Interagency Council on Homelessness**

    Interagency Council on Homelessness: The District of Columbia Interagency Council on Homelessness (ICH) is a group of cabinet-level leaders, providers of homeless services, advocates, homeless and formerly homeless leaders that come together to inform and guide the District's strategies and policies for meeting the needs of individuals and families who are homeless or at imminent risk of becoming homeless.

    Strategic Plan: The ICH *Homeward DC Strategic Plan* (2015-2020) envisions ending long-term homelessness in the District by 2020 with homelessness being a rare, brief, and non-recurring experience. The Strategic Plan is built on three (3) major goals: 1) finish the job of ending homelessness among veterans; 2) ending chronic homelessness among individuals and families; and 3) by 2020 any household experiencing housing loss will be rehoused within an average of 60 days or less.

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

    FY 2017 Winter Plan: The Homeless Services Reform Act (HSRA) of 2005 mandates that by September 1 of each year, a plan be in place describing how those who are homeless will be protected from cold weather injury. The Winter Plan describes how District government agencies and providers within the Continuum of Care (CoC) will coordinate to provide hypothermia shelter and other services for those who are homeless consistent with the right of consumers to shelter in severe weather conditions.

    This plan builds on past efforts, incorporates new strategies and responds to lessons learned from previous winters. The Plan addresses: 1) how the District will manage communications among stakeholders; 2) process for calling a hypothermia alert and the

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considerations involved; 3) process used to develop estimates for shelter capacity needs during the FY 2017 winter as well as the plan for delivering the number of beds/units needed; 4) transportation services that will be provided to ensure that clients have access to shelter and services; 5) services provided to help clients access shelter and while in shelter; 6) protocol and available resources for serving unaccompanied minors and transition aged youth (TAY); and 7) resources in place to monitor shelter operations as well as protocol for raising concerns and/or filing complaints.

- **District of Columbia 2017 Point-in-Time Count of People Experiencing Homelessness**

  The Community Partnership for the Prevention of Homelessness (TCP) has conducted the Point-in-Time (PIT) count, a requirement for all jurisdictions receiving federal homeless assistance funding, on behalf of the District since 2001. On January 25, 2017 TCP conducted the annual PIT count. It provides a snapshot of the number and demographic characteristics of adults and children who were experiencing homelessness in the District on that day. This single day enumeration of the homeless services CoC gives TCP and District government partners an opportunity to identify gaps in the current portfolio of services and informs future program planning with special consideration to *Homeward DC*, the local strategic plan to end homelessness.

  On the night of the PIT, there were 7,473 people who were experiencing homelessness in the District, 897 were unsheltered, 5,363 were in an emergency shelter, and 1,213 were in a transitional housing program on the night of the count. The total number of people experiencing homelessness decreased by 10.5% since the 2016 PIT count.

- **Homelessness in Metropolitan Washington Results and Analysis from the Annual Point-in-Time Count of Persons Experiencing Homelessness**

  FY 2017 was the 17th consecutive year the Metropolitan Washington Council of Governments (COG) Homeless Services Planning and Coordinating Committee conducted a regional enumeration of the area's homeless and formerly homeless population. Some of the findings for the District of Columbia are presented below.

  Overview of District Services: The District's CoC provides persons experiencing or at risk of experiencing homelessness a range of services including: homelessness prevention assistance, supportive services, outreach, severe weather and emergency shelter, transitional housing, rapid rehousing, targeted affordable housing, and permanent supportive housing. These services are available to families and unaccompanied individuals with many programs focused on providing service to key subpopulations such as persons living with disabilities, persons experiencing chronic homelessness, veterans, or youth.

  Families facing housing crises in the District can visit the Department of Human Services (DHS) Virginia Williams Family Resource Center and receive homelessness prevention services, emergency rental or utility assistance, housing services, or other community

resources such as Temporary Assistance for Needy Families (TANF), childcare assistance, access to the food stamp program, or Medicaid.

Unaccompanied individuals in need of homeless services may access the District's low barrier, severe weather, or temporary emergency shelters for overnight accommodation and meals. To access the CoC supportive housing resources, unaccompanied persons may visit one of 107 sites throughout the District associated with the Coordinated Assessment and Housing Placement (CAHP) system (including the District's low barrier, severe weather, and temporary shelters). Through CAHP, individuals experiencing homelessness are matched to the appropriate assistance that meets their immediate and long-term housing and service needs. Unaccompanied veterans or youth experiencing homelessness can receive population specific resources through CAHP as well.

D.C. 2017 Shelter and Housing Inventory: The data for the shelter and housing inventory includes the following:

Category	Units for Individuals	Units for Families	Beds in Family Units
Winter Shelter	818	-2	-
Emergency Shelter	2,329	1,035	3,545
Transitional Housing	888	230	626
Rapid Rehousing	272	1,398	4,217
Other Permanent and Permanent Supportive Housing	5,151	1,958	5,973

Point-In-Time 2017 Results: The data includes the following:

Category	2017	2016	2015	% Change 2016	% Change 2015
Total Number Counted	7,473	8,350	7,298	-10.5%	2.4%
Total Number of Individuals	3,583	3,683	3,821	-2.7%	-6.2%
Total Number of Families	1,166	1,491	1,131	-21.8%	3.1%
Total Persons in Families	3,890	4,667	3,477	-16.7%	11.9%
Total Adults in Families	1,609	1,945	1,428	-17.3%	12.7%
Total Children in Families	2,281	2,722	2,049	-16.2%	11.3%

Changes in Point-In-Time Since 2016:

In the past year, the District of Columbia has implemented significant policy changes, targeted investments, and system improvements. Highlights are provided below.

Veterans: The District has made progress toward achieving its goal of ending veteran homelessness. The lessons learned from this process will be instrumental in the efforts to ending homelessness for other populations, such as those who are chronically homeless. In order to sustain this momentum, however, greater homelessness prevention, along with enhanced coordination with jurisdictions surrounding the District, will be required to

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decrease high rates of inflow into the city's homeless services system. To illustrate this point, while 550 veterans were housed through the District's CAHP system between the PIT 2016 and 2017, the count of veterans at PIT 2017 decreased by just 65 persons from last year. The CoC sees an average of 130 veterans newly accessing homeless services each month, many of whom are accessing the region's VA-Grant Per Diem (GPD) beds that are centralized in the District.

The District's CoC includes over 1,200 units of permanent supportive housing for formerly homeless unaccompanied veterans and veteran-headed family households. In 2017, the CoC will increase its permanent supportive housing (PSH) inventory by reallocating funding to repurpose 30 units for veterans from transitional housing to PSH and will continue to house veterans through Supportive Services for Veteran Families (SSVF), a VA funded rapid rehousing program.

Families: In 2015 in accordance with the District's *Homeward DC* strategic plan, DHS implemented year-round access to family shelter. In past years, access to shelter had been limited to the District's Hypothermia Season (November through March). As a seasonal right-to-shelter jurisdiction, families in need of homeless services often had to wait until the winter months to access needed services, which made them more vulnerable throughout the rest of the year. This policy also caused inefficiencies in operations, as the District experienced sharp spikes each winter without additional staff or unit capacity to meet the need.

The District's move toward year-round access, coupled with increased homelessness prevention services, has not only had positive impacts on the families in the District experiencing homelessness, but has begun to bear positive results in terms of creating more efficiencies in the system. Beyond the 22% decrease in families counted at the PIT, the District has seen a marked decrease in the number of families seeking homeless services at the Virginia Williams Family Resource Center during the winter months leading to a 45% decrease in the number of families entering shelter this winter compared to last year. The reduction in placements is due in part to expanded prevention efforts that helped 1,760 families avoid having to enter the shelter system between PIT 2016 and 2017. The investments in targeted prevention programming have had a sizeable impact on young households in particular: between 2016 and 2017, the number of households headed by a parent aged 18-24 decreased by nearly 50%.

Also, greater investment in permanent housing resources like rapid rehousing, PSH, and targeted affordable housing have allowed families experiencing homelessness to return to a permanent housing setting more quickly, thereby contributing to the decrease in families experiencing homelessness at PIT. Some 670 families exited the emergency shelter system for one of the aforementioned permanent housing solutions, or to housing on their own, between PIT 2016 and 2017. In the past year, several family transitional housing programs have also reallocated their funding and retooled their service model to become either PSH or rapid rehousing programs. These resources have provided housing to 33 now formerly homeless families so far in 2017.

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Building on the successes seen among veterans, the CoC is working to reduce the length of stay among families experiencing homelessness, particularly in the emergency shelter system. This means working with families in the system, both long stayers and those newly entering, to identify service and housing needs and to connect them with one of the permanent housing models called for in *Homeward DC*. This has involved reviewing internal business processes to examine how to reduce paperwork and other administrative barriers, and improving outreach to, and partnership with, area landlords to increase the number of units available to households in the system searching for a unit.

Youth: Since youth experiencing homelessness often remain more hidden to the public eye (i.e., "couch surfing" versus sleeping on the street), PIT is not always the best tool for measuring the prevalence of homelessness among youth given the parameters of the count. However, the District has increased its investment in beds and services for youth in recent years, particularly for transition age youth (TAY), which led to more youth accessing services through the CoC's youth specific shelter and housing programs. During 2017 PIT, the count of unaccompanied youth increased by 17 individuals from 2016, reflecting the increase in resources available for this population.

The PIT count does not fully capture youth experiencing homelessness, in 2015 the District began conducting a separate annual Homeless Youth Census (HYC), an emerging best practice that is encouraged by U.S. Department of Housing and Urban Development (HUD). HYC is conducted by TCP and is modeled after PIT but is done over a 10-day period in early fall. HYC includes counts of youth experiencing homelessness as well as housing insecurity. The project informs strategic planning and further resource development for youth experiencing homelessness. Based on improved data collection for this population, the District has developed a comprehensive plan to end youth homelessness scheduled for release in 2017.

Since PIT 2016, DHS has brought online nearly 100 new units of emergency shelter, transitional housing, and PSH for parenting and non-parenting youth. In addition to the District's investments in programs for youth experiencing homelessness, TCP and partner agency Community Connections secured more than $1 million in HUD CoC Program resources to establish new programming for TAY that will likely begin before the end of 2017.

Permanent Housing Solutions: The steady number of individuals and families seeking assistance has been met in the District by policy changes, system improvements, and increased investments in solutions that are known to work including homelessness prevention and permanent housing interventions. As a result of these changes the District has not only held steady, it has actually been able to decrease the number of persons experiencing homelessness at a given time.

The data for singles and persons in families housed through each permanent housing solution is in the table that follows.

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Permanent Housing Solutions	Number Unaccompanied Individuals	Number Family Households
Other Permanent Housing- e.g., Targeted Affordable Housing (TAH)	1,559	651
Permanent Supportive Housing (PSH)	2,918	1,058
Rapid Rehousing	272	1,359

Point in Time Needs Assessment Results: The unaccompanied individuals and adults in families counted during PIT were surveyed to inform the CoC on the demographic make-up, service needs, barriers to housing, economic indicators, and primary reasons for homelessness. This helps the District identify gaps in the system and to plan the development of interventions that will strategically address these gaps.

Reported Disabling Conditions Among Persons Experiencing Homelessness:

Conditions	Unaccompanied Persons 2017	Unaccompanied Persons 2016	Adults In Families 2017	Adults In Families 2016	TOTAL All Adults 2017	TOTAL All Adults 2016
Chronic Substance Abuse (CSA)	28.9%	28.3%	3.5%	1.9%	19.3%	19.2%
Severe Mental Illness (SMI)	34.7%	26.5%	13.3%	8.9%	26.5%	20.4%
Dual Diagnosis (CSA & SMI)	14.1%	15.9%	1.6%	0.9%	9.4%	10.7%
Chronic Health Problem	19.6%	14.3%	2.9%	2.5%	13.3%	10.8%
Developmental Disability	4.6%	data not collected	3.5%	data not collected	4.2%	data not collected
Living with HIV/AIDS	4.1%	2.7%	0.3%	0.6%	2.7%	2.1%
Physical Disability	20.3%	23.4%	4.4%	2.8%	14.3%	17.4%

Reported Subpopulation Affiliation Among Persons Experiencing Homelessness:

Subpopulation Affiliation	Unaccompanied Persons 2017	Unaccompanied Persons 2016	Adults In Families 2017	Adults In Families 2016	TOTAL All Adults 2017	TOTAL All Adults 2016
Domestic Violence History	19.5%	15.8%	25.7%	19.6%	21.7%	16.9%
Limited English Proficiency	9.0%	9.7%	5.8%	5.3%	7.9%	8.5%
U.S. Military Veteran	9.4%	10.2%	0.2%	0.8%	6.2%	7.3%
Formerly in Foster Care	8.8%	7.3%	7.5%	12.5%	8.3%	8.9%
Formerly Resided in an Institutional Setting	35.2%	33.3%	8.3%	13.2%	24.8%	26.6%

Reasons Respondents Cited for Homelessness: Persons surveyed in the District were also asked to respond to questions about their primary reason for homelessness. For individuals, the primary reason for homelessness was Other Financial Reasons (as

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distinct from specifying that they were experiencing homelessness due to an eviction or foreclosure). For families, the most commonly reported reason was Friend/Family Conflict, though nearly half reported financial reasons (i.e., Eviction/Foreclosure or Other Financial Reasons). On both accounts, the information was consistent with what is reported year-round at programs using the Homeless Management Information System (HMIS).

The data for the reasons for homelessness includes the following:

Reasons for Homelessness	Unaccompanied Persons	Adults in Families	TOTAL (All Adults)
Homeless Due to Domestic Violence (caused current episode)	7.4%	8.4%	7.8%
Eviction/Foreclosure	9.3%	20.5%	13.7%
Other Financial Reasons	35.9%	24.9%	31.5%
Friend/Family Conflict	11.4%	31.5%	19.2%
Aged/Timed Out of Program	3.4%	0.8%	2.4%
Other	32.6%	13.9%	25.4%

Income and Employment: Unaccompanied persons and adults in families counted during the 2017 PIT were also asked to respond to questions about their employment and income. Thirty percent (30%) of adults in families and 36% of unaccompanied individuals reported that they did not receive income of any kind. For families, this is an increase of 10%, and for individuals it is a decrease of 15% from year to year.

At the 2017 PIT 16.7% of unaccompanied individuals and 25.5% of families reported that they were employed at least part time. There was an increase of reported employment among individuals and a decrease in employment in families since 2016. The most common source of income for individuals was from employment, while Temporary Assistance for Needy Families (TANF)/Public Assistance was the most common source of income for families. This is consistent with what has been recorded in previous PIT counts.

The data for unaccompanied persons and adults in families includes the following:

Income and Employment	Unaccompanied Persons	Adults in Families	TOTAL All Adults
Receives Income	40.2%	69.1%	49.8%
Employed	16.7%	25.5%	19.7%
Primary Source of Income:			
From Employment	15.1%	22.9%	17.5%
Social Security./Retirement	1.5%	0.4%	1.2%
SSI/SSDI/Disability	11.1%	11.8%	11.3%
TANF/Public Assistance	1.3%	32.6%	11.0%
Other	7.2%	1.1%	5.3%

- **Homeless Services Grants**

  - *Cooperative Agreements to Benefit Homeless Individuals (CABHI):* The D.C. Department of Behavioral Health (DBH) received a SAMHSA CABHI grant that began on October 2, 2015. The focus is to help people with behavioral health issues find

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housing and supportive services. CABHI's primary goal is to ensure that the most vulnerable people experiencing homelessness and chronic homelessness receive access to housing, treatment, and recovery support services. This includes veterans, singles, and youth. The other goals include: 1) enhance the infrastructure for coordinating, developing, planning, supporting and providing effective treatment and recovery support services; 2) expand and enhance treatment and recovery support services; and 3) prepare for program sustainability through evaluation, planning and ensuring the most effective use of resources.

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

A total of 391 clients have been enrolled and received services from three (3) providers in the DBH network, and a homeless services provider. A total of 108 have been successfully housed. The current enrollment is 283.

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

    Service Area: The PATH Grant funds are used to support two (2) DBH programs: 1) Homeless Outreach Program (HOP), and 2) Housing Subsidy Program (HSP). These programs serve homeless individuals throughout the District.

    PATH Funds Supported Services: The HOP conducts outreach and case finding for consumers who reside in locations unfit for human habitation (e.g., streets, abandoned vehicles, buildings); low barrier shelters; transitional programs; and other temporary residences. The HOP services include: crisis services, case management, transportation, and linkage services for persons with long-term mental health and substance use disorders.

    The HSP provides assistance for housing homeless consumers. This has historically included providing individuals who are homeless with first month rent and/or security deposits.

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Persons Served: HOP intends to serve a minimum of 500 homeless adults during the fiscal year. The services provided will include: outreach, case finding, interim case management, assistance in obtaining benefits, linkage to mental health and substance use services, and transportation to an initial mental health, medical, or substance use appointment.

As previously noted, PATH funds pay security deposits/first month rent for previously homeless consumers. HSP estimates that they could support and serve 16 sole head of household consumers (based on 1 bedroom program rent of $1,230).

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

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

SSI/SSDI Outreach, Access, and Recovery (SOAR): This is a national program designed to increase access to the disability income benefit programs administered by the Social Security Administration (SSA) for eligible adults who are experiencing or at risk of homelessness and have a mental illness, medical impairment, and/or a co-occurring substance use disorder.

As part of the new employee orientation and training, staff are enrolled in the SOAR training. All members of the HOP have been trained in SOAR. HOP staff attempt to assess each consumer's benefits needs, however consumer engagement and openness about their benefit is difficult. Consumers who are eligible and amenable to seeking benefits are targeted for quick assessment and enrolled in eligible programs.

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

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

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SPDAT assessment tool has provided an expedient process to transition individuals from homelessness into housing.

- **Targeted Services to Older Adults**

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

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

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

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

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

  - *Age-Friendly DC Initiative:* This initiative is part of an international effort launched by the World Health Organization (WHO) in 2007 and addresses two (2) significant demographic trends: 1) urbanization and 2) population aging. WHO identified 8 aspects of urban communities that influence the health and quality-of-life of the older people living there: 1) outdoor spaces and buildings, 2) transportation, 3) housing, 4) social participation, 5) respect and social inclusion, 6) civic participation and employment, 7) communication and information, and 8) community support and health services. The District added 9) emergency preparedness and resilience and 10) elder abuse, neglect and fraud. The District also developed an *Age-Friendly DC Strategic Plan 2014-2017*. An *Age-Friendly DC 2016 Progress Report* was also developed. Age-Friendly DC relies on a Mayoral-appointed Task Force for advice and guidance. The Task Force is composed of

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community leaders, deputy mayors, and agency directors, appointed by the Mayor, and each assigned to pay particular attention to one (1) of the 10 Age-Friendly DC domains.

The DBH participation as a member of this Initiative addresses issues related to:
1) introduce or expand primary mental health screening programs for older adults, 2) provide training on behavioral health for counselors and aides working in hospitals and home-based care units, and 3) expand the number of peer counseling and support programs and increase the number of older adult peer counselors.

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

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

- *DBH Performance Plans Older Adult Initiatives:* The DBH FY 2016 and FY 2017 Performance Plans included initiatives related to Older Adult Mental Health. These initiatives involved input from the Age-Friendly DC Committee. The FY 2016 focus was on seeking a behavioral health screening tool and trainings. The President of the American Psychiatric Association queried colleagues on behalf of the Age-Friendly DC Initiative representatives about these issues. The DBH Chief Clinical Officer and Adult Services Director met with chief psychiatrists of all District community-based hospitals who were reluctant about behavioral health screenings on all admittees.

During the FY 2017, the DBH survey of the private network and representatives of the Age-Friendly DC Initiative determined that multiple curricula were being used. DBH nor the Department of Health has the authority to require specific tools and screening city-wide. The D.C. Long-Term Care Coalition agreed to coordinate with the providers to conduct an audit of current practices and training to determine commonality among tools.

All providers have a curriculum to help staff understand mental health. The project has demonstrated that providers are: 1) interested in educating staff on behavioral health needs, and 2) providing individualized curriculum for their behavioral health staff.

Criterion 5: Management Systems

- **Financial Resources**

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

- **Staffing/Human Resources***:* In July 2017 the total number of Department of Behavioral Health staff was 1,319. This includes: 1) Mental Health Services (535), and 2) Saint Elizabeths Hospital (784).

    - *Vacancies Filled in FY 2017:* Critical vacancies/positions filled during FY 2017 include the following:
        - Director, Mobile Crisis Services
        - Forensic Clinical Administrator
        - Reimbursement Specialist
        - Pharmacist
        - Social Workers
        - Supervisory Psychiatric Nurses
        - Behavioral Health Technicians
        - Early Childhood Clinical Specialist
        - Dental Assistant
        - Housekeeping Aides
        - Mental Health Specialist
        - Supervisory Security and Safety Specialist
        - Psychiatric Nurses
        - Public Health Analyst
        - Community Services Review Logistics Specialist
        - Mental Health Counselor
        - Food Service Worker
        - Special Police Officers
        - Claims Management Analyst
        - Mental Health Counselor
        - Applied Research and Evaluation Manager
        - Forensic Mental Health Counselor
        - Billing Services Specialist
        - Budget Analyst

- *Human Resources Activities During FY 2017:* A number of significant human resource development activities were undertaken during FY 2017. They include:
    - Actively participating in and providing Human Resources consultation for the DBH Realignment.
    - Conducting more comprehensive Benefits Entitlement and Information Sessions for employees.
    - Inconjunction with the D.C. Office of Labor Relations, engaged in administering labor contracts for covered DBH employees.
    - Managing the Mandatory Drug and Alcohol Testing Program for employees serving children and youth.

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# of Students	Course Type	Course Name
1	Online	Adult-Acquired Traumatic Brain Injury: Existential Implications and Clinical Considerations
1	Online	Anger Management
3	Online	Anger Management in Trauma Therapy

- Continued to recruit/identify key/critical positions.
- Reviewed Departmental policies for Human Resources impact and revised as necessary.
- Managed the completion of suitability determinations for all DBH employees.
- Managed the DBH Family Medical Leave Act Program that includes the Paid Family Leave Program.
- Reviewed the identification/notification of Emergency and Essential Employees.
- Completed required Human Resources Reports on the Voluntary Leave Transfer and Leave Bank Programs.
- Continued active participation in the District's Classification and Compensation Reform Project (when not on hold).
- Continued Random, Periodic and Applicant Drug and Alcohol Testing for designated employees.
- Managed the Mayor's Summer Youth Employment Program (MBSYEP).
- Continued and expanded the number of Criminal Background and Traffic Records.
- Overall management of the DBH Performance Management Program.
- Coordinated/Facilitated Management Supervisory Service (MSS) Performance Management training sessions for DBH MSS employees.

- *DBH Training Institute Division:* In the DBH realignment this Division is in the Systems Transformation Administration. The focus is on enhancing the knowledge and competencies of the DBH provider network and internal and external customers through performance-based and data-driven learning environments.

  The data in the table that follows provides information about the DBH Training Institute courses provided in FY 2017 to date. It is organized by: 1) the number persons taking the course, 2) the course setting, and 3) the name of the course.

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3	Online	Anxiety Disorders: Diagnosis and Treatment
1	Online	Assessing Suicide Risk in Children: Guidelines for Developmentally Appropriate Interviewing
1	Online	Autism Spectrum Disorders
106	Classroom	Behavioral Health Disorders, Engagement & Referral
1	Online	Borderline Personality Disorder
1	Online	Brief CBT in the Treatment of Substance Abuse
1	Online	Brief Strategic / Interactional Therapies in the Treatment of Substance Abuse
27	Classroom	CAFAS Train-the-Trainer and Booster
31	Classroom	CBI Provider Series: Application of the National Standards on Culturally and Linguistically Appropriate Services in Daily Practice
57	Classroom	CBI Provider Training Series: CBI II & III Clinical Model Overview
20	Classroom	CBI Provider Training Series: Supervisory and Ethical Challenges
90	Classroom	CBI Provider Training Series: Youth and Family Engagement
1	Online	Childhood Sexuality: Discerning Healthy from Abnormal Sexual Behaviors
82	Classroom	Claims Review Committee: Process and Responsibility
35	Classroom	Clinical Supervision
1	Online	Couples Therapy: Recreating Partnership - A Solution-Oriented Collaborative Approach
27	Classroom	CSEC Series: Commercial Sexual Exploitation of Children (CSEC) 101
36	Classroom	CSEC Series: Screening and Assessment of Youth at-risk for Commercial Sex Trafficking in the District of Columbia
22	Classroom	CSEC Series: Strategies to Address Trauma
42	Classroom	CSEC Series: The Application of the Stages of Change Model for Commercially Sexually Exploited Youth and Their Families
34	Classroom	CSEC SERIES: The SERVE Model; A Brain-Based Approach for Complex Traumatic Stress
9	Classroom	CSR Overview and System Performance Indicator Training
1	Online	Cultural Competence: The Immigrant Experience
2	Online	Domestic Violence: Intimate Partner Abuse
29	Classroom	Drugs of Abuse and Co-Occurring Mental Health Disorders
11	Classroom	Empowering Interactions in Emergencies and Disasters
1	Online	ETH092 Ethics - Mandated Reporting and Risk
1	Online	Ethical and Legal Issues in Psychotherapy
2	Online	Ethical and Legal Issues in Substance Abuse Treatment
155	Classroom	Ethics in Contemporary Mental Health Practice and HIV/AIDS
53	Classroom	Five Key Elements of Behavioral Health Practice
1	Online	Grief: Parent Loss in Childhood and Adolescence: Interview with Colin Pereira-Webber, MA
41	Classroom	Hands-Only CPR/AED Awareness Training
30	Classroom	Health Insurance Portability and Accountability Act (HIPAA) and Privacy Fundamentals
155	Classroom	HIV Today: Pushing the Reset Button on Knowledge and Practice
5	Classroom	Human Resources 101 for Evidence-based Practice Supervisors-Top 10 HR Rules Every Supervisor Should Know
84	Online	iCAMS Modules #1, 2 and 3
2	Online	Interviewing Children
1	Online	Introduction to Military Culture for Clinicians
1	Online	MH05 Mental Health - Community Supports and Service Networking
1	Online	MH07 Mental Health - Advocacy
31	Classroom	Motivational Interviewing Training-of-Trainers
2	Online	Multiculturalism and Cultural Competence
3	Classroom	NO MORE BAD HIRES! HR Best Practices for Finding, Hiring, and Onboarding the BEST (TIP)
29	Classroom	Nonviolent Crisis Intervention (NCI)

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27	Classroom	Owning and Operating a Mental Health Community Residence Facility
1	Online	Pathological Gambling: Assessment and Treatment
7	Classroom	PECFAS Train-the-Trainer 1-Day Training
1	Online	PTSD #7: Engaging Survivors of Extreme Violence - Interview with Martha Bragin, PhD
9	Classroom	Recovery Coach Training Program Implementation
81	Classroom	safeTALK: Suicide Alertness for Everyone
26	Classroom	Stages of Change: Training-of-Trainers
1	Online	Suicide Crisis Intervention Model with 25 Practical Strategies for Implementation
1	Online	Supervision: Clinical Supervision - Principles and Practice
65	Classroom	TIP Model
30	Classroom	Trauma Focused Cognitive Behavior Therapy
5	Classroom	Trauma Systems Therapy
51	Classroom	Treatment Planning for Person-Centered Care: Training-of-Trainers
1	Online	Workers' Compensation-What Supervisors Need to Know
96	Classroom	Working in a Mental Health Community Residential Facility
69	Classroom	Treatment Planning for Person-Centered Care: Emerging Best Practice Training

- **Training Providers of Emergency Health Services**

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

  The data for the District Metropolitan Police Department and other agencies includes the following:

Fiscal Year	DC Metropolitan Police Department	Other Agencies	Total Trained	Active in the Field
FY 2015	756	122	878	711
FY 2016	868	128	996	852
FY 2017 YTD	946	193	1,139	997

- **Disaster Behavioral Health Training**

  The DBH Disaster Behavioral Health Training began in 2012. The purpose of the training is to help trainees: 1) understand the role of disaster behavioral health; 2) understand the structures in place for small scale and large scale events in the District of Columbia; 3)

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become familiar with disaster survivor stress responses, symptoms and approaches to empower resilience; and 4) learn psychological first aid.

During FY 2017 (October 2016 to date) DBH Disaster Services conducted trainings for the disaster responder cadre and for agencies requesting DBH disaster training. The FY 2017 year-to-date total includes the following: 1) Office of the Chief Medical Examiner (13); 2) Psychological First Aid (30); 3) Washington Hospital PsyStart (10); 4) Cultural Competency (11); 5) Active Shooter (57); and 6) Death Notification (3).

The persons trained include the following:

Fiscal Year	Persons Trained by DBH Disaster Services
2015	77
2016	38
2017 YTD	124

- **How State Plans to Expend the Grant**:

The District of Columbia Department of Behavioral Health FY 2018 tentative Spending Plan includes the following:

Proposed funds awarded to the District for the Mental Health Block Grant =$922,328

- Administrative Fee (5% total award) = $46,116
- Early Serious Mental Illness Project (10% total award) = $92,233
- DBH Behavioral Health Council Project = $5,000
- Peer Owned and Operated Services = $200,000
- Strategic Planning Consultant/Medicaid Redesign = $50,000
- IT Consultant= $150,000
- Remaining Funds for Projects to be Determined= $378,979

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Planning Steps

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

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current behavioral health system as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state?s 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 the 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 sets including, but not limited to, the **National Survey on Drug Use and Health** (NSDUH), the **Treatment Episode Data Set** (TEDS), the **National Facilities Surveys on Drug Abuse and Mental Health Services**, 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 use disorderprevention, and SUD treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase M/SUD services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving services and the types of services they are receiving.

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**[1] 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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[1] **http://www.healthypeople.gov/2020/default.aspx**

Footnotes:

Step 2: Identify the Unmet Service Needs and Critical Gaps Within the Current System

- **Early Childhood and Children**

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

  Most Important Early Childhood Unmet Service Needs Or Critical Gaps

  One of the unmet needs or critical gaps is that few individuals working with the early childhood population have received specific training in early childhood development. One of the initiatives for the D.C. Social Emotional and Early Development Project (D.C. SEED) is to provide Early Childhood trainings to a wide range of audiences (e.g., child development staff, Access HelpLine staff, and clinicians) to help increase knowledge regarding children birth to age 6. The developmental progress of the children will be measured by changes in knowledge. This issue is described in the Planning Tables under Priority Area 1.

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

  One of the goals of D.C. SEED is to support the expansion and strengthening of mental health services for children birth to age 6 who have been diagnosed with a serious emotional disturbance or are at risk for one. D.C. SEED will train providers on three (3) evidence-based programs which will increase the capacity for young children and families to receive services. Progress will be measured through monitoring the number of children receiving services as well as looking at improvements based on their functioning (pre/post assessments). This issue is described in the Planning Tables under Priority Area 2.

- **Transition Age Youth and Young Adults**

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

  - *Most Important Unmet Transition Age Youth and Young Adults Service Needs Or Critical Gaps*

The current provider network is somewhat fragmented causing a siloed system of care that complicates access for individuals transitioning from adolescence to adulthood. The delivery of mental health services has been divided into two (2) systems: one serving children and one serving adults, with different eligibility requirements, health care providers, and funding streams.

When a young person "ages out" by surpassing the DBH age-defined eligibility limit of 22, the services are discontinued and they are referred to the adult mental health system. This lack of continuity of care is not only disruptive, a youth must adjust to a new culture of care, with new case managers, therapists, and treatments. Also, the services in general may not be age-appropriate or consistent with the kind of care or treatment plan customized for the youth up until this point.

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

DBH and its providers need to develop more training opportunities that focus on the needs of TAY and YAs. This issue is described in the Planning Tables under Priority Area 3.

Another service need or critical gap is related to substance use disorder (SUD) treatment for TAY and YAs. The system was set up to provide SUD services to youth ages 12-20, however, the 21 and above population was integrated with the adult SUD population. Findings show that the young adult population was not ready to be integrated with the adults, which caused their needs to be unmet. In response to the increasing need to expand SUD treatment and recovery services to transition age youth (TAY), DBH implemented the expansion of the Adolescent Community Reinforcement Approach (A-CRA) services to now cover TAY ages 21-24. The expansion increases the infrastructure and service capacity for the SUD treatment programs. This issue is described in the Planning Tables under Priority Area 4.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #:   1

Priority Area: Training for persons working with early childhood populations

Priority Type: MHS

Population(s):   SED

Goal of the priority area:

Provide Early Childhood training to a wide range of audiences to help increase knowledge about children ages birth- 6.

Objective:

Conduct Early Childhood training and capture information related to the number of trainings and trainee affiliations.

Strategies to attain the objective:

Acquire and/or develop the Early Childhood training curriculum to be administered to the child development centers, Access HelpLine staff, clinicians, providers, etc.).

Annual Performance Indicators to measure goal success

Indicator #:   1

Indicator: Complete D.C. Social Emotional and Early Development Project (D.C. SEED) Start-Up Phase

Baseline Measurement: There is no baseline measure. A training schedule will be developed and implemented.

First-year target/outcome measurement: There is no target number established. The outcome is based on the number of Early Childhood trainings conducted, number of persons trained, and the trainee affiliations.

Second-year target/outcome measurement: There is no target number established. The Early Childhood trainings will continue as needed and/or requested.

Data Source:

Trainee recorded attendance and certificate of training.

Description of Data:

The number of Early Childhood trainings conducted and the trainee affiliations. Also, the impact of the training on increasing the number of people who are able to provide early childhood services.

Data issues/caveats that affect outcome measures::

None currently known.

Priority #:   2

Priority Area: Sufficient Number of Evidence-based Treatment Services for Young Children

Priority Type: MHS

Population(s):   SED

Goal of the priority area:

The D.C. Social Emotional and Early Development Project (D.C. SEED) will support the expansion and strengthening of mental health services for children birth-6.

Objective:

Provider mental health services for children birth-6 who have been diagnosed with a serious emotional disturbance or are at risk for one.

Strategies to attain the objective:

Providers will be trained on three (3) evidence-based programs which will increase the capacity for young children and families to receive services.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Complete D.C. Social Emotional and Early Development Project (D.C. SEED) Start-Up Phase
Baseline Measurement:	The baseline measure for progress through monitoring the number of children receiving mental health services will be determined in FY 2018.
First-year target/outcome measurement:	The first year will focus on the number of children receiving services and the service modality outcomes.
Second-year target/outcome measurement:	The second year will focus on improvements based on the child's level of functioning (via pre/post assessments).

Data Source:

DBH program and provider data.

Description of Data:

Evidence-based treatment services data and pre/post assessments.

Data issues/caveats that affect outcome measures::

None currently known.

Priority #:	3
Priority Area:	Provide training for Department of Behavioral Health (DBH) providers so they are better equipped to work with transition age youth (TAY) and young adults (YAs) age 16- 25. Training will include both evidenced-based practices (EBPs) and cultural understanding of the population.
Priority Type:	
Population(s):	SMI, SED

Goal of the priority area:

Offer evidenced based and cultural competence training to District providers and community entities so that they have the appropriate tools and skills to serve the changing needs of the TAY and YAs population.

Objective:

Improve mental health services offered to TAY and YAs to include EBPs and cultural understanding so that interventions and treatments are specific to the needs and culture of this population.

Strategies to attain the objective:

The EBP strategies include: 1) identify and prioritize the needs and skill deficits of District TAY and YAs; 2) identify specific EBPs to address the needs of TAY and YAs; 3) identify providers to train in EBPs and offer services; and 4) train service providers, monitor service delivery and evaluate impact. The cultural competence strategies include: 1) identify cultural competence training programs for professional and the community that include TAY and YAs voice and influence; 2) train providers and the community on cultural competence needs of TAY and YAs; and 3) monitor cultural competence and evaluate inclusion into programs.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	The number of TAY and YAs served by the chosen EBP trained provider and number of individuals (agencies and community entities) trained in TAY and YAs cultural competence.

Baseline Measurement:	Baseline data will not be available until FY 2018 after needs are prioritized, EBPs are chosen, and cultural competence training provided.
First-year target/outcome measurement:	There is no target number established. The outcome is based on the number of TAY served under the chosen EBP and the number of agencies and entities trained in TAY cultural competencies.
Second-year target/outcome measurement:	There is no target number established. The outcome is based on the number of TAY and YAs served by the chosen EBP and the success of TAY and YAs cultural competence training.

Data Source:

Program and provider data.

Description of Data:

The number of TAY and YAs served under the identified EBP and the number of individuals (agencies and community entities) trained in TAY and YAs cultural competence.

Data issues/caveats that affect outcome measures::

None currently known.

Priority #:	4
Priority Area:	Provide training for Department of Behavioral Health (DBH) providers certified to deliver substance use disorder (SUD) treatment for transition age young adults (21-24).
Priority Type:	SAT, MHS
Population(s):	SMI

Goal of the priority area:

Provide training to licensed clinicians and supervisors identified by the SUD providers to receive Adolescent Community Reinforcement Approach (A-CRA) for transition age young adults (21-24). A-CRA is an evidence-based intervention.

Objective:

Increase the number of transition age young adults that providers serve in the A-CRA SUD treatment program.

Strategies to attain the objective:

The strategies include: 1) identify providers that will offer A-CRA training to external clinicians, 2) identify providers that will offer A-CRA training to internal clinicians, and 3) provide the A-CRA training.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	The number of transition age young adults served by the A-CRA SUD treatment providers.
Baseline Measurement:	Baseline data will not be available until FY 2018.
First-year target/outcome measurement:	There is no target number established. The outcome is based on the number of transition age young adults that providers serve in the A-CRA SUD treatment program.
Second-year target/outcome measurement:	There is no target number established. The outcome is based on the number of transition age young adults that providers serve in the A-CRA SUD treatment program.

Data Source:

Program and provider data.

Description of Data:

The number of transition age young adults that providers serve in the A-CRA SUD treatment program.

Data issues/caveats that affect outcome measures::

None currently known.

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures

States must project how the SMHA and/or the SSA will use available funds to provide authorized services for the planning period for state fiscal years 2018/2019.

Planning Period Start Date: 7/1/2017   Planning Period End Date: 6/30/2019

Activity (See instructions for using Row 1.)	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other
1. Substance Abuse Prevention and Treatment							
a. Pregnant Women and Women with Dependent Children							
b. All Other							
2. Primary Prevention							
3. Tuberculosis Services							
4. Early Intervention Services for HIV							
5. State Hospital			$6,484,646	$7,495,422	$159,875,642	$0	$1,087,550
6. Other 24 Hour Care		$0	$6,109,944	$600,000	$29,064,000	$0	$0
7. Ambulatory/Community Non-24 Hour Care		$1,565,640	$12,728,148	$4,954,342	$0	$0	$9,693,380
8. Mental Health Primary[*]		$0	$0	$0	$423,700	$0	$0
9. Evidence-Based Practices for Early Serious Mental Illness (10 percent of total award MHBG)[**]		$186,784	$368,504	$0	$700,000	$0	$0
10. Administration (Excluding Program and Provider Level)		$92,232	$6,328,402	$0	$165,135,154	$0	$0
11. MHBG Total (Row 5, 6, 7, 8, 9 and 10)	$0	$1,844,656	$32,019,644	$13,049,764	$355,198,496	$0	$10,780,930

* While the state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED

** Column 9B should include Early Serious Mental Illness programs funded through MHBG set aside

Footnotes:

Revision made to correct 1 year amount to 2 years.

Planning Tables

Table 6 Categories for Expenditures for System Development/Non-Direct-Service Activities

Planning Period Start Date: 7/1/2017   Planning Period End Date: 6/30/2019

Activity	A. MHBG	B. SABG Treatment	C. SABG Prevention	D. SABG Combined*
1. Information Systems	$150,000	$118,393		
2. Infrastructure Support	$53,540			
3. Partnerships, community outreach, and needs assessment	$200,000			
4. Planning Council Activities (MHBG required, SABG optional)	$5,000			
5. Quality Assurance and Improvement	$25,000	$565,052		
6. Research and Evaluation	$25,000			
7. Training and Education	$50,000	$97,733		
8. Total	$508,540	$781,178	$0	$0

*Combined refers to non-direct service/system development expenditures that support both treatment and prevention systems.

Footnotes:

Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

Narrative Question
1. The Health Care System, Parity and Integration

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[25] 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.[26] It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.[27]

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.[28] SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.[29] For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.[30]

Health care professionals and persons who access M/SUD treatment services 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.[31] SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[32] The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and 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 M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.[33] 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, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes[34] and ACOs[35] 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. SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.[36] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[37]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[38] Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[39] SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who

experience health insurance coverage eligibility changes due to shifts in income and employment.[40] 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 in finding a provider.[41] 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 work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.[42] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to 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. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states? Medicaid authority in ensuring parity within Medicaid programs.

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues. Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.[43] SAMHSA recognizes that certain jurisdictions receiving block grant funds ? including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.[44] However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

[25] BG Druss et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Med Care. 2011 Jun; 49(6):599-604; Bradley Mathers, Mortality among people who inject drugs: a systematic review and meta-analysis, Bulletin of the World Health Organization, 2013; 91:102?123 http://www.who.int/bulletin/volumes/91/2/12-108282.pdf; MD Hert et al., Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care, World Psychiatry. Feb 2011; 10(1): 52?77

[26] Research Review of Health Promotion Programs for People with SMI, 2012, http://www.integration.samhsa.gov/health-wellness/wellnesswhitepaper; About SAMHSA's Wellness Efforts, 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

[27] 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/

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

[29] http://www.samhsa.gov/health-disparities/strategic-initiatives

[30] http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/

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[32] Health Care Integration, http:// samhsa.gov/health-reform/health-care-integration; SAMHSA-HRSA Center for Integrated Health Solutions, (http://www.integration.samhsa.gov/)

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[34] Health Homes, http://www.integration.samhsa.gov/integrated-care-models/health-homes

[35] New financing models, http://www.samhsa.gov/co-occurring/topics/primary-care/financing_final.aspx

[36] Waivers, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html; Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS Informational Bulletin, Dec. 2012, http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-03-12.pdf

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[38] Medicare-Medicaid Enrollee State Profiles, http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html; About the Compact of Free Association, http://uscompact.org/about/cofa.php

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[43] About the National Quality Strategy, http://www.ahrq.gov/workingforquality/about.htm; National Behavioral Health Quality Framework, Draft, August 2013, http://samhsa.gov/data/NBHQF

[44] Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, http://www.cms.gov/cciio/resources/letters/index.html; Affordable Care Act, Indian Health Service, http://www.ihs.gov/ACA/

Please respond to the following items in order to provide a description of the healthcare system and integration activities:

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community -based mental and substance use disorders settings.

    • D.C. Healthy Communities Collaborative (DCHCC) Community Health Needs Assessment: The DCHCC includes: 1) a coalition of four (4) hospitals (Children's National Health System, Howard University Hospital, Providence Health System, and Sibley Memorial Hospital); 2) four (4) federally qualified health centers (Bread for the City, Community of Hope, Mary's Center, and Unity Health Care); and 3) two (2) associations (D.C. Hospital Association and D.C. Primary Care Association).
    The DCHCC authored the 2016 Community Health Needs Assessment Report to serve as an evidence-based, community-driven foundation for community health improvement efforts. Four (4) priority community needs emerged: 1) mental health (prevention and treatment of psychological, emotional, and relational issues that lead to higher quality of life); 2) place-based care/bringing care to the community (care options that are convenient and culturally sensitive); 3) care coordination (deliberate organization of patient care activities and information sharing protocols among all of the participants concerned with a patient's care to achieve safer and more effective care); and 4) health literacy (ability to obtain, process, and understand basic health information and services needed to make appropriate health decisions).
    • Federally Qualified Health Centers (FQHCs): More commonly known as Community Health Centers (CHCs) these primary care centers are community-based and patient-directed. They serve those who have limited access to health care and include low income individuals, the uninsured and underinsured, immigrants, those who are homeless, and those who live in public housing. During FY 2017, the FQHCs below provided services in the District of Columbia.
    Community of Hope- Creates opportunities for low-income families in the District including those experiencing homelessness to achieve good health, a stable home, family-sustaining income, and hope. There are three (3) centers in the District.
    Elaine Ellis Center of Health- Provides comprehensive primary health care and social services to residents in the District.
    Family and Medical Counseling Services- Employs community-based, culturally competent approaches to provide comprehensive services that promote the emotional and physical health of families and individuals, regardless of income or social status, and maximize their quality of life.

La Clinica Del Pueblo- Serves the Latino and immigrant populations of the Washington, D.C. Metropolitan Area. The goal is to provide culturally appropriate health services, focusing on those most in need.

Mary's Center for Maternal and Child Care, Inc.- Provides health care, family literacy and social services to individuals whose needs often go unmet by the public and private systems. It uses a holistic, multipronged approach to help each participant access individualized services that set them on the path toward good health, stable families, and economic independence. Mary's Center is a DBH Mental Health Rehabilitation Services (MHRS) core services agency and has three (3) District health centers.

Unity Health Care, Inc.- Promotes healthier communities through compassion and comprehensive health and human services, regardless of ability to pay. Unity Heath Care has 10 clinic sites, 11 homeless sites, 3 school-based health centers, and 2 other specialty sites.

Whitman Walker Clinic- The mission is to provide high quality, culturally competent community health center services to District's diverse urban community, including individuals who face barriers to accessing care, and with a special expertise in Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ) and HIV care. There are two (2) centers in the District.

Bread for the City- This FQHC look-a-like provides District residents with comprehensive services, including food, clothing, medical care, and legal and social services. There are two (2) centers in the District.

• Health Homes 2/MyHealth GPS: The model includes: 1) providers integrate and coordinate all primary, acute, behavioral health, and long-term services and supports; 2) must include fee-for-service (FFS) and managed care organization (MCO) beneficiaries; and 3) Centers for Medicare and Medicaid Services (CMS) provides 90/10 match for the first 8 quarters. The eligibility requirements include: 1) have 2 or more chronic conditions; 2) have one chronic condition and are at risk for a second; and 3) have one serious mental illness (SMI). The required services include: 1) comprehensive care management; 2) care coordination; 3) health promotion; 4) comprehensive transitional care/follow-up; 5) patient and family support; and 6) referral to community and social support. The goals include: 1) improve the integration of physical and behavioral health care; 2) reduce healthcare costs (lower rates of avoidable Emergency Department use and reduce preventable hospital admissions and re-admissions); 3) improve the experience of care and quality of services delivered; and 4) improve health outcomes.

• DC Mental Health Access Project (DC MAP): This project supports the integration of health and mental health. 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.

• Assessment and Referral Center Division: This Division within the DBH Clinical Services Administration assesses and refers adults seeking substance use disorder treatment (e.g., detoxification, inpatient, outpatient, medication assisted, recovery support services). Also, the DBH Mobile Assessment and Referral Center (a mobile outreach vehicle) visits District communities to conduct assessment, referral, and HEP-C and HIV testing.

• Seriously Emotionally Disturbed (SED) Youth with Aggressive Behavior in Community and Other Settings: In FY 2017, DBH received technical assistance via a SAMHSA contractor (National Association of State Mental Health Program Directors) to address an increase in acts of physical aggression among youth with SED. Physically aggressive acts have been exhibited in a variety of community and secure settings. The consultant report reviews findings from the literature on local and national efforts to prevent and manage physical aggression in youth with SED. It includes information on effective screening, evidences-based approaches to intervention/treatment, outcomes, and limitations. The consultant conducted initial planning calls with representatives of the impacted agencies, followed by an on-site visit to present materials, discuss options, and provide guidance to meet the District's needs. Follow-up consultation will be provided remotely as needed to help ensure successful the implementation of recommendations. The on-site technical assistance occurred in July 2017 and the report has been forwarded to SAMHSA and the project team for review.

2. Describe how the state provide services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.

Approximately 70% of SUD clients have also received mental health services within the same year. This data has facilitated the need to fully integrate the two systems and address client's needs for co-occurring care. DBH has made significant progress in building the necessary infrastructure and a coordinated, integrated system of care for substance abuse treatment and recovery services, since the merger of the two (2) agencies in FY 2014. The District is in the process of redeveloping the system of access to care for individuals needing co-occurring treatment.

The award of the State Youth Treatment (SYT) grant from SAMHSA has enabled the District to enhance co-occurring treatment within the adolescent treatment network, the Adolescent–Community Rehabilitation Approach (A-CRA) was selected as the evidence-based practice to implement the SYT services. The A-CRA model incorporates primary care into the treatment modality as well as the various other family and community supports. This initiative has built capacity within the network as well as the workforce in the adolescent system. In FY 2017 continuing into FY 2018 DBH is expanding these services to the transitional aged youth (TAY) in the Adult Substance Abuse Rehabilitation Services (ASARS) programs, which is Medicaid reimbursable.

Additionally, in July 2017, the D.C. Department of Health Care Finance (DHCF), the single state agency for Medicaid, launched Health Homes 2. Primary care providers through incentivized payments couple a per member per month reimbursement rate and will be held accountable for providing and coordinating patients with others as defined in the individualized care plan. Services rendered are geared toward: 1) improving the integration of physical and behavioral health care; and 2) reducing health care costs

by the reduction of Medicaid beneficiaries' use of emergency department non-emergency visits; and 3) the reducing preventable hospital admissions and re-admissions. The primary care provider is also expected to improve the quality of care and quality of services delivered and improve health outcomes. To be eligible a Medicaid beneficiary must have three (3) or more chronic health care conditions, substance use disorder and mental illness are included in this definition.

In January 2016, the Department of Behavioral Health in conjunction with DHCF implemented Health Homes 1. Mental Health providers received a per member per month reimbursement for doing the same task as described above. The differences between the two (2) programs are as follows:

• Eligibility for Health Homes 1 is determined by an individual having a serious mental illness only.

• A mental health provider is responsible for providing mental health services and coordinating care with the primary provider as well as family members and stakeholders as defined in the individualized care plan.

• There is no incentive payment at this point for Health Home 1 providers.

• The Medicaid beneficiary can choose the Health Home that best meets his or her needs.

3.	Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs?	⦿ Yes ○ No
	and Medicaid?	⦿ Yes ○ No

4. Who is responsible for monitoring access to M/SUD services by the QHP?

The Department of Health Care Finance (state Medicaid agency) is responsible for monitoring the Quality Health Plan services.

5.	Is the SSA/SMHA involved in any coordinated care initiatives in the state?	⦿ Yes ○ No
6.	Do the behavioral health providers screen and refer for:	
a)	Prevention and wellness education	⦿ Yes ○ No
b)	Health risks such as	
i)	heart disease	⦿ Yes ○ No
ii)	hypertension	⦿ Yes ○ No
viii)	high cholesterol	⦿ Yes ○ No
ix)	diabetes	⦿ Yes ○ No
c)	Recovery supports	⦿ Yes ○ No
7.	Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care?	⦿ Yes ○ No
8.	Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services?	⦿ Yes ○ No

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

A work group comprised of the Department of Behavioral Health and the D.C. Department of Health Care Finance (DHCF), the single state agency for Medicaid, are currently utilizing the Centers for Medicare and Medicaid Services requirements to analyze parity compliance. A report will be issued in the fall of 2018.

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

There are no activities that the Department of Behavioral Health would like to highlight at this time.

Please indicate areas of technical assistance needed related to this section

Determining and implementing incentivized/alternative payment methodologies.

Footnotes:

Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[45], **Healthy People, 2020**[46], **National Stakeholder Strategy for Achieving Health Equity**[47], 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, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS)[48].

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the HHS Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The HHS Secretary's top priority in the Action Plan is to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."[49]

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[50]. 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[51]. 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 populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

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[45] **http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf**

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

[47] **http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf**

[48] **http://www.thinkculturalhealth.hhs.gov**

[49] **http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf**

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

Please respond to the following items:

1.   Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, LGBT, and age?

                a) Race   ○ Yes ○ No

                b) Ethnicity   ○ Yes ○ No

                c) Gender   ○ Yes ○ No

                d) Sexual orientation   ○ Yes ○ No

                e) Gender identity   ○ Yes ○ No

                f) Age   ○ Yes ○ No

2.   Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population?   ○ Yes ○ No

3.   Does the state have a plan to identify, address and monitor linguistic disparities/language barriers?   ○ Yes ○ No

4.   Does the state have a workforce-training plan to build the capacity of behavioral health providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations?   ○ Yes ○ No

5.   If yes, does this plan include the Culturally and Linguistically Appropriate Services(CLAS) standard?   ○ Yes ○ No

6.   Does the state have a budget item allocated to identifying and remedialing disparities in behavioral health care?   ○ Yes ○ No

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

      Please indicate areas of technical assistance needed related to this section

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Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, the purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ? Cost, (V = Q ? C)

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of behavioral health systems and services.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state behavioral health authorities, legislators, and others regarding the evidence of various mental and substance misuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. NREPP assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. NREPP ratings take into account the methodological rigor of evaluation studies, the size of a program's impact on an outcome, the degree to which a program was implemented as designed, and the strength of a program's conceptual framework. For each intervention reviewed, NREPP publishes a report called a program profile on this website. You will find research on the effectiveness of programs as reviewed and rated by NREPP certified reviewers. Each profile contains easily understandable ratings for individual outcomes based on solid evidence that indicates whether a program achieved its goals. 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[52], The New Freedom Commission on Mental Health[53], the IOM[54], and the NQF[55]. 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."[56] SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocol Series **(TIPS)**[57] are best practice guidelines for the SUD treatment. The 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 SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation **(KIT)**[58] 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 M/SUD services.

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[52] United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

[53] 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.

[54] 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.

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

[56] **http://psychiatryonline.org/**

[57] **http://store.samhsa.gov**

[58] **http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.pdf**

Please respond to the following items:

1.   Is information used regarding evidence-based or promising practices in your purchasing or policy decisions?   ○ Yes ○ No

2.   Which value based purchasing strategies do you use in your state (check all that apply):

a)   ☐   Leadership support, including investment of human and financial resources.

b)   ☐   Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.

c)   ☐   Use of financial and non-financial incentives for providers or consumers.

d)   ☐   Provider involvement in planning value-based purchasing.

e)   ☐   Use of accurate and reliable measures of quality in payment arrangements.

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

g)   ☐   Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).

h)   ☐   The state has an evaluation plan to assess the impact of its purchasing decisions.

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

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

Footnotes:

Environmental Factors and Plan

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

Narrative Question

Much of the mental health treatment and recovery are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcome across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

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

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

* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)? ⦿ Yes ○ No

2. Has the state implemented any evidence based practices (EBPs) for those with ESMI? ⦿ Yes ○ No

> If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI.
>
> 1. Transition to Independence Process (TIP): Provides a framework for conceptualizing and organizing services that are still billable under the traditional Medicaid structures.
> 2. TIP and Assertive Community Treatment (ACT): The integration of TIP and ACT has proven very successful with TAY.
> 3. Assertive Community Treatment (ACT): An evidence-based practice that improves outcomes for people with severe mental illness who are most vulnerable to homelessness and hospitalization.
> 4. Medication Management: Monitoring medications to confirm that the patient is complying with a medication regimen, while also ensuring he or she is avoiding potentially dangerous drug interactions and other complications.
> 5. Family Supports: Social support from family provides patients with practical help and can buffer the stresses of living with illness.
> 6. RA1SE and NAVIGATE-like Services: The RAISE Early Treatment Program (ETP) is a research study that compared two (2) different ways of providing treatment for people experiencing the early stages of schizophrenia and related illnesses. Both types of treatment emphasized a comprehensive initial evaluation at the earliest point after symptoms appear.
> The ETP treatments approach is based on the NAVIGATE model, a comprehensive program designed to provide early and effective treatment to individuals who have experienced a first episode psychosis that includes medication, psychosocial therapies, and supportive services that address the multiple problems associated with these illnesses.
> 7. Individual Placement and Support (IPS)/Supported Employment/Education (SEE): This evidence-based program is designed to help people with a psychiatric disorder achieve their vocational and educational goals including people who have had a recent psychosis episode.
> 8. Cognitive Behavioral Therapy for Psychosis (CBTp): This is a new evidence-based practice in the District. DBH provided support to Community Connections to arrange an extensive training and supervision package for 20 mental health

professionals in the District. The training was provided by the Institute of Cognitive Behavioral Therapy for Psychosis and occurred over four (4) days. The follow-up supervision is being provided by the four (4) trainers. The supervisors have completed 10 of the contracted 30 sessions. The CBTp introduces the standard CBT principles to a population of people that had not previously benefitted from the techniques. Conceptualizing hallucination and delusions as symptoms that are amenable to treatment, CBTp successfully ameliorates some of the most profound symptoms suffered by the clients.

3. How does the state promote the use of evidence-based practices for individuals with a ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?

The DBH is committed to improving the lives of children, youth, transition age youth, and families through the use of evidence-based practices. DBH contracts with Evidence Based Associates (EBA) to provide training, quality and fidelity reviews, and monitors EBPs. EBA also provides technical support to all District agencies implementing a DBH sponsored EBP and supports the DBH annual summit held on evidence-based and innovative programs for children, youth and families. In both venues, ongoing TA provided to agencies and the annual conference, EBA and DBH promotes the use of evidence-based practices for individuals with ESMI and offers guidance on the crafting of comprehensive individualized treatment plans.

There are currently nine (9) EBPs that include the following:
? Child Parent Psychotherapy for Family Violence- For ages 0-6 with a history of trauma
exposure or maltreatment and their caregivers.
? Trauma Systems Therapy- For ages 0-19 who have experienced traumatic events and/or
who live in environments with ongoing traumatic stress.
? Parent Child Interaction Therapy- For ages 2-6 who experience extreme behavioral
difficulties with 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.
? Cognitive Behavioral Therapy for Psychosis (CBTp)- An evidence-based treatment primarily designed to target psychotic symptoms
such as delusions and hallucinations that persist despite appropriate treatment with antipsychotic medication.

DBH awarded Community Connection six (6) grants over the past 3-years. They include: 1) three (3) grants focused on understanding and intervening in First Episode Psychosis (FEP); 2) one grant focused on the TAY System of Care; 3) one grant focused on CBTp, and 4) one grant focused on Supported Employment and Education for TAY.

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with a ESMI?   ⦿ Yes ○ No

5. Does the state collect data specifically related to ESMI?   ⦿ Yes ○ No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI?   ⦿ Yes ○ No

7. Please provide an updated description of the state's chosen EBPs for the 10 percent set-aside for ESMI.

See the description above about the nine (9) DBH EBPs. Some of the EBPs may be appropriate for use with the 10% set-aside for ESMI.

8. Please describe the planned activities for FFY 2018 and FFY 2019 for your state's ESMI programs including psychosis?

Community Connections is eager to participate in further funded projects with TAY and ESMI. They have started to build a foundation of care with previous grants and would like to find ways to sustain the service. Many of the activities required to successfully engage TAY and ESMI are not billable through traditional Medicaid funded services, so grant funding remains essential to the provision of service.
During the past year there have been tremendous positive outcomes through both the TAY-SOC and ESMI programs. There was a dramatic decrease in hospitalization, legal involvement and increased engagement with education and employment. Fourteen (14) clients were placed in competitive employment and several more completed general education development (GED) and High School Diplomas. Three (3) clients obtained permanent housing, four (4) others were placed in transitional housing and in two (2)

cases the housing issue was resolved due to improving conflict resolution skills, medication management and family education. The TAY-System of Care total number of TAY and Young Adults Served include the following:

1. Number enrolled in FEP = 48
2. Number engaged in treatment/ FEP=15
3. Number engaged and then referred out/FEP=3

9. Please explain the state's provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.

DBH, Community Connections of New York (CCNY) and Coordinated Care Services, Inc. (CCSI) are collaborating partners. This partnership draws upon the experience and expertise of all organizations in providing evaluation, data analysis, and technical assistance to the agencies supporting the efforts of ESMI. Utilizing existing databases CCNY has created a platform that allows the pulling of information and data. CCNY pulls data and provides a monthly, quarterly and annual report to DBH on agreed upon data points. These evaluation findings will be used to improve and promote an integrated system for youth and young adults. Evaluation services will provide the opportunity to identify successes and barriers encountered in the process of identifying, referring and early screening, to serve youth and young adults with serious mental illnesses. Evaluation services will allow continuous, quality improvement measurement and monitoring ensuring that the transition age youth system of care is operating optimally.

10. Please list the diagnostic categories identified for your state's ESMI programs.

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

1. Major Depressive Disorder
2. Schizoaffective Disorder Bipolar Type
3. Schizoaffective Disorder
4. Bipolar Disorder with Psychotic Features
5. Schizophrenia with Co-Occurring Substance Use disorder
6. Schizophrenia
7. Substance Induced Psychotic Disorder

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

There are no additional activities that the Department of Behavioral Health would like to highlight at this time.

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

The Department of Behavioral Health needs to identify additional evidence-based practices (EBPs) and training for staff who will be working with the early serious mental illness (ESMI) population.

Footnotes:

Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required MHBG

Narrative Question

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

1. Does your state have policies related to person centered planning?   ⦿ Yes ○ No

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

3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.

    After a comprehensive diagnostic assessment has been completed, the results of the assessments are reviewed with the consumer to ensure there is a shared and agreed upon understanding of the issues to be addressed within treatment. Based on this shared understanding, the treatment planning process begins by orienting the individual and his/her natural supporters to the process. This increases the likelihood of the consumer's actively participate in all steps of the plan development and implementation. Before the process of developing a treatment plan begins, the treatment team lead will encourage pre-planning activities and goal prioritization with the consumer. This allows the consumer to not only prepare for their planning meeting but to empower them to be voice their choice of how they would like for their recovery to look with the treatment team.

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

    The following activities/areas warrant special attention in the person-centered planning process:
    1. Conducting a comprehensive, strengths-based assessment;
    2. Developing an interpretive summary as a result of assessment;
    3. Understanding cultural concerns and preferences in planning and goal development;
    4. Orienting the individual and his natural supporters regarding the purpose and process
    of person-centered planning; and
    5. Encouraging pre-planning and prioritization on the part of the individual.

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

    There are no additional activities the Department of Behavioral Health would like to highlight at this time.

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

    There are no technical assistance needs related to this section at this time.

Footnotes:

Environmental Factors and Plan

6. Self-Direction - Requested

Narrative Question

In self-direction - also known as self-directed care - a service user or "participant" controls a flexible budget, purchasing goods and services to achieve personal recovery goals developed through a person-centered planning process. While this is not an allowable use of Block Grant Funds,the practice has shown to provide flexible supports for an individual's service. The self-direction budget may comprise the service dollars that would have been used to reimburse an individual's traditional mental health care, or it may be a smaller fixed amount that supplements a mental health benefit. In self-direction, the participant allocates the budget in a manner of his or her choosing within program guidelines. The participant is encouraged to think creatively about setting goals and is given a significant amount of freedom to work toward those goals. Purchases can range from computers and bicycles to dental care and outpatient mental health treatment.

Typically, a specially trained coach or broker supports the participant to identify resources, chart progress, and think creatively about the planning and budgeting processes. Often a peer specialist who has received additional training in self-direction performs the broker role. The broker or a separate agency assists the participant with financial management details such as budget tracking, holding and disbursing funds, and hiring and payroll logistics. Self-direction arrangements take different forms throughout the United States and are housed and administered in a variety of entities, including county and state behavioral health authorities, managed care companies, social service agencies, and advocacy organizations.

Self-direction is based on the premise that people with disabilities can and should make their own decisions about the supports and services they receive. Hallmarks of self-direction include voluntary participation, individual articulation of preferences and choices, and participant responsibility. In recent years, physical and mental health service systems have placed increasing emphasis on person-centered approaches to service delivery and organization. In this context, self-direction has emerged as a promising practice to support recovery and well-being for persons with mental health conditions. A small but growing evidence base has documented self-direction's impact on quality of life, community tenure, and psychological well-being.

Please respond to the following items:

1.   Does your state have policies related to self-direction?   ○ Yes ○ No

2.   Are there any concretely planned initiatives in our state specific to self-direction?   ○ Yes ○ No

     If yes, describe the currently planned initiatives. In particular, please answer the following questions:

     a)   How is this initiative financed:

     b)   What are the eligibility criteria?

     c)   How are budgets set, and what is the scope of the budget?

     d)   What role, if any, do peers with lived experience of the mental health system play in the initiative?

     e)   What, if any, research and evaluation activities are connected to the initiative?

     f)   If no, describe any action steps planned by the state in developing self-direction initiatives in the future.

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

     Please indicate areas of technical assistance needed to this section.

Footnotes:

Environmental Factors and Plan

7. Program Integrity - Required

Narrative Question

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds. While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: **http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf**. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the MHBG and SABG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of behavioral health benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following items:

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

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with programs requirements, including quality and safety standard? ⦿ Yes ○ No

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

• Mental Health Block Grant (MHBG) Funding Award Process: The Notice of Funding Availability (NOFA) and Request for Applications (RFA) have traditionally addressed the statutory restrictions on the use of the MHBG funds. This information is also included in the Pre-Application Conference along with program, performance and fiscal expectations.
• Mental Health Block Grant (MHBG) Sub-Grant Agreement: The MHBG Sub-Grant Agreement provides detail information about what is required and includes but is not limited to: 1) terms of the agreement, 2) background and purpose, 3) award period, 4) grant administrator, 5) scope and use of funds, 6) grant amount, 7) administrative requirements, 8) reporting requirements, and 9) fund disbursement plan and requirements.
• Accountability Administration: The Accountability Administration oversees provider certification, mental health community residence facility licensure, program integrity, quality improvement, incident management, major investigations, claims audits, and compliance monitoring. This Administration issues the annual Provider Scorecard.

The Accountability Administration includes a new division called Program Integrity that certified providers through audits and reviews to ensure that they meet service delivery and documentation standards for mental health and substance use disorder services.

Please indicate areas of technical assistance needed to this section

There are no technical assistance needs related to this section at this time.

Footnotes:

Environmental Factors and Plan

8. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the **2009 Memorandum on Tribal Consultation**[59] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

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

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

2. What specific concerns were raised during the consultation session(s) noted above?

Does the state have any activites related to this section that you would like to highlight?

Please indicate areas of technical assistance needed to this section

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Footnotes:

Environmental Factors and Plan

10. Statutory Criterion for MHBG - Required MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

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

Please respond to the following items

Criterion 1

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

    Clinical Services Administration- Supervises the operation of all clinical programs and sets standards for the provision of clinical care throughout the public behavioral health system. It includes all DBH directly provided assessment, referral, and clinical services; forensic services; the comprehensive emergency psychiatric program; and the disaster behavioral health program. The Administration oversees involuntary commitment at community hospitals, and coordinates services that assist individuals transitioning from psychiatric hospitals and nursing homes to community based behavioral health services.

    Community Services Administration- Develops, implements and monitors a comprehensive array of prevention, early intervention and community-based behavioral health services and supports for adults, children, youth, and their families that are culturally and linguistically competent and supports resiliency and recovery. This Administration includes services and supports in the former Adult Services, Children/Youth Services, Substance Use Disorder Prevention Services, and Treatment and Recovery Services.

    Consumer and Family Affairs Administration- Promotes and protects the rights of individuals with behavioral health disorders; encourages and facilitates consumer and client and family leadership of treatment and recovery plans, and ensures consumer and client voice in the development of the behavioral health system. The Administration also promotes consumer and client leadership, manages the peer certification training, and provides expertise on the consumer and client perspective. This Administration is made up of the following teams: Peer Support, Consumer Engagement, Consumer Rights, Quality Improvement and Saint Elizabeths Hospital. It also contracts with a Peer Operated Drop-In Center and in 2017 launched the D.C. Certified Peer Academy.

    Evidenced Based Practices- DBH implements a number of evidence-based and evidence supported practices across a variety of settings. This includes mental health, substance use disorder, and integrated health projects. These projects cross the developmental spectrum from infancy to early childhood, early, middle and late school age, through transition age youth, young adults, adults.

    District Agency and Other Partners- The DBH partners include but are not limited to:
    1) D.C. Public Schools, 2) D.C. Public Charter Schools, 3) Office of the State Superintendent of Education, 4) Child and Family Services Agency, 5) Department of Youth Rehabilitation Services, 6) Department on Disability Services, 7) Department on Human Services, 8) D.C. Office on Aging, 9) Department of Health, 10) Department of Health Care Finance, 11) Office of Disability Rights, 12) Rehabilitation Services Administration, 13) D.C. Housing Authority, 14) Department of Housing and Community Development, 15) Department of General Services, 16) District of Columbia Metropolitan Police Department, 17) Department of Corrections, 18) Superior Court of the District of Columbia, and 19) D.C. Superior Court Juvenile Division.

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

a)	Physical Health	⦿ Yes ○ No
b)	Mental Health	⦿ Yes ○ No
c)	Rehabilitation services	⦿ Yes ○ No
d)	Employment services	⦿ Yes ○ No
e)	Housing services	⦿ Yes ○ No
f)	Educational Services	⦿ Yes ○ No
g)	Substance misuse prevention and SUD treatment services	⦿ Yes ○ No

h)	Medical and dental services	⊙ Yes ○ No
i)	Support services	⊙ Yes ○ No
j)	Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)	⊙ Yes ○ No
k)	Services for persons with co-occuring M/SUDs	⊙ Yes ○ No

Please describe as needed (for example, best practices, service needs, concerns, etc)

The evidence-based practices were described in earlier sections of the Environmental Factors Plan.

3. Describe your state's case management services

In the District of Columbia Chapter 34 describes the mental health rehabilitation services (MHRS) standards. During August 2017 the proposed changes and amendments were disseminated for review and comment. In accordance with both the old and proposed standards, case management is not one of the nine (9) listed services. The District offers Community Support in lieu of case management.

Community Support services are rehabilitation and environmental supports considered essential to assist the consumer in achieving rehabilitation and recovery goals that focus on building and maintaining a therapeutic relationship with the consumer. These services may include but are not limited to: 1) a variety of interventions; 2) provided by a team of staff that is responsible for an assigned group of consumers, or by staff who are individually responsible for assigned consumers; 3) services provided to children and youth will include coordination with family and significant others and with other systems of care; 4) services can be provided at the MHRS provider site, natural settings or a residential facility with 16 beds or less; 5) providers will have service specific policies and procedures; and 6) qualified practitioners include psychiatrists, psychologists, licensed social workers, advanced practice nurses; registered nurses; licensed practical nurses; licensed professional counselors; social workers with supervision designation; and addiction counselors.

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

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

During FY 2017, SEH staff implemented an Improved Discharge Planning Initiative. The strategies focused on increasing the effectiveness of post discharge linkages with community-based treatment and support services. The measurement of effective linkages included the Interdisciplinary Recovery Plan (IRP) Observation Audit and the Discharge Plan of Care (DPOC) Audit. The IRP Audit examines if the family and/or Community Support Workers are invited to IRPs, and if there is active discussion about the discharge plan at each IRP. The DPOC Audit addresses whether patients are linked to a Core Service Agency/active treatment post discharge, and to appropriate housing.

The goal of this initiative is to assess the impact of in-hospital communication between individuals in care, community partners, and hospital treatment team members on the discharge planning process, in the hopes that this will result in positive impacts/outcomes for individuals in care as they transition from the Hospital back into the community.

Criterion 2: Mental Health System Data Epidemiology

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

Criterion 2

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

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

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI		
2.Children with SED		

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

The Department of Behavioral Health (DBH) does not generate data on prevalence. The information DBH receives is provided by SAMHSA, from the Center for Behavioral Health Statistics and Quality (CBHSQ). They fill in the prevalence information on the relevant Uniform Reporting System (URS) tables.

Criterion 3: Children's Services

Provides for a system of integrated services in order for children to receive care for their multiple needs. Services that should be integrated into a comprehensive system of care include: social services; educational services, including services provided under IDEA; juvenile justice services; substance abuse services; and health and mental health services.

Criterion 3

Does your state integrate the following services into a comprehensive system of care?

a)	Social Services	⦿ Yes ○ No
b)	Educational services, including services provided under IDE	⦿ Yes ○ No
c)	Juvenile justice services	⦿ Yes ○ No
d)	Substance misuse preventiion and SUD treatment services	⦿ Yes ○ No
e)	Health and mental health services	⦿ Yes ○ No
f)	Establishes defined geographic area for the provision of services of such system	⦿ Yes ○ No

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

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4

Describe your state's targeted services to rural and homeless populations and to older adults

These services are described in detail under Criterion 4 in the District's Application.

Criterion 5: Management Systems

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

Criterion 5

Describe your state's management systems.

These activities are described in detail under Criterion 5 in the District's Application.

Footnotes:

Environmental Factors and Plan

12. Quality Improvement Plan- Requested

Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1.   Has your state modified its CQI plan from FFY 2016-FFY 2017?   ○ Yes ○ No

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

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

Footnotes:

Environmental Factors and Plan

13. Trauma - Requested

Narrative Question

Trauma [60] is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective 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.

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. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with.

These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive behavioral health care. States should work with these communities to identify interventions that best meet the needs of these residents. In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing "business as usual." These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[61] paper.

60 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.*
61 *Ibid*

Please respond to the following items

1. Does the state have a plan or policy for behavioral health providers that guide how they will address individuals with trauma-related issues?   ○ Yes ○ No

2. Does the state provide information on trauma-specific assessment tools and interventions for behavioral health providers?   ○ Yes ○ No

3. Does the state have a plan to build the capacity of behavioral health providers and organizations to implement a trauma-informed approach to care?   ○ Yes ○ No

4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?   ○ Yes ○ No

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

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

Footnotes:

Environmental Factors and Plan

14. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[62]

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.[63]

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

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[62] 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**

[63] **http://csgjusticecenter.org/mental-health/**

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to behavioral health services?   ○ Yes ○ No

2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, behavioral health provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms?   ○ Yes ○ No

3. Does the state provide cross-trainings for 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 ○ No

4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address behavioral health and other essential domains such as employment, education, and finances?   ○ Yes ○ No

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

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

Footnotes:

Environmental Factors and Plan

15. Medication Assisted Treatment - Requested

Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], and 49[4].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA approved medication treatment should have access to those treatments based upon each individual patient's needs. In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate. SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders?   ○ Yes ○ No

2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly pregnant women?   ○ Yes ○ No

3. Does the state purchase any of the following medication with block grant funds?   ○ Yes ○ No

   a) ☐ Methadone

   b) ☐ Buprenophine, Buprenorphine/naloxone

   c) ☐ Disulfiram

   d) ☐ Acamprosate

   e) ☐ Naltrexone (oral, IM)

   f) ☐ Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately*?   ○ Yes ○ No

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

   Please indicate areas of technical assistance needed to this section.

   *Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.

Footnotes:

Environmental Factors and Plan

16. Crisis Services - Requested

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises. SAMHSA has recently released a publication, *Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies* that states may find helpful.[64] 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**[65],

"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 following are an array of services and supports used to address crisis response. Please check those that are used in your state:

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[64]**http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848**

[65]Practice Guidelines: Core Elements for Responding to Mental Health Crisis. 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 respond to the following items:

1. Crisis Prevention and Early Intervention

   a) ☐ Wellness Recovery Action Plan (WRAP) Crisis Planning
   b) ☐ Psychiatric Advance Directives
   c) ☐ Family Engagement
   d) ☐ Safety Planning
   e) ☐ Peer-Operated Warm Lines
   f) ☐ Peer-Run Crisis Respite Programs
   g) ☐ Suicide Prevention

2. Crisis Intervention/Stabilization

   a) ☐ Assessment/Triage (Living Room Model)
   b) ☐ Open Dialogue
   c) ☐ Crisis Residential/Respite
   d) ☐ Crisis Intervention Team/Law Enforcement
   e) ☐ Mobile Crisis Outreach
   f) ☐ Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. Post Crisis Intervention/Support

   a) ☐ WRAP Post-Crisis
   b) ☐ Peer Support/Peer Bridgers
   c) ☐ Follow-up Outreach and Support
   d) ☐ Family-to-Family Engagement

  e) ☐   Connection to care coordination and follow-up clinical care for individuals in crisis

  f) ☐   Follow-up crisis engagement with families and involved community members

  g) ☐   Recovery community coaches/peer recovery coaches

  h) ☐   Recovery community organization

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

  Please indicate areas of technical assistance needed to this section.

Footnotes:

Environmental Factors and Plan

17. Recovery - Required

Narrative Question

The implementation of recovery supports and services are 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. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, 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:

- Clubhouses

- Drop-in centers

- Recovery community centers

- Peer specialist

- Peer recovery coaching

- Peer wellness coaching

- Peer health navigators

- Family navigators/parent support partners/providers

- Peer-delivered motivational interviewing

- Peer-run respite services

- Peer-run crisis diversion services

- Telephone recovery checkups

- Warm lines

- Self-directed care

- Supportive housing models

- Evidenced-based supported employment

- Wellness Recovery Action Planning (WRAP)

- Whole Health Action Management (WHAM)

- Shared decision making

- Person-centered planning

- Self-care and wellness approaches

- Peer-run Seeking Safety groups/Wellness-based community campaign

- Room and board when receiving treatment

SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery

Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

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

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

    b) Required peer accreditation or certification?   ⦿ Yes ○ No

    c) Block grant funding of recovery support services.   ⦿ Yes ○ No

    d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?

    Persons in recovery including peers and family members are involved in the planning and implementation of the M/SUD system. This involvement includes the peer, family and youth peer certification programs and the recovery coaching training. Also, the DBH Behavioral Health Council addresses peer and family related issues through its membership that includes mental health and SUD providers, and District agency representatives.

2. Does the state measure the impact of your consumer and recovery community outreach activity?   ⦿ Yes ○ No

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

    The Department of Behavioral Health has a broad range of initiatives, programs, projects, treatment services and supports that address the needs of adults with serious mental illness (SMI), children/youth with serious emotional disturbances (SED), and their families. The recovery and support services for adults are described under Criterion 1 in the District's application.

    The child/youth and transition age youth initiatives are described in detail under Criterion 3- Children's services. This includes recovery oriented services and supports.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

    DBH trains people in mental health recovery and substance use disorder recovery to play a role in the treatment and services provided to other individuals with serious mental health and/OR substance use disorder issues. This is the focus of the DBH Recovery Coaching Training initiative.

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

    In the District of Columbia non-clinical services are provided to an individual by a certified Recovery Support Services provider to assist him/her in achieving or sustaining recovery from SUD. There are eight (8) billable recovery support services: 1) recovery support evaluation; 2) recovery support management; 3) recovery coaching (recovery mentoring and coaching); 4) recovery support service: life skills support services; 5) spiritual support services; 6) education support services; 7) recovery social activities; and 8) environmental stability.

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

    There are no technical assistance needs related to this section at this time.

Footnotes:

Environmental Factors and Plan

18. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in **Olmstead v. L.C., 527 U.S. 581 (1999)**, provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with 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 for Civil Rights **(OCR)** cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

Please respond to the following items

1. Does the state's Olmstead plan include :

    housing services provided.   ○ Yes ○ No

    home and community based services.   ○ Yes ○ No

    peer support services.   ○ Yes ○ No

    employment services.   ○ Yes ○ No

2. Does the state have a plan to transition individuals from hospital to community settings?   ○ Yes ○ No

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

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

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

Footnotes:

Environmental Factors and Plan

19. Children and Adolescents Behavioral Health Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community[66]. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24[67]. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death[68].

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[69]. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

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

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs[70].

According to data from the 2015 Report to Congress[71] on systems of care, services:
1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious 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 (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);

- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

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

[67]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.

[68]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.

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

[70]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**

[71] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

Please respond to the following items:

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

      a) The recovery and resilience of children and youth with SED?   ⦿ Yes ○ No

      b) The recovery and resilience of children and youth with SUD?   ○ Yes ○ No

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

      a) Child welfare?   ⦿ Yes ○ No

      b) Juvenile justice?   ⦿ Yes ○ No

      c) Education?   ⦿ Yes ○ No

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

      a) Service utilization?   ⦿ Yes ○ No

      b) Costs?   ⦿ Yes ○ No

      c) Outcomes for children and youth services?   ⦿ Yes ○ No

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

      a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families?   ⦿ Yes ○ No

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

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

      a) to the adult behavioral health system?   ⦿ Yes ○ No

      b) for youth in foster care?   ⦿ Yes ○ No

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

These services are described in detail under Criterion 3- Children's Services in the District's Application.

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

There are no activities that the Department of Behavioral Health would like to highlight at this time.

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

There are no technical assistance needs at this time.

Footnotes:

Environmental Factors and Plan

20. Suicide Prevention - Required MHBG

Narrative Question

Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges behavioral health agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide through the use of MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the behavioral health agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1.   Have you updated your state's suicide prevention plan in the last 2 years?   ○ Yes ● No

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

   Access HelpLine Division (AHL)- This Division is located within the Clinical Services Administration. One of the AHL roles is to provide telephonic suicide prevention and other counseling as appropriate. The AHL responds to incoming suicide and related calls on behalf of the: 1) Department of Behavioral Health, and 2) Washington Metropolitan Area Transit Authority, both suicide lines are housed at DBH and operated by AHL.

   Systems Transformation Administration- During 2017 the Strategic Management and Policy Division developed a Suicide Prevention and Intervention Policy. The Policy is being reviewed. It is envisioned that once approved the guidelines contained therein will help to lay the foundation for the development of the Department of Behavioral Health Suicide Prevention and Intervention Plan.

3.   Have you incorporated any strategies supportive of Zero Suicide?   ○ Yes ● No

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

5.   Have you begun any targeted or statewide initiatives since the FFY 2016-FFY 2017 plan was submitted?   ● Yes ○ No

   If so, please describe the population targeted.

   This law requires the Office of the State Superintendent for Education (OSSE) to adopt a rule requiring all District teachers and principals in public and charter schools to undergo training on suicide prevention, intervention, and postvention every 2 years. It also requires OSSE to develop and publish online written guidance to assist local education agencies (LEAs) in developing policies and procedures for handling various aspects of student mental and behavioral health. OSSE must examine and evaluate its guidance every 5 years, at a minimum, and notify LEAs within 30 days of updating the guidance. The law also requires OSSE to establish and implement a pilot program to collect school climate data (data regarding engagement, safety, and environment) through school climate surveys, and report school climate data to the Mayor and Council annually.

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

   During FY 2017 the Department of Behavioral Health developed a Suicide Prevention and Intervention Guidelines Policy.

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

   The Department of Behavioral Health (DBH) has developed a Suicide Prevention and Intervention Guidelines Policy. DBH would like to seek technical assistance related to developing a Suicide Prevention and Intervention Plan.

Footnotes:

The Department of Behavioral Health Suicide Prevention and Intervention Guidelines Policy will be uploaded in the Attachment section of the Application.

Department of Behavioral Health
TRANSMITTAL LETTER

SUBJECT		
Guidelines for Suicide Prevention and Intervention Planning		
POLICY NUMBER 310.1	**DATE** AUG 3 0 2017	**TL#** 310

Purpose. To establish guidelines for the development of a Suicide Prevention and Intervention Plan (Plan) that align with the 2012 National Strategy for Suicide Prevention[1] and the DC Healthy People 2020 Framework.[2]

Applicability. Applies to the Department of Behavioral Health (DBH).

Policy Clearance. Reviewed by affected responsible staff and cleared through appropriate Behavioral Health Authority (BHA) offices.

Effective Date. This policy is effective immediately.

Superseded Policies. None

Distribution. This policy will be posted on the DBH web site at www.dbh.dc.gov under Policies and Rules. Applicable entities are required to ensure that affected staff is familiar with the contents of this policy.

Tanya A. Royster, MD
Director, DBH

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[1] 2012 National Strategy for Suicide Prevention: GOALS AND OBJECTIVES FOR ACTION A report of the U.S. Surgeon General and of the National Action Alliance for Suicide Prevention
[2] The District of Columbia Healthy People 2020 Framework is our shared community agenda that monitors 150 objectives and targets for the year 2020 as well as recommends over 85 strategies to improve population health. DC Healthy People 2020 Framework Report - 7.1 MB (pdf)

Government of the District of Columbia

GOVERNMENT OF THE DISTRICT OF COLUMBIA ★ ★ ★ **DEPARTMENT OF BEHAVIORAL HEALTH**	**Policy No.** 310.1	**Date** AUG 3 0 2017	**Page 1**
	Supersedes **None**		

Subject: Guidelines for Suicide Prevention and Intervention Planning

1. **Purpose**. To establish guidelines for the development of a Suicide Prevention and Intervention Plan (Plan) that align with the 2012 National Strategy for Suicide Prevention[1] and the DC Healthy People 2020 Framework.[2]

2. **Applicability**. Applies to the Department of Behavioral Health (DBH).

3. **Authority**. The Department of Behavioral Health Establishment Act of 2013.

4. **Background.** Suicide is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance use disorder, painful losses, exposure to violence, and social isolation. Mental illness and substance use disorder are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, Substance Abuse and Mental Health Services Administration (SAMHSA) urges behavioral health agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with serious mental illness/ serious emotional disturbance (SMI/SED) who are at risk for suicide through the use of mental health block grant (MHBG) funds to address these risk factors and prevent suicide. SAMHSA encourages the behavioral health agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED. The DBH Access HelpLine suicide line calls present the following relevant figures:

Fiscal Year	Access HelpLine Suicide Calls	Access HelpLine/Washington Metropolitan Area Transit Authority Suicide Line Calls
FY 2015	3, 891	379
FY 2016	2,264	89
FY 2017 YTD	1,555	51

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[1] 2012 National Strategy for Suicide Prevention: GOALS AND OBJECTIVES FOR ACTION A report of the U.S. Surgeon General and of the National Action Alliance for Suicide Prevention

[2] The District of Columbia Healthy People 2020 Framework is our shared community agenda that monitors 150 objectives and targets for the year 2020 as well as recommends over 85 strategies to improve population health. ☑ DC Healthy People 2020 Framework Report - 7.1 MB (pdf)

5. **Definitions**.

5a. Consumers – refer to individuals who receive mental health and substance use disorder supports and/or services from DBH and contracted providers. Note: The common term used in the substance use disorder (SUD) service delivery systems is "clients" (also, see Exhibits 1 and 2 references to "Consumer").

5b. Suicide - direct violence towards oneself with the intent to end own life, and die as a result of the action. Suicide is a leading cause of death in the United States.[3]

5c. Suicide attempt - when people harm themselves with the intent to end their lives, but do not die as a result of their actions. Many more people survive suicide attempts than die, but they often have serious injuries. However, a suicide attempt does not always result in a physical injury.

6. **Policy**. The Department of Behavioral Health (DBH) is committed to promoting the health and safety of District residents through its Suicide Prevention and Intervention Plan and its practical implementation.

7. **Procedures**. The DBH Suicide Prevention and Intervention Plan shall:

7a. Establish goals and objectives that

(1) Lead to supportive service/support environments that promote healthy and empowered individuals, families, and communities;

(2) Enhance clinical and community preventive services;

(3) Promote the availability of timely treatment and support services; and

(4) Improve suicide prevention surveillance collection, research, and evaluation.

7b. Address integration of policies and practices that support suicide prevention through strategies that

(1) Foster positive public dialogue, counter shame, prejudice, and silence; and build public support for suicide prevention.

(2) Address the needs of vulnerable groups, be tailored to the cultural and situational contexts in which they are offered, and seek to eliminate disparities.

    a. Implement consumer/client-informed alternatives to hospitalization for individuals

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[3] Centers for Disease Control and Prevention (CDC). Web-based Injury Statistics Query and Reporting System (WISQARS) [Online]. (2013) National Center for Injury Prevention and Control, CDC (producer). Available from URL www.cdc.gov/injury/wisqars/index.html.

with suicide risk;

b. Develop alternatives to treatment in an emergency setting, such as same-day scheduling for mental health services and in-home crisis care;

c. Develop and implement protocols to ensure immediate and continuous follow-up after discharge from a crisis center or institutional setting; and

d. Educate family members and significant others about appropriate steps to support individuals at suicide risk during treatment and/or after discharge from a crisis center or institutional setting.

(3) Are coordinated and integrated with existing efforts addressing health and behavioral health and ensure continuity of care; and

(4) Promote changes in systems, policies, and environments that will support and facilitate the prevention of suicide and related problems.

7c. Take into consideration the following new findings:

(1) A better understanding of how suicide is related to mental illness, substance use disorder, trauma, violence, and other related issues;

(2) New information on groups that may be at an increased risk for suicidal behaviors; and

(3) Increased knowledge of the types of prevention and interventions that may be most effective for suicide.

7d. Recognize the importance of implementing suicide prevention efforts in a comprehensive and coordinated way;

(1) Collaborate with other public health and behavioral health stakeholders; and

(2) Promote efforts to reduce access to lethal means among individuals with identified suicide risks.

7e. Organize the development of the Plan that may include the following activities:

(1) Convening of relevant stakeholders (e.g., consumer/client advocacy groups, consumers/clients, provider agencies, other government agencies, hospitals, clinics, etc.) to develop the Plan;

(2) Developing and implementing an effective communications strategy for promoting mental health and emotional well-being that incorporates traditional and new media as part of the Plan.

a. Identify groups at risk and work with various stakeholders to implement suicide prevention policies and programs that address the needs of these groups; and

b. Sponsor training and disseminate information to mental health providers, professional associations, and consumers/clients and their families.

(3) Communicate messages of resilience, hope, and recovery to consumers/clients, and their families with mental and substance use disorders.

(4) Disseminate information about the DBH and District emergency numbers and the National Suicide Prevention Lifeline.

(5) Promote the availability of online support services and crisis outreach teams/mobile crisis.

(6) Develop protocols and improvement in the collaboration among crisis centers, law enforcement, mobile crisis teams, and social services to ensure timely access to care for individuals with suicide risk.

8. **Essential Elements in Organizing the Plan Committee**.

8a. Roles and Responsibilities.

(1) Plan Owner – this refers to the Director of DBH.

(2) Plan Sponsor – this Plan is sponsored by the Chief, Medical Officer, a DBH executive team member that signs off as the guarantor of the Plan and facilitates overcoming organizational roadblocks.

(3) Steering Committee - guides the Planning progress and provides ideas in the Plan.

(4) Project Manager - responsible for ensuring that the Plan is delivered on time, within scope and allotted resources. Also, analyses DBH's structures and processes to determine areas for improvement and creates a requirements specification for the Plan.

(5) Stakeholder - any person or group that has an active interest in the Plan outcome or process.

8b. Committee Logistics. The Plan Committee has a clearly defined mission including the following:

(1) Scope of Responsibility and Authority – refers to the extent of authority and subject matter expertise that the Committee has.

(2) Deliverables – refers to the outcomes of the Committee which is the Plan.

8c. Committee Charter. The Plan Committee will design the primary deliverables with input from selected stakeholders (e.g., govern committee formation, organization and operation).

8d. Collaboration, cooperation and communication. The Plan Committee will consider the following:

(1) Interaction guidelines - rules to guide interactions to ensure that all parties are treated with proper respect, consideration and decorum.

(2) Participation guidelines - protocols on how to carry out assigned roles and responsibilities (e.g., timeliness, attendance, and commitments).

(3) Communication guidelines - rules on sharing information, soliciting contributions/inputs, and how and when the various means of communication are to be utilized, including memos, email, meetings, through DBH website, and related activities.
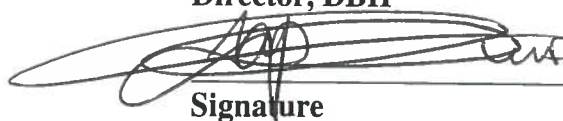
9. **Reviews, evaluation and reports.**

9a. Reviews shall be done in various phases of the Plan to measure the progress, identify areas for improvement, encourage decisions to be taken, including changes to objectives and the methodology.

9b. The Plan shall integrate processes that evaluates the measurable goals and the impact to those that the Plan intended to reach.

9c. The Plan shall incorporate report sharing to District and federal entities (e.g., SAMSHA).

Approved by:

Tanya A. Royster, MD
Director, DBH

8/30/2017

Signature   Date

Environmental Factors and Plan

21. Support of State Partners - Required MHBG

Narrative Question

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

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;

- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;

- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;

- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;

- The state public housing agencies which can be critical for the implementation of Olmstead;

- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and

- The state's office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in 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 respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period?   ⦿ Yes   ○ No

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

   If yes, with whom?

   The Department of Behavioral Health (DBH) has developed new partners as well as participated in new projects with existing partners. The new initiatives include: 1) Early Childhood Innovative Network (ECIN) that is part of the Children's National Health System to develop new strategies to support and improve services in child development centers and schools; 2) D.C. SEED a SAMHSA grant awarded to DBH that focuses on the system of care for children age 0-6 who are at risk of and/or experiencing serious emotional disturbances which also includes community partners; and 3) Office of the State Superintendent of Education (OSSE) continues to include DBH and other agencies in various initiatives such as the State Early Childhood Coordinating Council work groups (Data Committee and Health and Well Being Sub-Committee) and the Quality Improvement Network (QIN) that focuses on building high quality, comprehensive early childhood development and family engagement services for infants and toddlers.

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

   The Department of Behavioral Health (DBH) coordinates services through interagency partnerships, its provider network, and other community-based programs. The Department maximizes the efficiency, effectiveness, quality and cost-effectiveness of services and programs through both buyer and seller relationships. DBH provides its consumers/clients a variety of behavioral health treatment services and supports that allows them to move appropriately through inpatient, residential and community-based options. This may also include opportunities such as job training, employment, and housing.

Also, DBH works closely with the Office of the State Superintendent of Education on matters related to the Individuals with Disabilities Education Act.

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

The Department of Behavioral Health has identified partnerships with District agencies and other partners throughout this Application including services and supports for children, youth, transition age youth, young adults, adults, as well as mental health and SUD activities.

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

There are no technical assistance needs related to this section at this time.

Footnotes:

Environmental Factors and Plan

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

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 services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as 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 misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a BHPC, SAMHSA has created **Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.**[72]

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with behavioral health problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

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

Please respond to the following items:

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

    a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

    The District of Columbia Department of Behavioral Health (DBH) serves as the State Mental Health Authority (SMHA) and the District of Columbia Single State Agency (SSA) for substance use disorders. In the latter role DBH: 1) operates four (4) community prevention centers each serving two (2) of the 8 District wards; 2) provides services and contracts with community providers for substance use disorder (SUD) services and supports; 3) assess and refer adults seeking treatment for SUD to appropriate services; 4) the Mobile Assessment and Referral Center (MARC) visits communities throughout the District to conduct assessment, referral, and HEP-C and HIV testing; 5) annual prevention symposium; 6) adults, young adults and youth substance youth campaigns (marijuana use, synthetic drug use, opioid use); and 7) recovery coaching training. The Mayor of the District of Columbia, Muriel Bowser, participates with the leadership of Maryland and Virginia to address the regional opiod crisis. Also, the District has an Epidemiological Outcomes Workgroup (DC EOW).

    b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into i   ⊙ Yes ○ No

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linquistic, rural, suburban, urban, older adults, families of young children)?   ⊙ Yes ○ No

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

    The overall goals of the DBH/BHC is to advise the Department of Behavioral Health as follows:
    1. To ensure that individuals in need of mental health and/or substance use disorder services have access to services;
    2. To ensure that consumer and family directed services and supports for the prevention and treatment of mental health and substance use disorders maintain a focus on recovery and resilience;
    3. To advocate for District residents with serious emotional disturbances, mental health issues, and substance use disorders;
    4. To support the integration of mental and substance use disorder prevention, treatment and recovery services and supports into overall health services;
    5. To reduce disparities in the prevention and treatment of mental health and substance use disorders;
    6. To strengthen the coordination and collaboration with relevant state and community organizations in order to develop systems of care; and
    7. To provide input for the development of the SAMHSA Mental Health and Substance Abuse Block Grants.

    The DBH/BHC has achieved this primarily by sharing information, inviting relevant agency presentations and participation, and

whenever asked or invited to relevant Departmental endeavors.

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

The DBH/BHC members were invited to attend the SAMHSA Center for Substance Abuse (CSAT)/Substance Abuse Block Grant (SABG) Site Visit Meeting. The meeting was held August 16-17, 2017. The topics included: 1) DBH System Overview – Organizational Structure and Behavioral Heath Integration; 2) Overview of Substance Use Disorder System funded by SABG; 3) SAMHSA Updates, Overview of SABG Requirements, TA; 4) Substance Use Prevention; 5) Access, Screening, and Referral Center (ARC), & HIV & TB Screening; 6) Substance Abuse Treatment Services; 7) Women's Treatment Services - Pregnant Women and Women With Dependent Children; 8) Opioid Addiction and Medication Assisted Treatment (MAT); 9) Recovery and Recovery Support Services; 10) Financial Management Systems, Contracts, Electronic Data Systems; 11) Brief Listing/Summary of Additional SAMHSA Contracts; 12) Site Visit- So Others Might Eat (SOME) Outpatient and Intensive Outpatient; and 13) Site Visit- Medical Home Development Group (MHDG) Opioid Replacement Therapy (ORT).

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

The DBH/BHC has identified two (2) issues for technical assistance. The first issue is related to the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children). While the membership is diverse and every effort has been made to include the relevant populations, families of young children, all ages of consumers and persons who are not native English speakers are not represented. The DBH/BHC does not have a robust, ongoing recruitment strategy and would like to seek SAMHSA technical assistance related to this issue.

The second issue is related to expanding the integration of substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities. The DBH/BHC has currently achieved this integration through active members of the DBH/BHC who are service providers for this population. However, the DBH/BHC would like to expand to include other providers and consumers, and would like to seek SAMHSA technical assistance.

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.[73]

[73]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.

Footnotes:

The DBH/BHC involvement in the development of the District Mental Health Block Grant Application and the minutes are attached. Please note that the DBH/BHC meets every other month.

Behavioral Health Council Meeting Minutes

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BEHAVIORAL HEALTH COUNCIL MEETING Minutes
September 23, 2016, 10:00 a.m.-12:00 p.m.

Call to Order Chair, Department of Behavioral Health (DBH)/Behavioral Health Council (DBH/BHC)

This was a regularly scheduled meeting of the Department of Behavior Health/Behavioral Health Council (DBH/BHC). It was called to order by the Chair, Senora Simpson, at approximately 10:05 a.m. and ended at 11:35 a.m.

Meeting Participants

The participants included: Senora Simpson, Donna Anthony, Vivian Guerra, Mark Agosto, Mark LeVota, Cheryl Doby-Copeland, Davita Crockett, James Ballard III, Andrew Reese, Effie Smith, Jim Wotring, Leslie Ann Byam, Samantha Knox, Julie Kozminski, Faiza Majeed, Timothy Robinson, Jocelyn Route and Marie Morilus-Black.

- A quorum was available therefore the meeting continued.
- Agenda reviewed and approved with no additions
- Meeting Minutes from September 2016 were reviewed and approved.

Presentation

- No Wrong Door Presentation-Vivian Guerra and Mark Agosto
The goal of this initiative is to streamline intake and training for District residents in need of Long Term Support Services.

Committee Reports
1. **Advocacy Committee** (Chery Doby-Copeland, Chair) — Update provided.
2. **Program, Data and Policy Committee** (Agnes Venson, Chair) — No update provided.
3. **Block Grant Committee** (Effie Smith and Marie Morilus Black, Co-Chairs) No update provided.
4. **Ad Hoc By-Laws Committee** No update provided.

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BEHAVIORAL HEALTH COUNCIL MEETING Minutes
November 25, 2016, 10:00 a.m.-12:00 p.m.

Call to Order Chair, Department of Behavioral Health (DBH)/Behavioral Health Council (DBH/BHC)

This was a regularly scheduled meeting of the Department of Behavior Health/Behavioral Health Council (DBH/BHC). It was called to order by the Chair, Senora Simpson, at approximately 10:05 a.m. and ended at 11:35 a.m.

Meeting Participants

The participants included: Senora Simpson, Donna Anthony, Vivian Guerra, Mark Agosto, Mark LeVota, Cheryl Doby-Copeland, Davita Crockett, James Ballard III, Andrew Reese, Effie Smith, Jim Wotring, Leslie Ann Byam, Samantha Knox, Julie Kozminski, Faiza Majeed, Timothy Robinson, Jocelyn Route and Marie Morilus-Black.

- A quorum was available therefore the meeting continued.
- Agenda reviewed and approved with no additions
- Meeting Minutes from September 2016 were reviewed and approved.
- No Wrong Door Presentation-Vivian Guerra and Mark Agosto
    - Goal of this initiative is to streamline intake and training for District residents in need of Long Term Support Services.

- **Committee Reports**
1. **Advocacy Committee** (Chery Doby-Copeland, Chair) — Update provided.
2. **Program, Data and Policy Committee** (Agnes Venson, Chair) — No update provided.
3. **Block Grant Committee (Effie Smith and Marie Morilus Black, Co-Chairs)** No update provided.
4. **Ad Hoc By-Laws Committee** No update provided.

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BEHAVIORAL HEALTH COUNCIL MEETING Minutes

January 27, 2017 10:00 a.m.-12:00 p.m.

Meeting Participants:

The in-person participants: Senora Simpson, Effie Smith, Mark LeVota, Donna Anthony, Nicole Denny, Leslie-Ann Bynum, Jocelyn Route, Tanya Royster, MD, Director, James Wotring, Senior Deputy Director, Faiza Majeed, Juanita Reaves, and Cheryl Doby-Copeland.

Dial-in participants included: Colin Anthony and Trina Dutta

Call to Order, Chair Department of Behavioral Health (DBH) Behavioral Health Council (BHC)
The BHC was called to order by the Chair, Senora Simpson at 10: 05 am. A quorum was ascertained by roll call. The Chair appointed Cheryl Copeland as the recording Secretary in the absence of the Council Secretary.

Agenda
The agenda was adopted via acclimation.

Minutes
The minutes of November 1, 2016 were adopted as presented and will be available on the DBH website as required.

Director's State of DBH and Charge to the Council- Dr. Royster
Dr. Royster provided the Council with her vision for the Department and her expectation for the BHC to move toward identifying gaps in services by using a data driven approach.

Dr. Royster indicated her desire to have a legacy that provided a streamlined access to services by:

- Identification of data to support an initiative involving peer operated services/Peer Operated Center, which Ms. Effie Smith stressed that one has been active for 14 years. Peer services are suggested as a mechanism to help obtain/maintain recovery.

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- The need to always seek quality services.
- The need for "meaningful outcomes" at the provider and individual level.
- Collect data about the impact of the services we are providing as a means to connect to improved quality of life.

Ms. Simpson inquired about the Director's expectation and role of the BHC, particularly regarding its role in the administration of the Block Grant because the process of reviewing, selecting and monitoring the current grant recipients was changed by this administration, the role of the BHC Block Grant Standing Committee and the BHC's mandatory responsibility to prepare an annual report to SAMSHA regarding the disbursal of the grants, and evaluation of program outcomes was altered and the need to continue its function is unclear.

Dr. Royster informed the Council that the Office of Planning and Performance Management under Dr. Juanita Reaves, is managing the data, and Fiscal Services monitors the grants and will share the report with the BHC. Fiscal Services sends out contracts, policies, and they will monitor the grants in conjunction with the BHC.

Dr. Royster indicated the realignment of DBH is awaiting approval and would eventually collapse functions to make the Department more efficient.

Discussion of the fears/anxieties within the public based on the recent Executive Orders by the President.

Dr. Royster indicated that she is an "eternal optimist", and that the Department has a real opportunity and that people are talking more about their feelings. She suggested that the BHC could:

- Assist the DBH Access Helpline to let the pubic know of mental health services.
- Alert the public of the existence of the new Office of Legislative and Public Affairs which will assist the public in understanding DBH and how to access services.

Action Item 1: Invite Phyllis Jones to speak to the BHC about the vision and strategies of her office.
 Action Item 2: Invite the Director to return after the approval of a new Departmental Realignment.

Deputy Director Report- Dr. Wotring

The plan for a brief strategic planning session was eliminated by consensus and a Clarification of Meaningful Outcomes Discussion ensued.

The consensus of the body included the following:

The need to:

- Collect data/evidence that people are thriving- Macro outcomes (individuals staying in school, adequate housing, employment opportunities).
- Develop client level outcomes by partnering with other agencies.

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- Collect data individually and be able to make the case for clinical improvements individually versus District-wide.
- Clarify how to measure good outcomes for adults that are dually diagnosed.
- Develop an Ad Hoc Sub-committee to review various data that are collected by the agencies represented by the BHC (the Chief Information Officer is currently collecting data).
- Review the current service delivery system for the Department and the community service providers.

Action Item 3: BHC attendees should bring service data they are currently collecting to the next council meeting.
Action Item 4: Invite Brady Birdsong (Chief Information Officer), Laura Heaven (Research and Clinical Information Manager, and Donna Anthony (Office of the State Superintendent of Education) to discuss service data to the next BHC meeting.

Planning and Performance Management Officer Dr. Reaves

An update on the status of the State Plan was provided. It was also noted that the Council would be informed about its involvement in plan development in a timely manner.

Standing Committee Reports:

- **Block Grant - Effie Smith**

  The Committee suspended activity given the lack of clarification on what was required. The Block Grant Committee will work closely with Juanita Reaves, Ph.D. and Mr. Wotring and will provide reports on the current status of the grants.

- **Advocacy Committee - Cheryl Doby-Copeland**

  The Committee will be informed of the next steps based on the results of the data detailing existing programs and gaps in services.

- **Program Data Committee - Agnes Venson**
  The Committee will be informed after the results of the upcoming data discussion.

Unfinished Business:

There were no reports of any members having participated in the Wrong Door Initiative Activity or the Request for SAMHSA TA offerings.

New Business

- Appointment of an Ad Hoc Committee for the Development of the Council to review the functioning of the BHC by conducting a self-examination of the BHC. Members will include Donny Anthony, Mark LeVota, and Senora Simpson.

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- Nominating Committee to be formed to identify new members for the BHC, Nicole Denny was appointed as the Nominating Committee Chair.

Announcements

- No Wrong Door Initiative meeting- 2/7/2017, BHC members were encouraged to attend.
- SAMSHA Technical Assistance can be identified and submitted to the Project Officer.
- 2017 is the year for the full Block Grant Application. SAMSHA is creating a new application. BHC will need to be involved. Full application is due 9/1/2017. The DBH will need to identify the process. DBH/BHC should get the documents in July. The Council's input will need to be written and given to Dr. Royster.
- Ms. Faiza Majeed reported on a DC-NAMI and PDS DC Re-Entry Task Force along with Saint Elizabeths Hospital patient advocacy group wrote to the Deputy Mayor on the failure of DBH to pay for locally funded mental health services. Clients are not receiving mental health services because they do not have Medicaid. CSAs do not come into jails to help transition clients back into the community. DBH was asked to respond but has not as yet. This has implications for clients' choice. Dr. Royster indicated a letter was sent to the DC City Council. Mr. Wotring stated the letter went to the Deputy Mayor.

There were no members of the public present either in person or online; therefore, no one requested to speak.

Meeting adjourned at 11:36 am.

Next scheduled BHC meeting is March 24, 2017 at 10 am.

Cheryl Copeland Recorder

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Government of the District of Columbia
Department of Behavioral Health

BEHAVIORAL HEALTH COUNCIL MEETING- Minutes
March 24, 2017 10:00 a.m. - 12:00 p.m.

Call to Order, Chair Department of Behavioral Health, Behavioral Health Council (DBH/BHC)

This was a regularly scheduled meeting of the Department of Behavioral Health Behavioral Health Council (DBH/BHC). The BHC was called to order by the Chair, Senora Simpson at 10: 02 a.m.

A quorum was present
The Chair appointed Ms. Copeland to record Minutes in absence of a permanent Secretary.

Meeting Participants:
The in-person participants included: Senora Simpson, Mark LeVota, Donna Anthony, Nicole Denny, Jocelyn Route, James Wotring, Senior Deputy Director, Juanita Reaves, Yair Inspector, Donna Flenory, Tamitha Bland, Laura Heaven, Jennifer Lav, Colin Anthony, Donna Anthony and Cheryl Doby-Copeland.
Dial-in participants included: Doris Carter, Julie Kozminski and Effie Smith

Agenda approved with Ms. Devita Crockett reporting instead of Ms. Jones.

The 1/27/2017 Minutes were approved unanimously.

Standing Committee Reports- No standing committee reports available.

Unfinished Business

- **Applied Research and Evaluation Unit**
  (See January Minutes Action item 4) **Laura Heaven/Mr. Wotring**

The data analysis will guide the work of the DBH/BHC. The report entitled *Mental Health and Substance Use Report on Expenditures and Services* (MHEASURES) January 15, 2017 is available on line. The report is updated bi-annually and covers issues related to the numbers of people receiving both mental health and substance use services. The report is limited only to claim services, therefore Free Standing Mental Health services (FSMS) data is missing along with private insurance data. Children's National Medical Center (CNMC) or data post hospitalization is not included. CNMC is not required to give DBH data. We also need to collect data on outcomes; however outcomes have not been defined. It was suggested that CAFAS/PECFAS data can be used in the future.

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Additional data that would be useful included discharge data, i.e., administrative, successful completions/unsuccessful, etc. Also, how can data be captured that reflects interventions/input from natural and/or family run organizations. All of the additional information could inform gaps in the provision of mental health services as well as provide support to grass roots organizations that are seeking grants.

- **Office of Legislative/Public Affairs**
  (See January Minutes Action item 1)   **Davita Crockett**

The DBH Office of Legislative/Public Affairs purpose is to provide education/outreach while working with the Mayor's Office and the D.C. City Council. This office responds to constituent complaints and handles special projects assigned by Dr. Royster. Representatives from this office attend Advisory Neighborhood Commission (ANC) meetings, and work with other entities/constituents to provide an overview of DBH. In consultation with the Mayor's Office and the D.C. City Council the Office of Legislative/Public Affairs track hearings and legislation. For example, during January this office worked with several faith-based groups (Bishops/Ministers from D.C.) to sponsor Behavioral Health Sunday, a Sunday on which sermons where geared toward mental health services.

Ms. Crockett suggested that the BHC's role with regard to the Office of Legislative/Public Affairs might involve testifying at hearings, supporting the public outreach, and suggest meetings to support providing the community with information about DBH. For example, does the community know about the DBH/BHC? What should the BHC advocate for? How can social media assist? Should this group provide training for uninformed individuals on applying for grants? Is training something that the Block Grant Committee could do?

Ms. Crockett indicated she would attend the BHC meetings and provide updates as needed.

- **DBH Block Grant Policies, Procedures, Updates**   **Juanita Reaves**

Dr. Reaves monitors the sub-grantee progress reports. The DBH fiscal program staff monitor the expenditure reports. Progress reports were provided to the DBH/BHC for the 10 sub-grantees. The SAMHSA Draft FY18-FY19 Mental Health Block Grant Application was forwarded to the DBH/BHC for review on 3/23/17. The document included changes to the Block Grant requirements. It also added a provision for Behavioral Health Planning and Advisory Councils to identify a project for inclusion in Block Grant. The DBH/BHC will need to decide on a project. The current Block Grant ends on 9/30/17, if money is available the current 10 sub-grantees will be funded for a second.

The DBH/BHC noted that the draft application could be used by the Council for a BHC project; however the Council felt it needed clarity on the direction DBH is taking.

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Department of Administration and Management   **Mr. Wotring**

- Unable to report on the budget until the Mayor's office releases it.
- Realignment - An all staff meeting is scheduled for 3/28/17. The realignment was approved by the District. There will be diagrams/pamphlets at the next BHC meeting to aid in the discussion of the realignment. The realignment will be phased in with different units reporting to different places over the summer. Some Departments have been renamed.
- A small percentage of staff will move offices -3%. The realignment will impact about 17% of staff. Majority of staff will not have a job change.

Action Items

1. The Block Grant Committee should review all 10 sub-grantee reports and provide an assessment on the progress and make comments and suggestions to the BHC. Uniform reporting may be a suggestion. In addition, all BHC members should review the reports and provide comments to the Block Grant Committee.

2. The Data Analysis Committee should review reports on the fiscal aspects of the applications and report findings to the BHC.

3. Share data from OSSE, which would provide information on the numbers of children receiving services under IDEA, 504 Plans.

New Business

- A draft BHC Self-Assessment was disseminated and the Chair and requested feedback on the form and consideration for adopting this as an annual assessment and report.
- Open DBH discussion to reach consensus regarding:
  Role/Expectation of the BHC- to participate and gain a deeper understanding of DBH to provide information to Mr. Wotring and advise on big policy issues.
  Current/Future Directions- Person-centered care, peer support, making it clear what it is and what it is not.
- Fully integrate the old clinic services, outpatient services from Health Care financing with DBH. Data is currently being gathered on the Free Standing Clinics, which should be presented to the Council.

New Grant Announcement   **Jocelyn Route**

- Coordinating services for the 18-25 population who have intellectual disabilities, substance use, and mental health needs. A provider will be brought on that will work with the court system. Hospital for Sick Children works with his population.

- Investigate ways to better integrate health and mental health services- Health Home projects. There is a national initiative to investigate integrating whole health and mental

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health services for the adult population. Discussions are underway to place a mental health clinician in the doctor's office.

- **Explore Medicaid Options.** Meeting monthly with the Department of Health Care Finance to re-design the State Plan. There is a need modernize, therefore over the next year input is requested from providers and consumers.

Announcements -No new announcements

Public Comments -No Public comment and none in attendance

Next scheduled BHC meeting is June 2017, and the date will be determined after polling of the members by DBH.

Meeting Adjourned at 12:10 PM.

Cheryl Doby-Copeland, PhD, ATR-BC, LPC, LMFT

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Government of the District of Columbia
Department of Behavioral Health

Department of Behavioral Health Behavioral Health Council (BHC)
Regularly Scheduled Meeting
June 9, 2017   10 a.m.-12:00 p.m.
64 New York Avenue NW Washington DC 20002
In Person DBH-Conference Room 320
Conference Line 1866-803-2312 Participant Code: 27325876

10:00 a.m.   **Call to Order, Welcome, Introductions and Roll Call**   **S. Simpson**

              Approvals of Agenda
              Approval of March 24, 17, 2017 Minutes

10:10 a.m.   **Standing Committee Reports**

- **Program Data Policy**   **A. Venson**

- **Block Grant Committee**   **E. Smith**

     (See Action Items 1 and 2 March 24 meeting)

- **Advocacy Committee**   **C. Copeland**

Unfinished Business

10:20 a.m.   BHC Annual Assessment (See action Item 3 March 24 Meeting) S. Simpson

10:35 a.m.   DBH Department of Legislative and Public Affairs Updates   D. Crockett

10:45 a.m.   Departmental Administration and Management Update   J. Wotring

New Business

Nomination Committee Membership and future Meetings Council   S. Simpson

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11:45 a.m.   Announcements

11:55 a.m.   Public Comments

12:00 noon Adjournment

Note:
If any Council Member or Public Attendee needs an accommodation, please contact Ms. J. Route, Strategic Planning and Policy Officer at Office: (202) 671-3204 Cell: (202) 236-4555 prior to the meeting date.

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Environmental Factors and Plan

Behavioral Health Advisory Council Members

Start Year: 2018   End Year: 2019

Name	Type of Membership	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Gail Avent	Parents of children with SED		1214 I Street, S.E. Washington DC, 20003 PH: 202-249-1000	totalfamilycarecoalition@gmail.com
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, D.C. DC, 20011 PH: 202-832-8336	DCarter@calvaryhealthcare.org
Ann Chauvin	Providers	So Others Might Eat	1221 Taylor Street, N.W. Washington DC, 20011 PH: 202-797-8806	Achauvin@some.org
Yuliana Del Arroyo,	State Employees	Office of the State Superintendent of Education	810 First Street NE, 9th Floor Washington, D.C. DC, 20002 PH: 202-741-0478	Yuliana.delarroyo@dc.gov
Nicole Denny	State Employees		2435 Alabama Avenue, SE Washington, DC DC, 20020 PH: 202-671-6140	Nicole.denny@dc.gov
Luis Diaz	State Employees	Criminal Justice Coordinating Council	441 4th Street, N.W., Suite 715-North District of Columbia DC, 20001 PH: 202-442-9982	Luis.Diaz2@dc.gov
Cheryl Doby-Copeland	State Employees		821 Howard Road, SE Washington, DC DC, 20032 PH: 202-698-1836	Cheryl.copeland@dc.gov
Donna Flenory	Parents of children with SED		510 Division Avenue, NE Washington, DC DC, 20019 PH: 202-497-3097	dlflenory@gmail.com
Hammere Gebreyes	State Employees	District of Columbia Housing Authority	1133 North Capitol Street NE Washington DC, 20002 PH: 202-535-1500	hgebreye@dchousing.org
John Kirka	State Employees	Department on Disability Services	1125 15th Street, NW, 4th Floor Washington DC, 20005 PH: 202-442-8606 FX: 202-561-6974	John.Kirka@dc.gov

Samatha Knox	Family Members of Individuals in Recovery (to include family members of adults with SMI)		Washington DC, 20010	Samanthaknox08@gmail.com
Julie Kozminski	Providers		1220 12th Street, SE, Suite 120 Washington, DC DC, 20003 PH: 202-715-7966	jkozminski@unityhealthcare.org
Tammi Lambert	Others (Not State employees or providers)		905 6th Street, S.W., Apt. 708B Washington, DC DC, 20024 PH: 202-724-5454	Lambert.tammi@gmail.com
Evan Langholt,	Providers		2100 New York Avenue, NE Washington, DC DC, 20002 PH: 202-269-6333	evan_langholt@uss.salvationarmy.org
Jennifer Lav	Others (Not State employees or providers)		220 I Street, NE, Suite 130 Washington, DC DC, 20002 PH: 202-547-0198	jlav@uls-dc.org
Mark LeVota	Others (Not State employees or providers)	District of Columbia Behavioral Health Association	PO Box 33515 Washington DC, 20033 PH: 202-734-3709	Mark.LeVota@dcbehavioralhealth.org
Diane Lewis	State Employees	District of Columbia Health Benefit Exchange Authority	2200 Pennsylvania Ave., NW, 4th Floor East Washington, D.C. DC, 20037 PH: 202-966-7516	dlewis@acg-cos.com
Susan McPherson	State Employees	Child and Family Services Agency	200 I Street, SE Washington DC, 20003 PH: 202-442-6002	Susan.mcpherson@dc.gov
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@yahoo.com
Evelyn Sands,	Parents of children with SED		4030 Livingston Road, SE #301 Washington, DC DC, 20032 PH: 202-271-6032	esands231@gmail.com
Claudia Schlosberg	State Employees	Department of Health Care Finance	441 Fourth Street, NW, 900 South Washington, D.C. DC, 20001 PH: 202-442-9075	Claudia.schlosberg@dc.gov
Senora Simpson	Family Members of Individuals in Recovery (to include family members of adults with SMI)		323 Quackenbos, NE Washington, DC DC, 20011 PH: 202-529-2134	Ssimps2100@aol.com

Effie Smith	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Consumer Action Network	1300 L Street, NW, Suite 1000 Washington, D.C. DC, 20005 PH: 202-842-0001	esmith@can-dc.org
Sara Tribe Clark	State Employees	District of Columbia Office on Aging	500 K Street, NE Washington, D.C. DC, 20002 PH: 202-535-1367	Sara.tribe@dc.gov
Agnes Venson	State Employees	Department of Human Services	2100 Martin Luther King, Jr. Avenue, S.E. Washington DC, 20020 PH: 202-299-3620	Agnes.Venson@dc.gov
Tamara Weissman	Providers	Health Services for Children with Special Needs	1104 Allison Street NW Washington DC, 20011 PH: 202-722-1815	tweissman@hscn.org
Miya Wiseman	Family Members of Individuals in Recovery (to include family members of adults with SMI)		3105 18th Street, NE Washington, DC DC, 20018 PH: 202-270-6173	Miya714@yahoo.com
James Wotring	State Employees	Department of Behavioral Health	64 New York Avenue, N.E. Washington DC, 20002 PH: 202-299-5264	james.wotring@dc.gov

Footnotes:

The District of Columbia Department on Disability Services is considered the state's Vocational Rehabilitation agency. The information already appears in the Behavioral Health Advisory Council Members table.

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year: 2018   End Year: 2019

Type of Membership	Number	Percentage
Total Membership	**29**	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	3	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	3	
Parents of children with SED*	3	
Vacancies (Individuals and Family Members)	0	
Others (Not State employees or providers)	3	
Total Individuals in Recovery, Family Members & Others	**12**	**41.38%**
State Employees	12	
Providers	4	
Federally Recognized Tribe Representatives	0	
Vacancies	1	
Total State Employees & Providers	**17**	**58.62%**
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	17	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	11	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	**28**	
Persons in recovery from or providing treatment for or advocating for substance abuse services	5	

* 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?

While the Department of Behavioral Health Behavioral Health Council (DBH/BHC) did not make any recommendations to modify the application, the DBH/BHC participated in the review of the draft sections of the District of Columbia FY 2018- FY 2019 Mental Health Block Grant Application. This included: 1) providing DBH/BHC minutes of meetings, 2) providing comments about the adult system most important areas of strength and most important unmet needs and critical gaps; 2) providing comments about the child system most important areas of strength and most important unmet needs and critical gaps; 3) identifying technical assistance needs; and 4) attending the SAMHSA/CSAT SABG Site Visit Meeting.

Footnotes:

Environmental Factors and Plan

23. Public Comment on the State Plan - Required

Narrative Question

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

Please respond to the following items:

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

    a)   Public meetings or hearings?   ○ Yes   ● No

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

         If yes, provide URL:

         Website: http://www.dbh.dc.gov

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

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Footnotes: