District of Columbia

UNIFORM APPLICATION
FY 2024/2025 Combined MHBGSUPTRS BG ApplicationBehavioral Health Assessment and Plan

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

OMB - Approved 04/19/2021 - Expires 04/30/2024
(generated on 08/30/2023 2.19.25 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

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

State Information

State Information

Plan Year

Start Year 2024

End Year 2025

State SAPT Unique Entity Identification

Unique Entity ID SDACDT7L3ZQ5

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

Agency Name Department of Behavioral Health

Organizational Unit

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

City Washington

Zip Code 20002

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

First Name Barbara J.

Last Name Bazron

Agency Name Department of Behavioral Health

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

City Washington

Zip Code 20002

Telephone (202) 671-3180

Fax (202) 727-1596

Email Address barbara.bazron@dc.gov

State CMHS Unique Entity Identification

Unique Entity ID SDACDT7L3ZQ5

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

Agency Name District of Columbia Department of Behavioral Health

Organizational Unit

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

City Washington

Zip Code 20002

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

First Name Barbara J.

Last Name Bazron

Agency Name Department of Behavioral Health

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

City Washington

Zip Code	20002
Telephone	(202) 671-3180
Fax	(202) 727-1596
Email Address	barbara.bazron@dc.gov

III. Third Party Administrator of Mental Health Services

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

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

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

From	
To	

V. Date Submitted

Submission Date	
Revision Date	

VI. Contact Person Responsible for Application Submission

First Name	Renee
Last Name	Evans
Telephone	202-673-3536
Fax	
Email Address	renee.evans@dc.gov

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

State Information

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

Fiscal Year 2024

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
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Section 1947	Nondiscrimination	**42 USC § 300x-57**
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As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 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, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions

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

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

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

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

2. Certification Regarding Drug-Free Workplace Requirements

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

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

3. Certifications Regarding Lobbying

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

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

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

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

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

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

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

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

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

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

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

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

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

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

State: _____

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

Signature of CEO or Designee[1]: _____

Title: Director

Date Signed: _____

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

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Fiscal Year 2024

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11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions

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

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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.).
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17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

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

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

2. Certification Regarding Drug-Free Workplace Requirements

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

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

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

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

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

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

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

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

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

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

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

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

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

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

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

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

State: District of Columbia

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

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

Title: Director

Date Signed: 08/30/2023

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

GOVERNMENT OF THE DISTRICT OF COLUMBIA

ADMINISTRATIVE ISSUANCE SYSTEM

Mayor's Order 2015-146
May 27, 2015

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

ORIGINATING AGENCY: Office of the Mayor

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

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

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

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

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

MURIEL E. BOWSER
MAYOR

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

State Information

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

Fiscal Year 2024

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	**42 USC § 300x**
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	**42 USC § 300x-1**
Section 1913	Certain Agreements	**42 USC § 300x-2**
Section 1914	State Mental Health Planning Council	**42 USC § 300x-3**
Section 1915	Additional Provisions	**42 USC § 300x-4**
Section 1916	Restrictions on Use of Payments	**42 USC § 300x-5**
Section 1917	Application for Grant	**42 USC § 300x-6**
Section 1920	Early Serious Mental Illness	**42 USC § 300x-9**
Section 1920	Crisis Services	**42 USC § 300x-9**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**
Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**

Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 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, as applicable, with 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.
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18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
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b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
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The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

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

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

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

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

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

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

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

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

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

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

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

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

Signature of CEO or Designee[1]: _____

Title: Director

Date Signed: _____

mm/dd/yyyy

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

Please upload your state's Bipartisan Safer Communities Act (BSCA) – 2nd allotment proposal to here in addition to other documents. You may also upload it in the attachments section of this application.

Based on the guidance issued on October 11th, 2022, please submit a proposal that includes a narrative describing how the funds will be used to help individuals with SMI/SED, along with a budget for the total amount of the second allotment. The proposal should also explain any new projects planned with the second allotment and describe ongoing projects that will continue with the second allotment. The performance period for the second allotment is from September 30th, 2023, to September 29th, 2025, and the proposal should be titled "BSCA Funding Plan 2024. The proposed plans are due to SAMHSA by September 1, 2023.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

District of Columbia Department of Behavioral Health
Bipartisan Safer Communities Act (BSCA) Supplemental Funding Plan
Total Award: $148,155, 2nd Allotment

- **Crisis Set-Aside, 5% = $7,407.75**
- **ESMI Set Aside, 10% = $14,815.50**
- **Remaining Balance = $125,931.75**

Activity	FY24 Budget Allocation	FY25 Budget Allocation	Set-Aside Requirement
1. Training in Illness Management and Recovery / Program Development and implementation	$7,407.75	$7,407.75	ESMI/FEP
2. Training and Certification for CIT Coordinator, TTT, and Mental Health First Aid (First Responders) TTT, Certification for Stress First Aid Trainers	$7,407.75*	$5,000.00	Crisis*
3. Technology to support GPS-enabled mobile team dispatch as part of Air Traffic Control crisis call-center model	$50,000.00	$70,931.75	
Subtotal	$64,815.50	$83,339.50	
Total $148,155			

Budget Narrative

#1 – (New) — FEP Set-Aside

Plan: Provide specific, evidence-based services to transition age youth (TAY) affected by mental health emergencies.

Purpose: The District will use BSCA funding to support behavioral health crisis response training (e.g., therapeutic crisis intervention and de-escalation) for agencies and providers who work with Transitional Age Youth (TAY) ages 16-24 that are identified with SMI/SED diagnosis. This funding will be used to train programs/ and individuals working with the identified population in the manualized evidenced based practice of Illness Management and Recovery (IMR).

Once trained, specially trained mental health practitioners or specially trained peers will assist people who have lived experience of psychiatric symptoms to develop personal strategies for coping with situations that may arise during recovery process. IMR includes 10 modules that deliver psychoeducation about mental illness, cognitive-behavioral approaches to medication management, planning for relapse prevention, social skills training to strengthen social support, and coping skills to manage symptoms of mental illness. IMR can be provided either in an

individual or group format and general takes between 5-10 months to complete as individuals work progressively through the 10 modules.

Impact: The desired impact of providing this evidence-based service for TAY with SMI/SED diagnosis is to improve overall illness management and improve the TAY's self-esteem and self – efficacy which is a component of personal recovery.

Budget Breakdown:

Fiscal Year	Activity	Cost
FY 24	**Model Training** • Introductory and intensive skills training • Train the trainer	$3,703.87
FY 25	**Program Development** • Supervision consultation on group leadership and practice • Planned implementation support • Customized IMR for TAY population	$3,703.87
	TOTAL	$7,407.74

#2 – (New) — Crisis Set-Aside

Plan: Training and Certification for CIT Coordinator, TTT, and Mental Health First Aid (First Responders) TTT, Certification for Stress First Aid Trainers

Purpose: In addition to expanding crisis call center and mobile crisis staff to move away from an automatic law-enforcement response to a "health first" or clinician led response, DBH and MPD have been tasked by Mayor Muriel Bowser with increasing the skill and compassion officers bring to encounters with individuals in behavioral health crisis through training. We are currently on track to have all officers graduating from the academy trained in MHFA (First Responders) and all officers on patrol trained in MHFA or the longer Crisis Intervention Officer training curriculum modeled after the CIT International model.

Impact: The certification training is critical to our having enough certified trainers to assure that all officers on patrol have high quality, high-fidelity training in these national and internationally adopted models.

Budget Breakdown:

Fiscal Year	Activity	Cost
FY 24	**Model Training** • TTT MHFA • TTT CIO • Develop CIO Refresher Training	$7,407.75

FY 25	**Additional Training of Trainers and Maintaining Certification**	$5,000.00
	TOTAL	$12,407.75

#3 – (New) — Crisis Expansion-Technology Modernization

Plan: Procure and implement technology to support GPS-enabled mobile team dispatch as part of Air Traffic Control crisis call-center model

Purpose: Allow call center staff to track the whereabouts and availability of mobile crisis and co-response teams in real time to effectively deploy the most appropriate assets available anywhere in the District of Columbia.

Impact: This will optimize use of resources and advance our ability to assure citizens are getting the "right response, by the right team, at the right time."

Budget Breakdown:

Fiscal Year	Activity	Cost
FY 24	**Complete gap analysis and implementation plan, complete phase 1 acquisitions for** • Geo-tracking • Appointment Scheduling • Scheduling follow-ups	$50,000
FY 25	**Phase 2** • Acquisition, implementation and licensing etc.	$70,931.75
	TOTAL	$120,931.75

State Information

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

Fiscal Year 2024

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	**42 USC § 300x**
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	**42 USC § 300x-1**
Section 1913	Certain Agreements	**42 USC § 300x-2**
Section 1914	State Mental Health Planning Council	**42 USC § 300x-3**
Section 1915	Additional Provisions	**42 USC § 300x-4**
Section 1916	Restrictions on Use of Payments	**42 USC § 300x-5**
Section 1917	Application for Grant	**42 USC § 300x-6**
Section 1920	Early Serious Mental Illness	**42 USC § 300x-9**
Section 1920	Crisis Services	**42 USC § 300x-9**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**
Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**

Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 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, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to

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

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

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

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

2. Certification Regarding Drug-Free Workplace Requirements

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

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

3. Certifications Regarding Lobbying

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

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

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

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
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Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

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

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

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

HHS Assurances of Compliance (HHS 690)

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

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

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

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

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

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

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

Signature of CEO or Designee[1]: 

Title: Director

Date Signed: 08/30/2023

mm/dd/yyyy

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

Please upload your state's Bipartisan Safer Communities Act (BSCA) – 2nd allotment proposal to here in addition to other documents. You may also upload it in the attachments section of this application.

Based on the guidance issued on October 11th, 2022, please submit a proposal that includes a narrative describing how the funds will be used to help individuals with SMI/SED, along with a budget for the total amount of the second allotment. The proposal should also explain any new projects planned with the second allotment and describe ongoing projects that will continue with the second allotment. The performance period for the second allotment is from September 30th, 2023, to September 29th, 2025, and the proposal should be titled "BSCA Funding Plan 2024. The proposed plans are due to SAMHSA by September 1, 2023.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

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

District of Columbia Department of Behavioral Health
Bipartisan Safer Communities Act (BSCA) Supplemental Funding Plan
Total Award: $148,155, 2nd Allotment

- **Crisis Set-Aside, 5% = $7,407.75**
- **ESMI Set Aside, 10% = $14,815.50**
- **Remaining Balance = $125,931.75**

Activity	FY24 Budget Allocation	FY25 Budget Allocation	Set-Aside Requirement
1. Training in Illness Management and Recovery / Program Development and implementation	$7,407.75	$7,407.75	ESMI/FEP
2. Training and Certification for CIT Coordinator, TTT, and Mental Health First Aid (First Responders) TTT, Certification for Stress First Aid Trainers	$7,407.75*	$5,000.00	Crisis*
3. Technology to support GPS-enabled mobile team dispatch as part of Air Traffic Control crisis call-center model	$50,000.00	$70,931.75	
Subtotal	$64,815.50	$83,339.50	
Total $148,155			

Budget Narrative

#1 – (New) — FEP Set-Aside

Plan: Provide specific, evidence-based services to transition age youth (TAY) affected by mental health emergencies.

Purpose: The District will use BSCA funding to support behavioral health crisis response training (e.g., therapeutic crisis intervention and de-escalation) for agencies and providers who work with Transitional Age Youth (TAY) ages 16-24 that are identified with SMI/SED diagnosis. This funding will be used to train programs/ and individuals working with the identified population in the manualized evidenced based practice of Illness Management and Recovery (IMR).

Once trained, specially trained mental health practitioners or specially trained peers will assist people who have lived experience of psychiatric symptoms to develop personal strategies for coping with situations that may arise during recovery process. IMR includes 10 modules that deliver psychoeducation about mental illness, cognitive-behavioral approaches to medication management, planning for relapse prevention, social skills training to strengthen social support, and coping skills to manage symptoms of mental illness. IMR can be provided either in an

individual or group format and general takes between 5-10 months to complete as individuals work progressively through the 10 modules.

Impact: The desired impact of providing this evidence-based service for TAY with SMI/SED diagnosis is to improve overall illness management and improve the TAY's self-esteem and self – efficacy which is a component of personal recovery.

Budget Breakdown:

Fiscal Year	Activity	Cost
FY 24	**Model Training** • Introductory and intensive skills training • Train the trainer	$3,703.87
FY 25	**Program Development** • Supervision consultation on group leadership and practice • Planned implementation support • Customized IMR for TAY population	$3,703.87
	TOTAL	$7,407.74

#2 – (New) — Crisis Set-Aside

Plan: Training and Certification for CIT Coordinator, TTT, and Mental Health First Aid (First Responders) TTT, Certification for Stress First Aid Trainers

Purpose: In addition to expanding crisis call center and mobile crisis staff to move away from an automatic law-enforcement response to a "health first" or clinician led response, DBH and MPD have been tasked by Mayor Muriel Bowser with increasing the skill and compassion officers bring to encounters with individuals in behavioral health crisis through training. We are currently on track to have all officers graduating from the academy trained in MHFA (First Responders) and all officers on patrol trained in MHFA or the longer Crisis Intervention Officer training curriculum modeled after the CIT International model.

Impact: The certification training is critical to our having enough certified trainers to assure that all officers on patrol have high quality, high-fidelity training in these national and internationally adopted models.

Budget Breakdown:

Fiscal Year	Activity	Cost
FY 24	**Model Training** • TTT MHFA • TTT CIO • Develop CIO Refresher Training	$7,407.75

FY 25	**Additional Training of Trainers and Maintaining Certification**	$5,000.00
	TOTAL	$12,407.75

#3 – (New) — Crisis Expansion-Technology Modernization

Plan: Procure and implement technology to support GPS-enabled mobile team dispatch as part of Air Traffic Control crisis call-center model

Purpose: Allow call center staff to track the whereabouts and availability of mobile crisis and co-response teams in real time to effectively deploy the most appropriate assets available anywhere in the District of Columbia.

Impact: This will optimize use of resources and advance our ability to assure citizens are getting the "right response, by the right team, at the right time."

Budget Breakdown:

Fiscal Year	Activity	Cost
FY 24	**Complete gap analysis and implementation plan, complete phase 1 acquisitions for** • Geo-tracking • Appointment Scheduling • Scheduling follow-ups	$50,000
FY 25	**Phase 2** • Acquisition, implementation and licensing etc.	$70,931.75
	TOTAL	$120,931.75

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:

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

The DC Department of Behavioral Health does not participate in lobbying activities.

Planning Steps

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

Narrative Question:

Provide an overview of the state's M/SUD prevention (description of the current prevention system's attention to individuals in need of substance use primary prevention), early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. In general, the overview should reflect the MHBG and SUPTRS BG criteria detailed in "Environmental Factors and Plan" section.

Further, in support of the **Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government**, SAMHSA is committed to advancing equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. Therefore, the description should also include how these systems address the needs of underserved communities. Examples of system strengths might include long-standing interagency relationships, coordinated planning, training systems, and an active network of prevention coalitions. The lack of such strengths might be considered needs of the system, which should be discussed under Step 2. This narrative must include a discussion of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

District of Columbia

Department of Behavioral Health

Strategic Plan

2019

DBH DEPARTMENT OF BEHAVIORAL HEALTH

WE ARE WASHINGTON DC GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

Letter from the Director

Dear District Residents and Partners,

I am proud to release the Department of Behavioral Health Strategic Plan which is the result of months of engagement with providers, consumers, clients, and other partners to improve behavioral health care for all residents. This Strategic Plan represents a shared vision for an integrated, recovery-oriented, culturally appropriate behavioral health care system that is person-centered and promotes parity with physical health care. The Plan advances health equity with strategies for achieving system outcomes as well as population health improvements and aligns with the DC Healthy People 2020 Framework, which ranks mental health and substance use disorders among the leading health indicators.

Work already is well underway to implement the Strategic Plan with achievements in expanding behavioral health services to all public schools, making easier access to substance use disorder treatment services, and doubling our resources for individual psychiatric crisis and public emergencies. I am very excited about the new Medicaid funding for inpatient care and the recovery support services provided by peers that the new 1115 Behavioral Health Transformation Demonstration Project brings to our residents.

This Strategic Plan serves as our guidepost to ensure that our efforts are coordinated, sustained, and accountable. We are excited to work with you to realize a wellness-oriented community where all District residents can live healthy, fulfilling lives.

Sincerely,

Barbara J. Bazron, Ph.D.
Director, Department of Behavioral Health

Introduction

The District of Columbia Department of Behavioral Health (DBH) envisions a thriving community where prevention is possible, and recovery from mental health and substance use disorders is the expectation. DBH and its partners are committed to this vision by providing evidence-based prevention, intervention, and treatment services for children, youth, and adults that are innovative, person-centered, well-coordinated, and easy to navigate. DBH is proud of the services it provides and its recent programmatic accomplishments, including our work to address the opioid epidemic, expand school-based behavioral health services, and create a new 24-hour Community Response Team.

These efforts, while powerful, are not enough. There are nearly daily reminders of the impact that mental illness and substance use disorders are having on individuals, families, and communities across the District. Recent assessments and community engagement efforts have identified the need to reduce fragmentation of services; better integrate mental health, substance use disorder, and primary care medical services; and expand access to peer support, trauma-informed care, and recovery support services. Our challenges are clear, and it is no surprise that mental health and substance use disorders are considered to be a leading health problem facing the District and our health system.

This Strategic Plan is evidence of our continued commitment to address the challenges we face and transform the District's behavioral health system. Together with our partners, we are making notable progress—but we must continue to innovate and refine our services in ways that promote prevention and early intervention, expand access and engagement in care, improve care coordination and service integration, and foster recovery and resilience. DBH must also continue to strengthen internal systems to improve communication, promote accountability, and build workforce capacity.

This Strategic Plan provides a roadmap for DBH and its partners to align our collective efforts with our vision and guide DBH's continued efforts to become a nationally recognized behavioral health system. This three-year plan is a critical step in DBH's efforts to lead change.

OUR APPROACH

In the Summer of 2018, DBH embarked on a comprehensive, collaborative community engagement and planning process to develop this Strategic Plan. DBH brought together consumers, clients and their families, advocates, behavioral health practitioners, community-based service providers, government leaders, and other community members. Throughout the process, hundreds of stakeholders and partners were invited to participate in 15 community engagement sessions and several online follow-up surveys. More than 400 people provided important feedback, which shaped and drove the development of the plan. This Strategic Plan would not have been nearly as strong without this collaborative process.

DBH also used the Results-Based Accountability (RBA) model to inform components of the Strategic Plan, which included meetings with service providers to gather feedback on community need and outcome measurement. The RBA process collected additional information from consumers through six RBA listening sessions.

OUR STRATEGIC PLAN

The Strategic Plan is organized around five high-priority goals, each of which has a set of objectives and strategic initiatives that together outline the steps that DBH will take over the next three years to achieve its vision and inspire action across the system. The goals are high-level statements that clarify what needs to be done to achieve DBH's vision. The objectives describe the specific, measurable steps that need to occur to achieve the goals. The strategic initiatives are the activities that, when implemented, will drive achievement towards the goals and objectives.

The first step to implement the Strategic Plan is creating a series of detailed action plans. These plans will guide the initial implementation process and help ensure that system-wide efforts are aligned, focused, and well-coordinated. These action plans will also include a set of measurable indicators and timelines for each objective, which will allow DBH to monitor progress and hold itself accountable. The plans will be developed through a series of targeted, collaborative efforts.

District residents deserve access to high-quality behavioral health services and the opportunity to lead healthy and fulfilling lives, and this Strategic Plan will enhance our work to achieve this goal.

I. Vision
II. Mission
III. Values
IV. Goals, Objectives, and Initiatives

Strategic Plan

OUR VISION STATEMENT

The District of Columbia is a thriving community where prevention is possible, and recovery from mental health and substance use disorders is the expectation. The Department of Behavioral Health (DBH) is committed to:

- A wellness-oriented community where there is no stigma toward receiving behavioral health treatment;
- People with behavioral health disorders living long, safe, and fulfilling lives;
- Preventing trauma, homelessness, substance use disorder, and criminal justice system involvement;
- Strong collaborations with partner organizations to achieve this vision.

OUR MISSION

The mission of DBH is to develop, manage, and oversee a public behavioral health system for adults, children, and youth and their families that is consumer driven, community-based, and culturally competent and supports prevention, resiliency, and recovery and the overall well-being of the District of Columbia.

OUR VALUES

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


GOAL 1: PREVENTION & EARLY INTERVENTION
GOAL 2: ACCESS TO QUALITY SERVICES
GOAL 3: RECOVERY & RESILIENCE
GOAL 4: PARTNERSHIP, INTEGRATION, & COORDINATION
GOAL 5: LEADERSHIP, INNOVATION & ACCOUNTABILITY
OUR STRATEGIC GOALS

Goal 1: Prevention & Early Intervention

This goal promotes behavioral health wellness through prevention and early intervention services and supports.

Awareness and education campaigns designed to reduce the occurrence of mental illness and substance use disorders and to lessen the stigma associated with them are critical components of a behavioral health strategy. Efforts that promote universal behavioral health screenings to identify those who need and would benefit from referrals to services are also essential. These screenings allow people to identify issues and engage in timely, appropriate treatment before the issues could become severe and lead to other adverse outcomes, such as homelessness, suicide, and criminal justice system involvement.

DBH is committed to prevention and early intervention by promoting education, awareness, and screening campaigns that are comprehensive, data-driven, and culturally and linguistically responsive. These efforts can help people who live in the District to identify issues early; gain the knowledge, skills, and necessary supports to make healthy choices; change harmful behaviors; recognize if they or those around them may have a problem; and link themselves or those around them to the care they need in a timely way.

	OBJECTIVES	STRATEGIC INITIATIVES
1	**Increase Awareness.** Increase awareness of and counteract stigma toward mental health and substance use disorders.	A. Implement targeted awareness campaigns to educate the community about health promotion, behavioral health conditions, and risk factors, along with self-help and treatment options. B. Coordinate training programs and professional development opportunities in agencies across the District including the Office of the State Superintendent of Education (OSSE), DC Public Schools (DCPS), DC Public Charter Schools, and DBH to bring awareness of mandatory youth behavioral health trainings for school administrators and educators. C. Improve the DBH website to ensure that it provides relevant and user-friendly content for consumers, providers, and partners. D. Implement the evidence-based Whole School, Whole Community, Whole Child approach that provides parents, educators, school staff, and child care providers access to trainings on how to communicate effectively about behavioral health.

GOAL 1: PREVENTION & EARLY INTERVENTION

	OBJECTIVES	STRATEGIC INITIATIVES
2	**Reduce Occurrence and Severity of Mental Illness and Substance Use Disorders.** Reduce the occurrence and severity of mental illness and substance use disorders among at-risk populations in the District.	A. Implement screenings and early intervention activities in non-clinical targeted settings, such as schools, child development centers, and other community settings. B. Promote universal screenings for mental health and substance use disorders in primary care medical and urgent care settings. C. Implement a system-wide trauma-informed approach to care guided by SAMSHA's six key principles (including safety and peer support) and ten implementation domains for organization change (including physical environment and governance/leadership).
3	**Reduce Adverse Outcomes.** Reduce the impact of adverse outcomes (e.g., homelessness, justice system involvement, poverty) associated with mental illness and substance use disorders.	A. Improve the quality and quantity of support services (e.g., education, employment, community re-entry, recovery coaching, transportation, dependent care, and housing) that are available to people in recovery. B. Continue our partnership and collaboration with the Interagency Council on Homelessness (ICH) to: 1) increase service connectivity; 2) improve homelessness prevention efforts for those exiting Saint Elizabeths and other hospitals; and 3) improve targeting of available housing resources. C. Increase access to harm reduction education to individuals, families, and communities. D. Develop and implement protocols for Mental Health Rehabilitation Services (MHRS) and Substance Use Disorder (SUD) Services, utilizing the Homeless Management Information System (HMIS) to identify consumers who are experiencing homelessness, are ready for independent living, and would benefit from housing supports.

Goal 2: Access To Quality Services

This goal ensures that individuals and families receive high-quality services to meet their unique needs, resulting in access to the right services, at the right time, in the right amount.

Routine and timely assessment coupled with the immediate availability of evidence-based treatment that is well-coordinated, trauma-informed, and person-centered is essential to accessing quality service.

DBH is committed to a "no wrong door" approach and to the implementation of comprehensive, routine assessments. DBH is also committed to enhanced care coordination to ensure that high-quality services are available in a timely and integrated manner across the District's service continuum.

	OBJECTIVES	STRATEGIC INITIATIVES
1	**Increase Alignment between Community Need and the District's Behavioral Health System.** Conduct a comprehensive behavioral health needs assessment to ensure that services across the District are aligned with community need.	A. Build on the 2016-2017 DC Health Systems Plan by assessing community behavioral health needs and the strength of DC's Behavioral Health System through: • Quantitative data collection (including hospital discharge data); • Qualitative data collection (interviews, focus groups, surveys); • Community engagement (resident and provider forums); • Integrated analysis and prioritization of key findings with community residents, service providers across sectors, and senior leadership at DBH; • Reporting of key findings, priorities, and recommendations; • Identification of proven evidence-informed strategies in light of findings, priorities, and recommendations. B. Strengthen our culturally and linguistically responsive service delivery system by developing guidelines and standards.
2	**Increase Access to Routine Comprehensive Assessment**. Increase the number of individuals who receive routine, comprehensive assessments and are connected to the right services, at the right time, in the right amount.	A. Establish and implement best practices for comprehensive and routine medical and behavioral health assessment and referral across all DBH contracted behavioral health service delivery providers. B. Expand co-located, integrated behavioral health models to DC sister agencies and other community partners to promote timely access to behavioral health services, including in primary care and urgent care settings. C. Expand the use of Screening, Brief Intervention, Referral, and Treatment (SBIRT) programs among social service agencies that conduct intake assessments.

GOAL 2: ACCESS TO QUALITY SERVICES

	OBJECTIVES	STRATEGIC INITIATIVES
3	**Increase Access to Substance Use Disorder Services.** Ensure timely access across the District to high-quality substance use disorder treatment and recovery support services.	A. Develop and implement a model for initiating medication-assisted treatment (MAT) in emergency departments (ED) and other community partner settings with a warm handoff from peer recovery coaches to community-based services. B. Create 24-hour SUD assessment and referral sites in the District. C. Expand the number of SUD intake and assessment sites throughout the community.
4	**Reduce Barriers to Care.** Increase care coordination to ensure that consumers/clients can move seamlessly across the continuum of care.	A. Provide culturally competent outreach and community response through a Community Response Team (CRT), which will provide a multi-site, multidisciplinary, 24/7 model of care to improve behavioral health outcomes in the District. B. Expand school-based behavioral health programs to all public and charter schools to improve access to care within the school-based population. C. Strengthen health information technology and operational system standards to ensure continuity of care for individuals transitioning from institutional or acute care facilities to community outpatient providers. D. Improve information sharing, health information exchange, and other care coordination systems between residential facilities and outpatient treatment providers. E. Implement screening for social determinants of health and other barriers that hinder care coordination and develop enhanced referral mechanisms.
5	**Improve Consumer/Client Experience.** Improve the consumer/client experience with the mental health and substance use disorder service delivery system.	A. Implement training, staff development, and public health education activities based on guidelines reflecting current best practices for cultural and linguistic competence. B. Develop and implement plans to incorporate consumer/client input to inform DBH decision-making related to program and service improvements. C. Expand the use of peer counselors to promote consumer/client engagement and improve outcomes across the array of DBH and community-based programs. D. Employ a comprehensive trauma-informed approach to treatment, including standardized screening, assessment, and treatment protocols.
6	**Improve the Quality of Services.** Improve the quality of mental health and substance use disorder services by enhancing program monitoring, evaluation, and continuous quality improvement activities.	A. Implement existing or newly developed clinical practice standards for all DBH staff and contracted providers. B. Enhance leadership-driven standards and processes that support the implementation of continuous quality improvement (CQI) activities of DBH staff and contracted providers. C. Increase delivery, monitoring, and evaluation of evidence-based services and programs. D. Integrate peer counselors into existing and emerging CQI activities.

Goal 3: Recovery & Resilience

This goal builds and supports a community that promotes recovery and resilience to help individuals and families thrive.

Affirming that all can recover from or manage mental illness and substance use disorders and thrive in the community is critical when addressing the behavioral health needs of individuals. Promoting resilience involves creating opportunities for individuals and families to cope with challenges and to reduce or manage adverse outcomes. Supporting people as they make decisions about their care and designing programs to ensure that they receive community, family, and peer support services will foster recovery and resilience. A focus on optimism; building upon an individual's skills, supports, and resources; and addressing the person's needs holistically is at the core of recovery.

DBH is committed to developing innovative and effective person-centered practices that promote community integration, enhance connections with family and peers, and reinforce natural supports for recovery and resilience.

	OBJECTIVES	STRATEGIC INITIATIVES
1	**Increase Person-Centered Practice.** Increase the number of individuals served or supported by DBH who receive person-centered care that empowers them, their families, and/or their caregivers.	A. Promote the use of research-based person-centered practices that individualize care and support shared decision-making, such as motivational interviewing and stage-wise assessment. B. Develop practice standards, trainings, and accountability measures that drive system-wide improvements in person-centered assessments and treatment plans. C. Design a system that encourages individuals to have control over the amount, length, and type of services they receive and that honors the culture, strength, and unique recovery of those served.
2	**Increase Community Integration and Independence.** Increase consumers'/clients' ability to integrate into their community, maximize independence, and participate fully in their environment.	A. Enhance engagement of community employers to support consumers/clients in securing and maintaining meaningful employment. B. Integrate Free Standing Mental Health Clinics (FSMHC) into DBH and the District's broader service system. C. Support treatment interventions that reduce rates of incarceration, when appropriate. D. Conduct regular level-of-care assessments for consumers in community residential facilities (CRF) to support independence and integration into the community. E. Require regular level of care assessments for Assertive Community Treatment (ACT) consumers to ensure access to the appropriate level of placement.

GOAL 3: RECOVERY & RESILIENCE

	OBJECTIVES	STRATEGIC INITIATIVES
3	**Increase Peer Services and Natural Supports.** Increase the use of peer services and natural supports for clients served or supported by DBH.	A. Expand peer and natural support initiatives and models based on best practices to bridge peer-identified gaps in behavioral health services. B. Provide resources to peer-operated centers, in order to connect hard–to-reach consumers/clients and their families with clinical treatment. C. Build system capacity to incorporate peer and natural supports in the ongoing treatment of consumers.

Goal 4: Partnership, Integration, & Coordination

This goal strengthens community partnerships to better integrate and coordinate services towards a sustained and shared vision of excellence.

It is vital to work internally within DBH and externally with community partners to improve collaboration, coordinate care, integrate services, marshal resources, and align strategies. Strong organizational structures and systems that drive service integration and care coordination are essential to effective partnerships that seek to reduce the impact of mental illness and substance use disorders in the District.

DBH is committed to addressing the administrative, operational, and policy-oriented barriers to care coordination and service integration in ways that break down the silos between the mental health and substance use systems and promote effective and efficient community partnerships.

	OBJECTIVES	STRATEGIC INITIATIVES
1	**Reduce Barriers to Care Coordination and Service Integration.** Reduce the administrative, financial, programmatic, and structural barriers that hinder care coordination and service integration.	A. Integrate Medicaid payment strategies for medical/surgical and behavioral health services that promote both fiscal and practice-level integration. B. Participate in service planning for the new acute care hospital in Southeast DC to ensure that behavioral health care services provided by the new hospital are appropriate and well-coordinated with Saint Elizabeths Hospital, DC's other hospitals, and behavioral health services throughout the District. C. Promote better information sharing and health information exchange between DC's psychiatric hospitals and psychiatric units and other clinical and non-clinical partners. D. Promote integration of behavioral health services with primary care and other clinical and community settings. E. Support evidence-informed programs and policies that improve care transitions from the hospital and other acute care settings to the home.
2	**Strengthen Relationships with Contracted Providers.** Promote transparency, timely and collaborative discussions, clear decision-making processes, and mutual respect between DBH and its contracted providers.	A. Develop and implement best practices for information technology platforms to support DBH and provider programs and services. B. Improve messaging mechanisms to share key information with providers. C. Continue to review and update policies and regulations to address provider challenges. D. Facilitate the sharing of clinical and operational best practices among providers.

GOAL 4: PARTNERSHIP, INTEGRATION, & COORDINATION

	OBJECTIVES	STRATEGIC INITIATIVES
3	**Increase the Integration of Mental Health and Substance Use Services.** Support program, policy, and system initiatives that facilitate the integration of mental health and substance use disorder services across the District.	A. Integrate Mental Health and Substance Use capabilities across DBH direct services: Assessment and Referral Center (ARC), Urgent Care, Comprehensive Psychiatric Emergency Program (CPEP). B. Implement current best practices and models from other jurisdictions on system-wide integration of mental health and SUD. C. Integrate federal block grant applications for mental health and SUD. D. Place recovery coaches at DBH clinical service sites to help individuals identify and make necessary connections to SUD treatment.
4	**Enhance Community Partnerships.** Enhance community partnerships between DBH and its clinical and non-clinical partners throughout the District.	A. Complete an agency-wide inventory and evaluation of existing MOUs (memorandum of understanding) and MOAs (memorandum of agreements) to determine which ones need to be modified, extended/continued, discontinued, or created. Develop a centralized repository of all past and current agreements. B. Promote new and existing partnerships with community partners, such as Neighborhood Collaboratives, to build health system capacity to serve children/youth, those impacted by incarceration, those who are unstably housed/homeless, and other vulnerable segments.

Goal 5: Leadership, Innovation, & Accountability

This goal will transform the District's behavioral health system into a nationally recognized, results-based model of care by promoting a common vision, accountable collective action, research, training and education, transparency, and innovative programs.

Success in implementing DBH's Strategic Plan will require strong leadership; a committed, well-trained workforce; and an effective internal system capable of facilitating partnership and promoting quality and accountability.

DBH is committed to promoting a common vision, developing strong community partnerships, building internal capacity, and developing the data collection, monitoring, and performance improvement systems necessary to promote accountability and implement innovative, evidence-based, and emerging programs.

	OBJECTIVES	STRATEGIC INITIATIVES
1	**Promote a Strong Workforce.** Increase competency, retention, and accountability of the behavioral health workforce to foster innovation and ensure that staff are capable of meeting the needs of DC's residents and providing the highest quality care.	A. Conduct behavioral health workforce needs assessment to identify strengths, weaknesses, and actions necessary to improve competency, recruitment, and retention. B. Develop core competency skillsets for primary position categories in the system to establish and standardize performance benchmarks. C. Streamline DBH's learning and development functions to deliver high-quality workforce support aligned with agency priorities. D. Begin monitoring comprehensive and customized provider employee onboarding plans.
2	**Enhance Performance Management Systems.** Enhance existing planning, accountability, and outcome monitoring systems to promote data-driven decision making and the achievement of DBH goals.	A. Review and refine evidence-based practice (EBP) monitoring and reporting to improve system performance. B. Research and explore implementation of best practice payment systems, such as value-based payments. C. Use innovative approaches to report program performance measures and population outcome indicators.

GOAL 5: LEADERSHIP, INNOVATION, & ACCOUNTABILITY

	OBJECTIVES	STRATEGIC INITIATIVES
3	**Increase Innovative Programs.** Work collaboratively to promote innovative programs and practices that lead to improvements in the lives of individuals, families, and communities.	A. Research and develop new evidence-based programs and promising practices that address service gaps for high-risk, priority populations. B. Leverage the state's flexibility afforded by the Section 1115 Medicaid waiver authority to drive behavioral health care delivery system change from volume-driven care to value-based care.
4	**Enhance DBH's Research Infrastructure.** Build on DBH and Saint Elizabeths' tradition of research and evaluation to promote innovation and support evidence-informed decision-making.	A. Increase research activities and start new initiatives to bring the latest advances in health care to the District's services. B. Increase research specific to the DC population so that treatments targeted to our population can be designed and implemented. C. Expand clinical and translational research at Saint Elizabeths Hospital and throughout the agency.
5	**Promote Clinician Education.** Promote the education of the next generation of clinicians to work with the District's diverse population.	A. Embed trainees at all levels of DBH service and create opportunities throughout the Saint Elizabeths Hospital medical educational programs to train, recruit, and retain the next generation of clinicians to work with the District's diverse population. B. Support and maintain the highest level of accreditation possible for educational training programs. C. Promote agency thought leaders to present at local, national, and international conferences to attract the best and the brightest students and to encourage Saint Elizabeths Hospital faculty to present at national conferences.

LIVE.LONG.DC. STRATEGIC PLAN 2.0:

THE DISTRICT'S PLAN TO REDUCE OPIOID USE, MISUSE, AND RELATED DEATHS

LIVE LONG DC
Saving lives from the opioid epidemic

March 2021

Updated August 2021

Letter from Mayor Muriel Bowser

Too many of our neighbors in Washington, DC lose their lives to substance use disorders leaving family and friends to carry their memories forward. Far too often these losses are related to opioids. That is why in December 2018, I released "LIVE.LONG.DC.," Washington, DC's Strategic Plan to Reduce Opioid Use, Misuse, and Related Deaths. The Plan is our blueprint to combat the opioid epidemic and details how we will move forward with urgency to increase prevention, harm reduction, treatment, and recovery services. The Plan reflects the thoughtful input of public and private partners, including DC government agencies, individuals with lived experience, hospital leaders, physicians, treatment providers, community-based organizations, and federal partners. After a decline in fatal opioid overdoses in 2018, opioid overdoses have continued to rise in 2019 and 2020 (similar to trends across the nation). Unfortunately, as we battled the COVID-19 pandemic, residents who struggled with substance use disorders suffered. While they adhered to social distancing guidelines to protect other neighbors, the isolation may have further exacerbated their disorders and put them at risk for a fatal overdose. As a result, where we previously saw improvement in opioid-related deaths, the increase over the past year could have been partially due to the pandemic. These trends highlight the ever pressing need to address the risk factors associated with substance use disorders, especially opioid use disorder.

Despite the trends observed, the LIVE.LONG.DC (LLDC) plan continues to address the most prevalent risk factors of an opioid overdose and has resulted in some key successes through the hard work, innovation, and passion of stakeholders, which include:

- Successfully reversing 82.5% of reported attempted overdose reversals.
- Increasing community awareness through social marketing campaigns, educating District residents on the availability of naloxone, and accessibility of treatment and support services.
- Establishing 24-hour community outreach providing harm reduction, overdose response, and connecting people to treatment in all 8 wards.

Although these successes are notable, there is still much work to be done to reduce the impact of the epidemic on our city. That is why I am releasing LLDC 2.0. This updated plan incorporates new strategies and builds on what we have learned over the past two years. With input from more stakeholders and creative approaches, we will make a difference for those who need help and support the most.

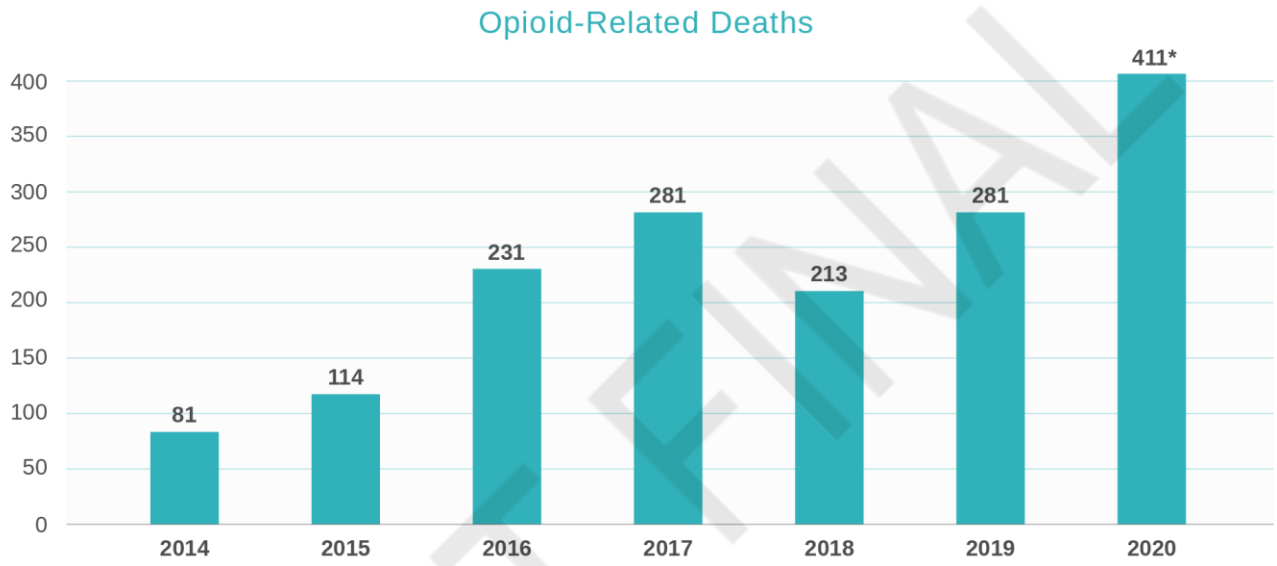
I want to thank all who contributed to this thoughtful revision of the Plan and those going forward for doing your part to address the issue. Together, we will help all Washingtonians live safer and stronger lives.

Muriel Bowser
Mayor

The Crisis

As opioid-related deaths continue to rise across the nation, Washington, DC has also experienced an alarming increase in fatal opioid overdoses. National trends largely reflect new opioid users who are White (non-Hispanic), younger adults who begin their addiction by experimenting with prescription drugs with the potential of progressing to heroin usage (Phillips, et.al, 2017). However, Washington, DC's epidemic presents different trends in use. The graph below reflects the trend of fatal opioid overdoses since 2014. Fatal overdoses hit the first peak in 2017, with 281 overdoses, but declined in 2018 when we had begun implementation of an organized effort to combat the issue. In 2019, fatalities returned to the 2017 levels and hit an all-time high in 2020.

WASHINGTON, DC'S EPIDEMIC IN A SNAPSHOT



- From 2016 to 2020, approximately 76% of all fatal opioid overdoses occurred among adults between the ages of 40–69 years old, and such deaths were most prevalent among people ages 50–59 (35%). During this time period, when there was a 50% increase in deaths overall, 50–59 year olds have seen a slight increase in deaths (6%), but other age groups have seen larger increases: 56% for 60–69 year olds; 129% for 20–29 year olds; 155% for 30–39 year olds; 1,200% for 70–79 year olds.
- Overall, 84% of all deaths were among African-Americans. This trend has remained consistent across years.
- Fatal overdoses due to opioid drug use were more common among males (72% of deaths were males in 2020).
- From 2016 to 2019, opioid-related fatal overdoses were most prevalent in Wards 5, 6, 7, and 8, with Ward 8 experiencing the most deaths.
- In 2020, 94% of fatal opioid overdoses involved fentanyl or a fentanyl analog (compared to 22% of cases in the first quarter of 2015).

The Approach

To comprehensively address the opioid epidemic in Washington, DC, it is essential for local public and private partners to continue to work together in a coordinated manner for an optimal impact. This kind of partnership yields expertise in creating agile, cross-discipline, public-private leadership coalitions, rapidly aligning on targets and coordinated actions, and maintaining accountability on outcomes that will cause short- and long-term impacts. In October 2017, a group of 40 stakeholders, representing both the public and private sectors, convened for a Summit focused on how to jointly address Washington, DC's opioid epidemic. Out of the Summit, the Strategic Planning Working Group was created.

In late November 2017, the working group members began to conduct stakeholder engagement sessions to assess the needs regarding prevention and early intervention, harm reduction, acute treatment, sustained recovery, and criminal justice. These sessions and the feedback from the working group members informed the draft plan, which was finalized at the end of February 2018.

In March 2018, the working group convened and membership for the seven Opioid Strategy Groups (OSGs) were formed to map out the implementation of the goals and associated strategies in the Plan. Leadership and membership of the OSGs were finalized in April 2018.

In 2020, an acknowledgement of the impacts of fentanyl on the rising death rate and the impacts of COVID-19 shifted the focus of the LLDC vision. The goal of LLDC has evolved to encompass a holistic, person-centered system of care that needs to be tackled at the community level. The OSGs reconvened in July 2020 to gather input and ideas from stakeholders on new LLDC strategies to inform the 2021 Plan revision (LLDC 2.0). The draft Plan was posted for public comment in March 2021 and released on August 31, 2021, International Overdose Awareness Day.

Stakeholders

Below is a group of stakeholders that has been working to achieve this vision:

Non-Governmental Agencies

- Amazing Gospel Souls Inc.
- AmeriHealth Caritas DC
- Aquila Recovery
- BridgePoint Healthcare
- Capital Clubhouse
- Children's National Health System
- Community Connections
- Consumer Action Network
- DC Hospital Association (DCHA)
- DC Prevention Centers
- DC Primary Care Association (DCPCA)
- DC Recovery Community Alliance (DCRCA)
- Dreamers and Achievers Center
- Engage Strategies
- Family Medical and Counseling Services (FCMS)
- Fihankara Akoma Ntoaso (FAN)
- Foundation for Contemporary Mental Health (FCMH)
- Georgetown University
- George Washington University (GWU)
- Grubbs Pharmacy
- Hillcrest
- Honoring Individual Power & Strength (HIPS)
- Howard University
- Inner City Family Services
- Johns Hopkins University
- MBI
- McClendon Center
- Medical Home Development Group (MHDG)
- Medical Society of the District of Columbia
- Miriam's Kitchen
- Mosaic Group
- Oxford House
- Pathways to Housing
- Partners in Drug Abuse Rehabilitation Counseling (PIDARC)
- Pew Charitable Trusts
- Psychiatric Institute of Washington (PIW)
- Revise, Inc.
- Second Chance Care
- So Others Might Eat (SOME)
- Sibley Memorial Hospital
- Total Family Care Coalition
- United Medical Center (UMC)
- United Planning Organization (UPO)
- Unity Health Care
- Whitman-Walker Health
- Woodley House
- Zane Networks LLC

DC Government Agencies

- Criminal Justice Coordinating Council (CJCC)
- Council of the District of Columbia
- Department of Behavioral Health (DBH)
- Department of Corrections (DOC)
- Department of Forensic Sciences (DFS)
- Department of Health (DC Health)
- Department of Human Services (DHS)
- Department of Health Care Finance (DHCF)
- Department of Human Services (DHS)
- DC Public Schools (DCPS)
- Department of Aging and Community Living (DACL)
- DC Public Libraries (DCPL)
- DC Superior Court
- Executive Office of the Mayor (EOM)
- Fire and Emergency Services (FEMS)
- Homeland Security and Emergency Management Agency (HSEMA)
- Metropolitan Police Department (MPD)
- Office of the Attorney General (OAG)
- Office of the Chief Medical Examiner (OCME)
- Office of the Deputy Mayor of Health and Human Services (DMHHS)
- Office of the State Superintendent of Education (OSSE)

Federal Government Agencies

- Court Services and Offender Supervision Agency (CSOSA)
- Department of Justice (DOJ)
- Drug Enforcement Agency (DEA)
- Federal Bureau of Investigations (FBI)
- Federal Bureau of Prisons (FBOP)
- Pretrial Services Agency (PSA)

Accomplishments and Highlights from Original Plan

Since LLDC was published in December 2018, much work has been done to meet the Plan goals. The following successes have helped move us closer to reaching our goal of reducing opioid use, misuse, and related deaths:

Goal 1

- Instituted an Opioid Fatality Review Board composed of 15 people from 10+ agencies/organizations across DC. The purpose of the Board is to examine the cases of opioid decedents, review existing data, and make recommendations.
- Received approval on the innovative 1115 waiver that expanded Medicaid coverage for behavioral health services including Psychosocial Rehabilitation Services, residential and inpatient Institutions for Mental Disease (IMD) stays, and recovery support services. Additionally, it removed co-pays for medication for opioid use disorder (MOUD) services and allows psychologists and other behavioral health professionals to bill Medicaid for certain services. In addition, as a condition of reimbursement for services authorized under Chapter 86, IMDs are required to have a participation agreement with the DC Health Information Exchange (DC HIE).
- Connected all Chapter 63 certified providers to the DC HIE. As of spring 2020, the DC HIE includes two registered HIE partners, Chesapeake Regional Information System for our Patients (CRISP) and the District of Columbia Primary Care Association (CPC-HIE). (CRISP is the District's Designated HIE partner.) The CRISP HIE data now includes naloxone distribution in the ambulance data feed as well as the hospital discharge data. There is also an alert for an overdose event in the system.
- Solicited input from stakeholders through a DBH and DHCF Behavioral Health RFI on approaches to integrate behavioral services more fully into the benefits offered through the District's Medicaid managed care program. Stakeholders agreed the vision for this effort is to transform behavioral health care in the District to achieve a whole-person, population-based, integrated Medicaid behavioral health system that is comprehensive, coordinated, high quality, culturally competent, and equitable.
- Implemented Overdose Detection Mapping Application Program (ODMAP) to create an overdose tracking and response system that uses data to inform decision making and enables the deployment of outreach workers to the scene of an overdose.

Goal 2

- Launched public education campaigns, including an anti-stigma campaign, to increase awareness about opioid use, treatment, and recovery.
- Awarded $1,150,000 in grants to 23 faith-based institutions to plan for opioid awareness activities and provide information about treatment and recovery services and supports.

Goal 3

- Increased Prescription Drug Monitoring Program (PDMP) registrations due to 2018 legislation requiring mandatory registration for providers: 2,586 users in 2018 → 16,277 users in 2019.

Goal 4

- Expanded education and distribution of naloxone, including enabling 28 pharmacies across all 8 wards to distribute naloxone for free.
- Launched Text to Live ("LiveLongDC" to 888-111) to receive information about where to access treatment and free naloxone from 35 pharmacies and community sites.

- Expanded peer support across the District to include harm reduction services, treatment, and recovery support by growing the network of peer workers through programs such as Rapid Peer Responders and hospital-based peers who support patients after an overdose.

- Expanded outreach capacity to include 6+ outreach teams who are working across the District to connect individuals to needed resources including MOUD, syringe exchange, naloxone, opioid use disorder (OUD) treatment, clothing, housing, and food.
- In FY 20, trained stakeholders distributed nearly 32,094 naloxone kits including 1,115 by FEMS at the scene of an overdose. Between October 2018 through February 2021, there were 2,074 successful reversals with naloxone out of 2,511 reported attempted reversals (82.5% success rate).

Goal 5

- Implemented Screening, Brief Intervention, Referral, and Treatment (SBIRT) in five emergency departments (with a sixth one launching soon) and the induction of MOUD, in conjunction with peer engagement and referrals to community services and supports. Since program inception (May 2019), 258,052 screenings have been completed and 9,923 patients with risky alcohol or substance use behaviors were given a brief intervention to assess their willingness to change their behavior since program inception.
- Funded the expansion of buprenorphine in eight community clinics and established the Buprenorphine Drug Assistance Plan (BupDAP), a benefit for the uninsured or underinsured.
- Created Supported Employment services for individuals with OUD, which became available in March 2020 for individuals with substance use disorders (SUD) under the 1115 Waiver.
- Established four peer-operated centers that are focused on serving the needs of individuals with OUD. Since March 2020, they served 11,339 individuals and conducted 729 group sessions (mainly virtual).

Goal 6

- Offering all three forms of MOUD in the DC Jail.
- Providing naloxone to individuals upon discharge from the jail.

Goal 7

- Better characterized the supply of illegal opioids, including the discovery of new opioids, through advanced testing at the DFS opioid surveillance lab.
- Enacted the provisions in the SAFE DC Act, which criminalizes synthetic drugs, including variants of fentanyl, based on the class of the chemical compounds, rather than the individual compound, strengthening law enforcement officials' ability to test for and prosecute cases against sellers and distributors of these drugs.

The Modified Plan

Under the leadership of Mayor Bowser, the public-private Strategic Planning Working Group developed a comprehensive strategic plan aimed at reducing opioid use, misuse, and opioid-related deaths. As a result, LLDC covers the spectrum, from prevention through harm reduction, treatment, and recovery supports as well as interdiction. The original Plan has seven goals, each with a set of related strategies. The Appendix provides the detailed status of each of the 50 strategies and their connection to the modified plan (LLDC 2.0). In summary, 10 strategies have been fully completed, 18 have been completed but are expanding in LLDC 2.0, 13 have been completed and are ongoing, 5 have been partially completed, and 3 have not started, and 1 will not be implemented.

The modified plan builds on effective strategies from the original plan. It also adopts new strategies based on lessons learned and our evolving understanding of the best way to combat the opioid epidemic using a person-centered approach through an equity and culturally competent lens. The modified plan includes: 1) a greater focus on saving lives from opioid overdoses by increasing harm reduction activities; 2) developing the peer workforce and a stronger integration of peers with lived experience within organizations, which has proven to be effective in encouraging individuals to get into and stay in treatment; 3) better coordination of treatment and supports to sustain recovery tailored to individual needs, including better coordination of treatment with the criminal justice system; and, 4) engagement with vulnerable populations including pregnant and parenting individuals, youth and young adults, and residents of skilled nursing facilities. LLDC 2.0 will implement a targeted approach at the community level using data to address the needs at hotspots, which includes the deployment of a mobile unit to meet individuals where they live. LLDC 2.0 consists of six Opioid Strategy Areas (listed below) with each area guided by Opioid Strategy Groups (OSGs) responsible for overseeing strategies related to that area of focus. There are a total of 49 strategies with 13 new strategies.

Investments to implement the plan in FY 2019 included grant and local funds including many hours of funded personnel services totaling $32,255,028. The modified plan is supported in FY 2021 with the $39,506,837 in Substance Abuse and Mental Health Services Administration (SAMHSA) State Opioid Response funds and the $5,896,694.96 in Centers for Disease Control and Prevention (CDC) Overdose Data to Action Program funds, and the $4,750,000 in Centers for Medicare & Medicaid Services (CMS) Support Act Section 1003 Planning Grant for the Demonstration Project to Increase Substance Use Provider Capacity funds, as well as local funds including personnel services. The funding amounts listed for each strategy below are subject to change due to implementation schedules.

Opioid Strategy Areas in LIVE.LONG.DC. (LLDC) 2.0

Regulations, Data and Continuous Quality Improvement: Support a comprehensive, data-driven surveillance and response infrastructure that addresses emerging trends in substance use disorder and opioid-related overdoses.

Prevention, Education, and Coordination: Educate District residents and stakeholders on opioid use disorder, its risks, and harm reduction approaches through coordinated community efforts.

Harm Reduction: Support the awareness and availability of, and access to, harm reduction services in the District of Columbia.

Treatment: Ensure knowledge of, and equitable access to, high-quality substance use disorder treatment services.

Recovery: Expand reach and impact of the highest quality recovery support services available and promote a recovery-oriented system of care.

Interdiction and Criminal Justice: Strengthen public safety and justice strategies that reduce the supply and usage of illegal opioids in the District of Columbia.

Strategies in LLDC 2.0

(New strategies are designated in red with an *)

REGULATIONS, DATA, AND CONTINUOUS QUALITY IMPROVEMENT

RD.1	Convene Opioid Fatality Review Board (OFRB) to review opioid-related deaths and develop recommendations to reduce opioid-related fatalities.
RD.2	Strengthen the infrastructure for data and surveillance to understand the scope of opioid-related overdoses (fatal and nonfatal) and the demographics of the population with opioid use disorder.
RD.3	Expand Department of Behavioral Health's Assessment and Referral (AR) sites to establish multiple points of entry and expedite access into the system of care for substance use disorder treatment services.
RD.4	Build the capacity of substance use disorder treatment providers by maximizing the use of Medicaid funds to support prevention, treatment, and sustained recovery; and seek the alignment of payment policies between the Department of Health Care Finance (DHCF) and other local agencies.
RD.5*	Strengthen Health Information Exchange (HIE) infrastructure, incorporating patient consent, to support coordination of substance use disorder treatment across continuum of care.

PREVENTION, EDUCATION, AND COORDINATION

PE.1	Train youth and adult peer educators, in conjunction with individuals in recovery, to conduct education and outreach activities in schools and other community settings.
PE.2	Provide age-appropriate, evidence-based, culturally competent education and prevention initiatives in all Washington, DC public and charter schools regarding the risk of illegal drug use, prescription drug misuse, and safe disposal of medications.
PE.3	Conduct outreach and training in community settings (e.g., after-school programs, summer camps, churches, and community centers) to engage youth, parents, educators, school staff, and childcare providers on effective communication and engagement strategies to support individuals impacted by substance use disorders.

PE.4	Create multiple social marketing campaigns, including anti-stigma campaigns, using a variety of media with clear messages to multiple target audiences (e.g., youth and young adults, current people who use drugs [PWUD]) to increase awareness about opioid use, treatment, and recovery.
PE.5	Increase the targeted advertisement of treatment and recovery programs throughout Washington, DC.
PE.6	Educate and promote the Good Samaritan Law (laws offering legal protection to people who give reasonable assistance to those who are, or who they believe to be, injured, ill, in peril, or otherwise incapacitated) for community and law enforcement.
PE.7	Provide education and/or seminars about maintaining sobriety to patients receiving opioid medications and individuals in recovery.
PE.8	Expand the use of Screening, Brief Intervention, Referral, and Treatment (SBIRT) programs among social service agencies that conduct intake assessments.
PE.9	Develop a comprehensive workforce development strategy to strengthen the behavioral health workforce's ability to provide services in multiple care settings, including peer support specialists/recovery coaches, holistic pain management providers, and those trained to treat patients with co-occurring mental health diagnoses and substance use disorder.
PE.10	Encourage provider continuing education on evidence-based guidelines for the appropriate prescribing and monitoring of opioids and other evidence-based/best practices such as warm hand-offs, 12-step model programs, Acceptance and Commitment Therapy, and SBIRT.
PE.11*	Ensure coordination across stakeholders, wards, and jurisdictional/regional areas to connect consumers, review data, and inform progress.

HARM REDUCTION

HR.1	Increase harm reduction education to families and communities, including naloxone distribution to those most affected (PWUD).
HR.2	Make naloxone available in public spaces in partnership with a community-wide training initiative.
HR.3	Explore the feasibility of supporting additional harm reduction strategies including safe consumption sites and fentanyl test strips.
HR.4	Continue syringe services programs in combination with other harm reduction services (such as naloxone distribution) and assessment for new site selection, including the development of community pharmacy-based needle exchange and safe disposal sites.
HR.5	Expand the use of peers with lived experience to engage individuals with substance use disorders in harm reduction programs and services.
HR.6	Encourage continuing education for medical providers on increasing prescriptions of naloxone for persons identified with OUD or those at risk.
HR.7*	Explore the feasibility of developing a 24/7 harm reduction drop-in center that provides comprehensive services and engage individuals in conversations about treatment and recovery.

TREATMENT

TR.1	Develop and implement a model for initiating MOUD in emergency departments (ED), ensuring a direct path to ongoing care (via a warm hand-off from peer recovery coaches) that is patient-centered, sustainable, and takes into consideration the characteristics of the implementing health system.
TR.2	Integrate physical and behavioral health treatment and programming to deliver whole-person care and improve well-being.
TR.3	Create 24-hour intake and crisis intervention sites throughout Washington, DC.
TR.4	Encourage provider continuing education on evidence-based guidelines for the appropriate prescribing of MOUD, with a target audience of addiction treatment providers and primary care providers who are most likely to encounter patients who are seeking this therapy.
TR.5*	Employ peers to engage with patients in DC hospital inpatient units and conduct post-discharge outreach.
TR.6*	Establish a community of practice (COP) for providers working with individuals with opioid use disorders.
TR.7*	Implement a mobile van to provide behavioral health screenings, assessments, and referrals; and services and supports.
TR.8*	Develop and implement a comprehensive care coordination/care management system to care for and follow clients with SUD/OUD.
TR.9*	Implement the use of universal screening measures for pregnant women and individuals with children, and provide training to OB/GYNs, nurses, and individuals who interact with them on treatment options.
TR.10*	Create a skilled nursing and long-term care facilities training program.

RECOVERY

RE.1	Increase the presence of peer support groups/programs (e.g., 12-step programs, clubhouses, 24-hour wellness centers, sober houses, peer-operated centers) throughout the community (e.g., faith-based institutions, community centers, schools) for individuals in recovery and monitor the quality and effectiveness of programming.
RE.2	Improve the quality and quantity of support services (e.g., education, employment, community re-entry, recovery coaching, transportation, dependent care, and housing) that are available to individuals in recovery.
RE.3*	Establish a Peer University to provide comprehensive training, education, and workforce opportunities for peers that will help them be eligible for national/international certification.

INTERDICTION AND CRIMINAL JUSTICE

IC.1	Engage and collaborate with the drug court for diversion of individuals with substance use disorder who are arrested.
IC.2	Conduct targeted education and awareness campaigns to criminal justice agencies and stakeholders including, but not limited to, judges, prosecutors, defense attorneys, and supervision officers focused on reducing the use of incarceration as a means of accessing substance use disorder treatment and accepting MOUD as a treatment option for offenders.

IC.3	Ensure individuals incarcerated with the Department of Corrections (DOC) continue to receive MOUD as prescribed at the time of arrest, or MOUD is made available to individuals in need.
IC.4	Coordinate with the DOC, Court Services and Offender Supervision Agency, the Federal Bureau of Prisons (FBOP), and other relevant stakeholders to develop a wraparound approach to reintegrate individuals with substance use disorder and a history with MOUD into the community upon release.
IC.5	Explore developing forums or mechanisms for people to discuss their road to recovery with individuals with substance use disorder, the community, and criminal justice stakeholders.
IC.6	Establish effective and coordinated communication channels between justice and public health agency partners to improve continuity of care.
IC.7*	Create a common and accurate understanding of how each agency of the District's public safety, justice system, Health and Behavioral Health system works and interfaces, with a focus on how to best serve PWUD and achieve desired public health and public safety outcomes.
IC.8*	Monitor the screening of substance use disorders prior to arraignment and provide immediate handoff to treatment after arraignment.
IC.9*	Encourage and support ongoing training for dispatchers and first responders around crisis and outreach services to encourage pre-arrest diversion.
IC.10	Enhance surveillance program and data collection efforts in order to determine and characterize the status of the regional supply of illegal drugs.
IC.11	Identify and fill resource gaps preventing law enforcement efforts from using existing laws to reduce the supply of illegal opioids.
IC.12	Continue to collaborate with Metropolitan Police Department (MPD) and federal efforts to identify locations where opioids are illegally sold (street level trafficking) as well as individuals who traffic opioids to direct enforcement efforts toward these targets.
IC.13	Coordinate with federal law enforcement agencies, including the Department of Homeland Security Customs Enforcement and United States Postal Inspector, to target opioid trafficking through the United States Postal Service and other parcel shipping companies.

REGULATIONS, DATA, AND CONTINUOUS QUALITY IMPROVEMENT

Support a comprehensive, data-driven surveillance and response infrastructure that addresses emerging trends in substance use disorder and opioid-related overdoses.

Strategy	Lead/ Supporting Agencies	Action Steps	Targeted Completion Date	Measures of Success	Funding
RD.1 (Formerly Strategy 1.1) **Convene Opioid Fatality Review Board (OFRB) to review all opioid related deaths that occur in Washington, DC and develop recommendations to reduce opioid-related fatalities.**	OCME OFRB CA	• Provide notice about OFRB meetings in accordance with the Board of Ethics and Government Accountability (BEGA) Open Meetings Act requirements. • Convene monthly (or as scheduled) Opioid Fatality Review Board case review meetings. • Convene quarterly (or as scheduled) recommendation sub-committee meetings. • Publish OFRB Annual Report to include case trends, findings, adopted recommendations, and agency responses.	As scheduled Monthly As scheduled 3/31/22	• OFRB convenes monthly meetings and reviews, at a minimum, 12 opioid overdose fatality cases annually. • The OFRB develops and adopts recommendations to improve systems, policies, and programs in an effort to reduce the number of opioid overdose fatalities in the District. • Recommendations and agency responses are made publicly available through the publishing of the OFRB Annual Report. • The recommendations are tracked by the CA's office on the status of implementation, inclusion into agency performance plans, and further outcomes.	$351,119
RD.2 (Formerly Strategy 1.4) **Strengthen the infrastructure for data and surveillance to understand the scope of opioid-related overdoses (fatal and nonfatal) and the demographics of the population with opioid use disorder, as well as the**	DBH DC Health FEMS MPD DFS DHCF DOC	• Expand data dashboard to connect disparate data sources, including DHCF, FEMS, DOC, DHS, and DC Health to create mapping for how individuals flow through or have connected with the different systems. • Convene bi-monthly meetings with data work group. • Make enhancements to ODMAP by including fatal overdoses and MPD responses.	11/30/21 6 times per year 11/30/21	• Memorandum of understanding (MOUs) are established with at least two additional partnering agencies for data sharing. • An opioid data strategy guides the District in collecting and analyzing data in real time to inform proactive programming. • Aggregate data from OCME and services is reviewed bi-monthly to understand demographics of fatalities how clients	$604,614

Strategy	Lead/ Supporting Agencies	Action Steps	Targeted Completion Date	Measures of Success	Funding

effectiveness of the treatment and recovery support system.	DHS
	OCME
		• Use ODMAP to track hotspots, overdose clusters, and identify areas for targeted outreach and support services.
		  ○ Deploy outreach teams and workers immediately after OD spikes/clusters to distribute naloxone and use individual-level data to provide timely follow up to an individual after an OD.
		  ○ Deploy mobile truck sign where OD clusters occurred.
		• Conduct analyses of illegal substances seized, in needle or urine samples, or found in fatalities and share monthly report with stakeholders.
		• Promote data collection, sharing, and analysis within the law enforcement community.
		• Expand FEMS Street Calls Mobile Integrated Health Care Team to include a focus on OUD and use data to identify high utilizers.
		• Procure contractor for evaluation services of the SOR grant.
		• Conduct SOR evaluation.
			Ongoing
			
			Ongoing
			
			11/30/21
			
			11/30/21
			
			10/15/21
			
			Ongoing
				flow through system, identify gaps in the system, and measure progress in addressing gaps.
				• Improved understanding from MPD officers and first responders about what they are encountering on the streets, especially around individuals who OD, and a response is deployed to meet those needs.
				• Monthly area-level surveillance conducted using ODMAP and other data to measure OD trends, usage trends, and naloxone distribution/ administration, and impact of programs.
				• At least 75% of individuals who experience an OD are contacted by an outreach worker within 72 hours and provided information about services and supports.
				• DFS findings are shared with a broader audience including the public to ensure a better understanding of drug use trends by various target populations.
				• Decrease in FEMS utilization among previously high-utilizing individuals with OUD through the provision of social worker services.	

RD.3 (Formerly Strategy 1.6) **Expand Department of Behavioral Health's Assessment and Referral (AR) sites to establish multiple points of entry and expedite access into the system of care for substance use disorder treatment services.**	DBH	• Engage substance use disorder (SUD) providers on the decentralization of AR process and required activities. • In partnership with SUD treatment providers, identify potential barriers to implementation of AR. • Develop and implement strategies to overcome barriers.	Ongoing Ongoing Ongoing	• All SUD providers have intake hours that are updated and kept in a calendar that is accessible and available to the public.	In-Kind

Strategy	Lead/ Supporting Agencies	Action Steps	Targeted Completion Date	Measures of Success	Funding
		• Require all SUD providers to become AR sites. • Create a calendar of intake hours for SUD providers.	2/2020 4/30/21		
RD.4 (Formerly Strategy 1.7) **Build the capacity of substance use disorder treatment providers by maximizing the use of Medicaid funds to support prevention, treatment, and sustained recovery; and seeking the alignment of payment policies between the Department Health Care Finance (DHCF) and other local agencies.**	DHCF DBH	• Explore how providers that provide stand-alone peer support services (e.g., peers in the ED, peer-operated centers) can more easily become DBH-certified providers in order to bill Medicaid. • Convene a workgroup to review options (e.g., what other jurisdictions are doing, and the Medicare bundled rates) to consider a health care financing regulation that allows for bundled payments for methadone providers.	6/30/22 12/31/21	• At least two organizations that provide peer services become DBH-certified providers. • Increase in billable peer support services. • A recommendation for addressing bundled rates for Medicaid is finalized is provided to DHCF. • Simplify payment strategy for DC Health Homes to per member per quarter rate and flexibility to utilize telehealth, with SUD as a qualifying condition.	In-Kind
RD.5 (New Strategy) **Strengthen Health Information Exchange (HIE) infrastructure incorporating patient consent, to support coordination of substance use disorder treatment across continuum of care.**	DHCF DBH	• Develop consent management tools to facilitate appropriate exchange of 42 CFR Part 2 data via the DC HIE. • Upgrade DBH DATA WITS system to support communication and referrals with District behavioral health providers and connection to DC HIE. • Align and coordinate with the Community Resource Information Exchange (CoRIE) to connect health and social service providers using the DC HIE, to address health-related social needs to improve health equity, well-being, and quality of life, along with provider directory and referral.	9/30/21 9/30/21 9/30/21	• SUD providers are able to exchange 42 CFR Part 2 records via the DC HIE. • Clients receiving substance use disorder services are able to complete electronic consents to allow for sharing of protected health information and provider directory information. • Behavioral health organizations can make referrals to community-based organizations to address their clients' needs for housing, food, and other social determinants of health.	$1,700,000

PREVENTION, EDUCATION, AND COORDINATION

Through coordinated community efforts at the Ward-level, educate District residents, stakeholders, and health professionals about opioids, OUD, and effective prevention/early intervention, harm reduction, treatment, and recovery approaches.

Strategy	Lead/ Supporting Agencies	Action Steps	Targeted Completion Date	Measures of Success	Funding
PE.1 (Formerly Strategy 2.1) **Train youth and adult peer educators, in conjunction with individuals in recovery, to conduct education and outreach activities in schools and other community settings.**	DBH OSSE DCPR DOES	• Expand youth peer training program to 20 additional peers. • Deploy youth peers in schools and other settings. • Create a plan for continuously recruiting additional youth peers into the training program for the next cohort. • Graduate youth peers into a paid peer program and/or become mentors (as part of DC Summer Job program, DC Department of Recreation [DCPR], Department of Employment Services [DOES], DC Police, among others). • Offer a unit on opioid and stimulant use within the health curriculum. • Connect youth peers with the behavioral health service to better understand the connection between two programs. • Build upon existing DBH SUD prevention education and outreach efforts (e.g., DCPCs expanded work around opioid misuse). • Develop a sustainability plan for peer education programming.	6/30/22 6/30/22 6/30/22 6/30/22 6/30/22 6/30/22 6/30/22 6/30/22	• Twenty additional student peers are trained. • A new opioid and stimulant unit are introduced into the health education curriculum. • A sustainability plan is developed for continuously recruiting additional youth peers into the training program for the next cohort. • Identify DCPCS's with present gaps in health education content through school health profiles. • Establish .5-1-hour credit toward graduation requirements for DCPS students who become Certified Youth Peer Specialists.	$125,000
PE.2 (Formerly Strategy 2.2) **Provide age-appropriate, evidence-based, culturally competent education and**	DBH DCPS DCPCS	• Continue to use evidence-based/evidence-informed curriculums (e.g., This is Not About Drugs, Project Alert, LifeSkills) in DC Public Schools (DCPS) and DC Public Charter Schools (DCPCS). • Plan and implement evidence-based prevention initiatives.	6/30/22 6/30/22	• The SUD prevention curriculum continues to be implemented in at least 20 DCPS and DCPCS. • Evidence-based prevention initiatives are maintained in participating	$747,671

Strategy	Lead/ Supporting Agencies	Action Steps	Targeted Completion Date	Measures of Success	Funding
prevention initiatives in all Washington, DC public and charter schools regarding the risk of illegal drug use, prescription drug misuse, and safe disposal of medications.				schools by DC Prevention Centers (DCPCs) and prevention sub-grantees.	
PE.3 (Formerly Strategy 2.3) **Conduct outreach and training activities in community settings (e.g., after-school programs, summer camps, churches, and community centers) to engage youth, parents, educators, school staff, and childcare providers on effective communication and engagement strategies to support individuals impacted by substance use disorders.**	DBH DC Health	• Build upon existing District prevention efforts (e.g., annual prevention symposium, brown bag sessions, School Resource Fair series, Beat the Streets, DC Prevention Center outreach) to expand education around opioids. • Conduct outreach and facilitate a minimum of three presentations each year and one event focused on opioids and OUD. • Partner with the faith-based community to increase outreach and education around prevention, treatment, recovery, and harm reduction. • Conduct events focused on SUD education and coordinate with other grantees in the ward. • Promote two newly produced DBH web courses to educate individuals, especially family members, on OUD and treatment and recovery support services. • Educate local university staff and university students at new student orientation on opioids and OUD and provide naloxone training. • Identify champions (e.g., staff from college administration, student affairs, health centers, sororities and fraternities, athletics, campus recovery communities) at each university to take the naloxone train-the-trainer session so that this training can be conducted each year with new students. • Conduct roundtable discussions about the DC opioid epidemic and the widespread nature of fentanyl with	12/31/21 9/29/21 9/29/21 9/29/21 Ongoing 5/31/22 5/31/22 5/31/22	• A minimum of three youth- and young adult-focused activities aimed at providing education around the health risks associated with opioid use and misuse and also effective alternatives to opioid misuse were conducted by DCPCs and prevention sub-grantees. • A minimum of one prevention event focused on SUD education occurs quarterly in each ward and the lists of activities/events are posted at livelong.dc.gov. Events targeted youth at risk (sex trafficked, foster care youth, LGBTQ, communities with high rates of violence, and COVID-19 affected communities) and seniors. • A minimum of two opioid-focused activities will be conducted each year by the 39 faith-based grantees. Activities targeted youth and seniors. • DBH web courses are advertised regularly to community stakeholders, including families, K-12 educators and clinicians, and there is 10% increase in participation annually. • Opioid and naloxone training is incorporated into new student orientation and at least two	$2,167,671

Strategy	Lead/ Supporting Agencies	Action Steps	Targeted Completion Date	Measures of Success	Funding
		students, professors, and college staff at all local universities.		roundtable discussions occur each year at each university.	
PE.4 (Formerly Strategy 2.4) **Create multiple social marketing campaigns, including anti-stigma campaigns, using a variety of media with clear messages to multiple target audiences (e.g., youth and young adults, current people who use drugs [PWUD], seniors) to increase awareness about opioid use, treatment, and recovery.**	DBH DC Health All Government Partners OSSE	• Engage clients, family members, and other community stakeholders on new campaign development. • Launch campaigns across the District and coordinate with existing partner events. • Create campaigns in other languages (e.g., Spanish). • Implement "Be Ready" campaign that includes information/messages about the dangers of fentanyl, naloxone promotion through the Text-To-Live program, and where to access treatment and recovery services and supports. • Re-launch "Don't Use Alone" campaign. • Create a repository at http://livelong.dc.gov/ that would allow for social marketing materials to be downloaded. • Partner with George Washington (GW) University to pitch a youth-focused social marketing and media kit. • Increase Drug Take Back locations.	Ongoing Ongoing Ongoing 2/28/21 11/30/21 9/30/21 9/29/21 9/29/21	• Campaigns implemented using feedback from stakeholders and running in hotspots (e.g., billboards, sidewalk sketches) and data (e.g., ODMAP data) is being used to target subpopulations with increased overdoses (both fatal and non-fatal). • Campaigns have anti-stigma messaging. • Repository of social marketing materials are available at livelong.dc.gov for public access. • A youth-focused social marketing and media kit is launched in partnership with GW. • Five additional Drug Take Back locations are established.	$1,759,813
PE.5 (Formerly Strategy 2.5) **Increase the targeted advertisement of treatment and recovery programs throughout the District.**	DBH DC Health	• Create an interactive map of services and supports by ward and post map or link to map on governmental partners websites. • Launch a marketing campaign (e.g., brochure, a short video, testimonials from actual clients, profiles of the assessment staff) to build awareness for District residents and families on programs/services available, including services for individuals in the justice system with OUD and how to access them. • Launch campaign using the stories of individuals with lived experience to reduce stigma and promote available services and supports.	7/31/21 7/31/21 5/31/21	• Government websites are updated to provide an interactive map about harm reduction, treatment and recovery support services and how to access, or will post a link to sites that provide this updated information. • The marketing campaign increases the public's knowledge about available services and supports and how to access them. • Campaign reduces stigma around treatment.	$100,000

Strategy	Lead/ Supporting Agencies	Action Steps	Targeted Completion Date	Measures of Success	Funding
PE.6 (Formerly Strategy 2.6) **Educate and promote the Good Samaritan Law (laws offering legal protection to people who give reasonable assistance to those who are, or who they believe to be, injured, ill, in peril, or otherwise incapacitated) for community and law enforcement.**	DC Health DBH MPD	• Educate the community on the Good Samaritan Law during opioid-related outreach events and training, etc. • Educate law enforcement on Good Samaritan Law through training academies. • Promote free modules on Opioid Learning Institute, particularly naloxone administration training.	Ongoing Ongoing Ongoing	• The Good Samaritan Law is included as a topic during opioid-related outreach events and training. • Good Samaritan Law provided for all new law enforcement recruits. • There is a 10% increase annually in individuals taking online classes.	TBD
PE.7 (Formerly Strategy 2.7) **Provide education and/or seminars about maintaining sobriety to patients receiving opioid medications and individuals in recovery.**	DBH	• Host monthly educational events in various community settings.	Monthly	• Peer-operated Centers launched monthly education events for the community and a consolidated calendar of all centers is posted at livelong.dc.gov.	$100,000
PE.8 (Formerly Strategy 3.1) **Expand the use of Screening, Brief Intervention, Referral, and Treatment (SBIRT) programs among social service agencies that conduct intake assessments.**	DC Health DBH	• Expand SBIRT training to two additional emergency departments (ED) and seven inpatient settings. • Provide opportunities for organizations to be trained on SBIRT, including updating their electronic health record (EHR) and creating a screening protocol.	6/30/21 2 times per year	• All acute care hospital ED staff conducting intakes and peers on seven inpatient units are trained on SBIRT and are using it. • SBIRT training is offered to providers twice a year.	$100,000

Strategy	Lead/ Supporting Agencies	Action Steps	Targeted Completion Date	Measures of Success	Funding
PE.9 (Formerly Strategy 3.5) **Develop a comprehensive workforce development strategy to strengthen the behavioral health workforce's ability to provide services in multiple care settings including peer support specialists/recovery coaches, holistic pain management providers, and those trained to treat patients with co-occurring mental health diagnosis and substance use disorder.**	DBH UDC	• Develop an MOU with the University of the District of Columbia (UDC) to develop an SUD certificate program targeted at social workers and counselors. • Create a Certified Addiction Counselor (CAC) training program to include classroom training and access to internships in DC agencies in order to obtain 180 or 500 hours of supervised experience.	9/29/21 9/29/21	• UDC develops courses for SUD certificate program to include a module on non-office-based, integrative OUD Treatment Services and support. • Individuals trained in the UDC certificate program will be partnered with DC agencies for employment. • CAC curriculum, with a focus on opioids, is delivered with grant support to 40 individuals through the Catholic Charities Institute's Professional Education Counseling Program. • Eighty percent of individuals completing CAC training obtain supervision hours and take CAC exam. • Seventy percent of individuals taking CAC exam continue to work at DC providers.	$819,568
PE.10 (Formerly Strategy 3.6) **Encourage provider continuing education on evidence-based guidelines for the appropriate prescribing and monitoring of opioids and other evidence-based practices such as warm hand-offs, 12-step model programs,**	DC Health	• Continue promotion of 20 free modules on Opioid Learning Institute (OLI) and update courses, as needed.	Ongoing	• Ten percent increase annually in individuals taking online classes.	$183,750

Strategy	Lead/ Supporting Agencies	Action Steps	Targeted Completion Date	Measures of Success	Funding
Acceptance and Commitment Therapy, and SBIRT.					
PE.11 (New Strategy) **Ensure coordination across stakeholders, wards, and jurisdictional/regional areas to connect consumers, review data, and inform progress.**	DBH MPD DC Health	• Conduct meetings with treatment providers, prevention centers, peer-operated centers and other stakeholders (e.g., mutual aid groups, faith-based organizations) to ensure coordination around opioid initiatives (e.g., events, outreach, and programming) at the ward level to maximize impact and reach a wider audience across the ward. • Create a ward-level engagement plan to connect ward-based opioid activities; discuss latest data, trends, and developments, and strategize about new approaches to continually improve efforts. • Engage family and community members in ward-based opioid activities including being a part of a neighborhood overdose response team. • Engage jurisdictional and regional partners (e.g., Prince George's and Montgomery Counties) to proactively respond to trends in opioid data and interdiction efforts and ensure ongoing research to identify and leverage best practices. Include law enforcement, health departments, and jail staff. • Ensure ongoing research to identify and leverage best practices from other states where fatalities are decreasing.	2/28/21 9/30/21 7/31/21 Annually starting 8/30/21 Ongoing	• Regularly scheduled meetings conducted with key stakeholders at the ward, jurisdictional, and regional levels. • Champion(s) are identified in each ward to oversee the coordination around opioid initiatives (e.g., events, outreach, and programming) and coordination efforts are documented on the LLDC website. • Family and community members understand how to access resources and support in their communities and how to administer naloxone. • Meetings are held annually with jurisdictional partners. • Best practice research is shared with stakeholders to inform policies and practices.	$50,000

HARM REDUCTION

Support the awareness and availability of, and access to, harm reduction services in the District of Columbia.

Strategy	Lead/ Supporting Agencies	Action Steps	Targeted Completion Date	Measures of Success	Funding
HR.1 (Formerly Strategy 4.1) **Increase harm reduction education to families and communities, including naloxone distribution to those most affected (PWUD).**	DC Health DBH FEMS MPD UCC DHS	• Conduct monthly opioid overdose prevention and naloxone administration trainings and target them to priority populations (e.g., shelter and inpatient treatment residents, outreach providers). • Promote online naloxone training to DC residents, employees, and others. • Expand live naloxone trainings to organizations/agencies across the District through a train-the-trainer model. • Use ODMAP data to alert community response networks when suspected overdoses are reported in public places. • Develop a naloxone delivery program (e.g., Text to Live), piloting both mail-based and in-person distribution to an individual's residence. • Expand DC Health Pharmacy Pilot Program to additional pharmacies that distribute naloxone for free. • Engage community leaders to carry naloxone and give testimonials to reduce the stigma around naloxone use. • Create a plan for 'naloxone giveaway days' (e.g., International Overdose Awareness Day) and engage community members in conversations about opioid use and harm reduction approaches.	Monthly Ongoing Monthly Ongoing 2/28/21 Ongoing 8/30/21 3/30/21	• Bi-monthly Opioid overdose prevention and naloxone administration trainings implemented. • The number of new attendees for online trainings increases by 10% each year. • Thirty individuals, including peers, are trained each year in train-the-trainer. • Five new community-based providers become distribution sites each year. • Family and community members are aware of naloxone training through ward-level engagement. • At a minimum, 40,000 naloxone kits are distributed each fiscal year. • Improved focus on public places in areas with highest incidence of overdoses. • Pharmacy Pilot Program is expanded to five additional pharmacies each year. • Text-to-Live is launched and there is an 10% annual increase in the number of individuals accessing the information. • International Overdose Awareness Day is adopted by 10 new providers each year. • A training is held for city leaders on naloxone administration.	$1,591,285

Strategy	Lead/ Supporting Agencies	Action Steps	Targeted Completion Date	Measures of Success	Funding
				• Implemented plan for naloxone giveaway days and 10 new providers participate in International Overdose Awareness Day each year.	

HR.2 (Formerly Strategy 4.2)
Make naloxone available in public spaces in partnership with a community-wide training initiative.
	DC Health	• Implement a naloxone distribution, administration, and training plan for communities and individuals.
		  ○ Ensure additional community-based organizations have a standing order to distribute naloxone.
		  ○ Ensure withdrawal management programs, the jails, treatment facilities, EDs, and hospitals are distributing naloxone to individuals when they are discharged.
		• Increase the capacity of harm reduction workers, outreach workers, peers, law enforcement, and corrections officials to distribute naloxone.
		  ○ Expand Leave Behind program for first responders (FEMS and MPD), which provides individuals and bystanders with naloxone following an overdose.
			Ongoing
			
			Ongoing
			
			12/31/21
				• Ten new distribution sites added each year.
				• Leave Behind program is continued at FEMS and established at MPD.
				• Vending machine program is created and implemented.
					$100,000

HR.3 (Formerly Strategy 4.3) **Explore the feasibility of supporting additional harm reduction strategies including safe consumption sites and fentanyl test strips.**	DC Health DBH	• Continue to convene meetings with invested stakeholders to discuss the feasibility of establishing a safe consumption site and review research from sites in other jurisdictions. • Conduct a feasibility and needs assessment focused on establishing a safe consumption site in the District with the following issues to be addressed: medical supervision, the definition of a site, location of a site, requirements for other services, and understanding with local law enforcement.	Quarterly 12/31/21	• Work group meets regularly. • A sites' infrastructure plan is refined and resources identified. • The topic of "safe consumption sites" is included in all community conversations. • All CBOs have access to fentanyl test strips for distribution to their clients.	TBD

Strategy	Lead/ Supporting Agencies	Action Steps	Targeted Completion Date	Measures of Success	Funding
		• Refine a plan that will define sites' infrastructure and necessary resources. • Include "safe consumption sites" as a topic in the community conversations. • Implement a distribution plan for fentanyl test strips to community-based organizations (CBOs).	Ongoing Ongoing 5/15/21		
HR.4 (Formerly Strategy 4.4) **Continue syringe services programs in combination with other harm reduction services and assessment for new site selection and safe disposal sites.**	DC Health	• Continue operations of syringe services programs (SSP) and incorporate MOUD induction where applicable. • Continue to collect relevant metrics to track progress of SSPs.	2/28/21 Ongoing	• Expand from 3 to 4 SSPs and increase access to MOUD induction. • Monthly SSP data is analyzed for continuous quality improvement (CQI).	$809,226
HR.5 (Formerly Strategy 4.6) **Expand the use of peers with lived experience to engage individuals with substance use disorders in harm reduction programs and services.**	DBH DC Health	• Provide training opportunities for peers to attain national certification to become recovery coaches and harm reduction specialists. • Create on-the-job learning opportunities for peers to get experience in treatment facilities and harm reduction organizations. • Expand Rapid Peer Responder (RPR) program and have RPRs become experts in their assigned ward. • Establish a coordinated deployment of harm reduction outreach workers and teams that target specific wards, days, and times. • Recruit peers to join community overdose response networks and receive alerts when active overdoses are reported from FEMS.	9/29/21 12/31/21 3/31/21 3/31/21 7/31/21	• Fifty peers are provided necessary training for national certification. • Fifty peers are provided on the job learning opportunities. • A plan for coordinated outreach approach, using peers with lived experience is developed and implemented. • RPRs connect, at a minimum, 10 individuals per month to support services, such as treatment, housing, and nutrition support. • RPRs distribute, at a minimum, 200 naloxone units monthly. • Four additional harm reduction outreach teams are established and there is a coordinated approach to outreach.	$456,590

Strategy	Lead/ Supporting Agencies	Action Steps	Targeted Completion Date	Measures of Success	Funding
				• At a minimum, two peers per ward are receiving overdose alerts.	
HR.6 (Formerly Strategy 3.8) **Encourage continuing education for medical providers on increasing prescriptions of naloxone for persons identified with OUD or those at risk.**	DC Health	• Advertise continuing education module on naloxone for prescribers and dispensers. • Encourage providers to administer naloxone through email blasts, seminars, trainings, etc.	Ongoing Ongoing	• Increased the frequency and amount of communications and education targeted towards prescribers by 5%.	$10,000
HR.7 (New Strategy) **Explore the feasibility of developing a 24/7 harm reduction drop-in center that provides comprehensive services and engage individuals in conversations about treatment and recovery.**	DC Health DBH	• Conduct a feasibility and needs assessment focused on establishing a 24/7 harm reduction site. • Design service model based on assessment. • Hold community engagements sessions to inform individuals about the availability of these harm reduction services. • Design a women-specific approach to harm reduction based on an assessment of this population and their needs. • Develop and implement a stabilization and sobering center.	12/31/21 TBD TBD 12/31/21 5/31/22	• Clients with OUD have access to services 24/7. • A women-specific approach to harm reduction is implemented.	TBD

TREATMENT

Ensure knowledge of, and equitable access to, high-quality substance use disorder treatment services. Develop and implement a shared vision between the District's justice and public health agencies to address the needs of individuals who come in contact with the criminal justice system.

Strategy	Lead/ Supporting Agencies	Action Steps	Targeted Completion Date	Measures of Success	Funding
TR.1 (Formerly Strategy 5.4) **Develop and implement a model for initiating MOUD in emergency departments (ED), ensuring a direct path to ongoing care that is patient-centered, sustainable, and takes into consideration the characteristics of the implementing health system.**	DC Health DBH	• Expand ED MOUD Induction program to a total of six District hospitals. • Expand SBIRT protocols in emergency departments to include a focus on stimulants. • Expand 90-day peer outreach for individuals refusing treatment at the ED. • Identify three additional "fast track" MOUD community providers (e.g., appointments are made prior to release from hospital) for warm handoff annually. • Encourage hospital providers to become waivered to prescribe buprenorphine. • Change discharge workflow in ED to include naloxone upon release. • Provide recurring educational opportunities for ED providers and peers on each of the following topics: MOUD, SBIRT, trauma-informed approaches, history of SUD in DC, and pain management alternatives. • Monitor and evaluate progress. • Expand advertising for BupDAP, an access point for buprenorphine for uninsured and underinsured individuals.	2/28/21 4/30/21 Ongoing 9/29/21 6/30/21 9/29/21 Twice per year Monthly Ongoing	• ED MOUD initiation initiative is active in six hospitals and includes an additional focus on stimulants. • Peer outreach is active in six hospitals and individuals refusing treatment are followed for 90 days. • At least three new "fast track" sites are identified annually. • Each hospital has a buprenorphine-waivered physician working in the ED. • At least 90% of patients leaving ED receive naloxone. • At least two educational opportunities are provided annually for ED providers and peers to provide information on best practices. • At least 75% of individuals entering ED are given SBIRT screening. • At least 60% of individuals with a positive screen get a brief intervention. • At least 15% of individuals receiving a brief intervention are referred to treatment. • At least 50% of individuals referred to treatment are linked to treatment.	$2,266,093

Strategy	Lead/ Supporting Agencies	Action Steps	Targeted Completion Date	Measures of Success	Funding
				• At least 95% of clinically eligible patients who receive MOUD in the ED are referred to a provider for follow-up MOUD treatment. • Clients are enrolled in BupDAP within two days of submitting application and claims continue to expand each year by 5%.	
TR.2 (Formerly Strategy 5.5) **Integrate physical and behavioral health treatment and programming to deliver whole-person care and improve well-being.**	DHCF DBH DC Health	• Release RFA for wellness activities. • Offer wellness activities (e.g., massage, acupuncture, mindfulness, yoga) to complement formal treatment to individuals on MOUD at a minimum of eight providers. • Provide contingency management training to SUD providers and provide resources for implementing. • Implement three grants for integrated care for individuals with OUD who also have co-occurring conditions (e.g., hepatitis C/HIV). • Encourage use of opioid alternatives and pain management approaches for patients and users. • Increase access to physical health supports for individuals in SUD treatment to move toward an integrative care model that focuses on social determinants of health. • Encourage providers to participate in Integrated Care Technical Assistance (ICTA). • Continue telehealth expansion benefits through Medicaid (i.e., prolong operations and benefits during COVID). • Explore options to increase access to telehealth to reduce disparities gap. • Release RFA to expand access to MOUD through teleMAT and award grants.	2/28/21 5/30/21 5/30/21 9/30/21 Ongoing 6/30/21 12/31/21 6/30/21 2/28/21 4/1/21	• Individuals have access to wellness activities and there is an increase in quality of life/well-being measures for clients receiving MOUD in a minimum of eight programs. • Contingency management is implemented at a minimum of eight programs offering MOUD and data is collected to monitor progress. • There is an increase in the number of individuals screened and treated for related health conditions through integrated care for individuals with OUD who also have co-occurring conditions (e.g., hepatitis C/HIV). • At least 10 providers that serve individuals with OUD participate in ICTA. • There is a 5% increase in participants taking online courses on opioid prescribing. • Clients have secure access to telehealth options whether at home or in their community at convenient locations. • A reimbursement model is available that supports telehealth in an equivalent manner as in person. • There is increased access to care, including MOUD, through teleMAT, which will be	$5,176,149

Strategy	Lead/ Supporting Agencies	Action Steps	Targeted Completion Date	Measures of Success	Funding
				measured by higher rates of provision of telehealth services, participation, and continuing treatment.	
TR.3 (Formerly Strategy 3.2) **Create 24-Hour intake and crisis intervention sites throughout the District.**	DBH	• Continue the 24-hour/day operations of the Community Response Team (CRT). • Initiate pilot with Department for Hire Vehicles (DFHV) to provide on-demand transportation to help individuals connect with OUD/SUD services. • Continue implementation of grants to establish community and hospital SUD crisis stabilization beds. • Explore making CPEP beds available for OUD and MOUD induction. • Develop a sustainability plan for 24/7 services and supports including CRT and crisis stabilization beds.	Ongoing 3/31/21 9/29/21 9/29/21 12/31/21	• Staff trained to conduct SUD screening and crisis intervention and are available 24 hours a day. • Protocols and processes for accessing transportation services established. • Annual increase in number of those receiving transportation services to get to initial appointments. • Crisis stabilization beds expand by 10% each year and are at 80% capacity. • Fifty percent of individuals linked to SUD treatment upon discharge from crisis stabilization beds. • Any individual wanting MOUD induction will receive it at any time of the day. • A sustainability plan is implemented.	$2,662,120
TR.4 (Formerly Strategy 3.7) **Increase provider continuing education on evidence-based guidelines for the appropriate prescribing of MOUD, with a target audience of addiction treatment providers and primary care providers who are most likely to encounter patients who are seeking this therapy.**	DC Health DBH	• Procure trainer to provide technical assistance to MOUD prescribers. • Provide virtual expert consultation (e.g., ECHO) around clinical cases to increase practitioners' capability in dealing with individuals coping with OUD.	4/30/21 Monthly	• Provided consultation to at least 100 individuals each year.	$52,500

Strategy	Lead/ Supporting Agencies	Action Steps	Targeted Completion Date	Measures of Success	Funding
TR.5 (New Strategy) **Employ peers to engage with patients in DC hospital inpatient units and conduct post-discharge outreach.**	DBH	• Establish initiative to have hospital-based peers provide support (brief interventions) and referrals to treatment to patients in inpatient settings as well as post-discharge outreach in the community for individuals not linked to treatment. • Change discharge workflow to include naloxone upon release.	4/30/21 9/29/21	• Peers are hired for inpatient units in seven hospitals, SBIRT is actively used, and at least 50% of individuals referred to treatment are linked to treatment. • At a minimum 50% of individuals refusing treatment and not connected to treatment are followed for 90 days post-discharge to get them connected to treatment. • At least 90% of discharged patients receive naloxone.	$896,992
TR.6 (New Strategy) **Establish a community of practice (COP) for providers working with individuals with opioid use disorders.**	DBH DC Health	• Conduct a survey of all DATA-waivered providers and other providers that work with individuals with OUD to understand their training and technical assistance needs. • Conduct an inventory of existing training and technical assistance initiatives in the District. • Create a training and technical assistance plan that also includes training on nontraditional, non-office-based, integrative OUD treatment services and supports. • Implement a COP.	8/15/21 8/15/21 9/15/21 10/15/21	• The needs assessment and training and technical assistance inventory review inform the development of a coordinated plan. • Providers are participating in the community of practice and there is a 5% increase in attendance each month.	$52,500
TR.7 (New Strategy) **Implement a mobile van to provide behavioral screenings, assessments, and referrals; and services and supports.**	DBH DC Health	• Hire nurses and licensed clinicians for van. • Conduct SUD assessments and referrals in hotspots and other areas of need. • Recruit SUD providers and primary health care providers to collaborate around providing services and supports and produce a monthly schedule.	3/31/21 4/1/21 1/15/22	• Clinical staff are hired for van and are conducting SUD assessments in hotspots. • A monthly schedule established and SUD providers and other stakeholders incorporated into the schedule. • Individuals with SUD have greater access to general health screenings and other services.	$535,094

Strategy	Lead/ Supporting Agencies	Action Steps	Targeted Completion Date	Measures of Success	Funding
		• Establish a monthly schedule with SUD providers and other stakeholders incorporated into the schedule. • Recruit MOUD providers to work on the van.	1/15/22 8/31/21	• MOUD is accessible near where individuals live/work. • Increased rates of deployment to hot spots, increased screenings, assessments, referrals, and linkages to treatment. • There is a 10% annual increase in individuals experiencing homelessness with OUD interacting with the van.	
TR.8 (New Strategy) **Develop and implement a comprehensive care coordination/care management system to care for and follow clients with SUD/OUD.**	DBH DHCF	• Meet with providers and peers to develop a vision for care management model(s) (e.g., pay-for-performance, recovery capital, recovery-oriented system of care). • Release RFA for care management. • Develop guidelines and structure to support care management. • Ensure successful transition of OUD clients to Medicaid managed care by October 2022.	12/31/20 2/28/21 3/31/21 10/1/22	• Care management grants are awarded and implemented and at least 100 individuals with multiple overdoses, as well as special populations (pregnant women), receive care management. • An approach is in place to actively re-engage individuals in treatment. • There is a reduction in readmissions to hospitals, higher levels of SUD services, and repeat overdoses.	$1,133,155
TR.9 (New Strategy) **Implement the use of universal screening measures for pregnant women and individuals with children and provide training to OB/GYNs, nurses, and individuals who interact with them on treatment options.**	DBH DC Health	• Assess the baseline numbers of woman who have OUD and are pregnant. • Conduct second virtual conference on Treating Pregnant Women and Women with Children with OUD. • Release RFA to develop a plan for using universal screening measures and implement plan. • Release RFA to develop a treatment program(s) for pregnant women and new mothers and fathers and implement programs that also focus on social determinants of health.	9/30/21 12/31/21 9/29/21 9/29/21	• Improved understanding of population and numbers of women to be served. • Education opportunities have been provided to at least 50 individuals who treat pregnant women. • Universal screening measures are developed and being used. • Treatment program(s) for pregnant women and new mothers and fathers are established and are at 50% capacity. • Standards of care that integrates parental and familial involvement are established.	$1,085,928

Strategy	Lead/ Supporting Agencies	Action Steps	Targeted Completion Date	Measures of Success	Funding
TR.10 (New Strategy) **Create a skilled nursing and long-term care facilities training program.**	DBH DC Health	• Develop at least one online training for staff at skilled nursing and long-term care facilities that are focused on SBIRT, SUD/OUD, and naloxone administration. • Inform staff about available DATA waiver trainings. • Invite staff to newly developed community of practice.	9/30/21 Ongoing Ongoing	• OUD, SBIRT, and naloxone training available and used at least eight facilities. • MOUD is supported in facilities and at least one staff is DATA-waivered at each facility. • Individuals representing various facilities are participating in learning communities. • Long-term services and support (LTSS) providers are participating in the ICTA.	$100,000

RECOVERY

Expand reach and impact of the highest quality recovery support services available and promote a recovery-oriented system of care.

Strategy	Lead/ Supporting Agencies	Action Steps	Targeted Completion Date	Measures of Success	Funding
RE.1 (Formerly Strategy 5.6) **Increase the presence of peer support groups/programs (e.g., 12-step programs, clubhouse, 24-hour wellness centers, sober houses, peer-operated centers) throughout the community (e.g., faith-based institutions, community centers, schools) for individuals in recovery and monitor the quality and effectiveness of programming.**	DBH	• Conduct regular OUD-specific outreach, support groups, and programming at the four peer-operated centers and create a shared calendar of events. • Include programming that engages family members and friends of individuals with OUD.	Ongoing 6/30/21	• A shared calendar of events is created among the four peer operated-centers and posted at livelong.dc.gov each month. • Increase of 10% annually in individuals served and connected to treatment. • Supports are implemented for family members and friends.	$1,483,057

RE.2 (Formerly Strategy 5.7)
Improve the quality and quantity of support services (e.g.., education, employment, community re-entry, recovery coaching, transportation, dependent care, and housing) that are available to individuals in recovery.
	DHCF
	DOES
	DHS
	Office for Victim Services and Justice Grants (OVSJG)
	DBH
	DFHV
	DC Health
		• Create a plan for building a continuum of housing options and supports based on individuals' level of recovery, including meeting the needs of special populations.
		  ○ Participate in the Medicaid Learning Collaborative on Advancing Housing-Related Supports for Individuals with SUD.
		  ○ Conduct an analysis of available housing options and barriers to housing.
			12/30/21	• Plan is created for building a continuum of housing options.
				• Environmental Stability expanded by a minimum of 25 slots and tracking system established.
				• Housing First teams serve at a minimum 1,000 clients each year.
				• Sixty recovery housing slots are created for individuals with OUD through grant program.
					$2,449,188

Strategy	Lead/ Supporting Agencies	Action Steps	Targeted Completion Date	Measures of Success	Funding
	DOES	○ Expand environmental stability (ES) for individuals leaving inpatient and residential settings as well as returning citizens. ○ Develop Housing First team(s) to serve OUD population. ○ Release RFA or work with existing providers to increase housing options. ○ Increase availability of recovery housing that support MOUD. ○ Increase availability of housing for returning citizens with OUD. ○ Ensure all SUD treatment and recovery facilities are MOUD-friendly and provide education, where applicable. • Expand supportive employment (SE). ○ Create partnership with DOES to offer job skills training to individuals with OUD. ○ Support start-up costs for organizations to develop SE programs.	6/30/21	• At a minimum, 10 returning citizens with OUD receive transitional housing annually through grant program. • All SUD providers take online MOUD training courses and support individuals with OUD on MOUD. • There is a higher retention of individuals receiving MOUD at grantee programs. • A minimum of twenty individuals participate in DOES Project Empowerment or equivalent. • A minimum of twenty individuals participate in SE.	
RE.3 (New Strategy) **Establish a Peer Academy to provide comprehensive training, education, and workforce opportunities for peers that will help them be eligible for national/international certification.**	DBH DC Health	• Establish Peer Academy through DBH that incorporates Certified Peer Specialist and Recovery Coach training material into curriculum and align trainings and courses to national/international certifications (e.g., IC&RC). • Provide training on nontraditional, non-office-based, integrative OUD treatment services and supports. • Ensure providers and community organizations are involved in trainings so that they understand the roles of peers and how to supervise peers. In addition, they can train on the workforce landscape.	9/29/21 9/29/21 9/29/21	• Creation of a consolidated revised training curriculum to address co-occurring mental health diagnosis and SUD. • Minimum of 50 individuals receive training per year. • Testing prep is offered for National Association for Alcoholism and Drug Abuse Counselors and/or IC&RC certification for 50 individuals per year. • Peer pay scale is shared with providers. • Increase in peer retention in SUD programs.	$187,100

Strategy	Lead/ Supporting Agencies	Action Steps	Targeted Completion Date	Measures of Success	Funding
		• Coordinate peer support opportunities and pathways for employment as peer workers. • Establish suggested peer pay scale. • Continue monthly COP for peers to provide support by addressing employment challenges and sharing successes as well as providing a focus on personal development and clinical awareness.	10/31/21 12/30/21 Monthly	• COP is offered monthly and there is a 5% increase in participation each year.	

INTERDICTION AND CRIMINAL JUSTICE

Strengthen public safety and justice strategies that reduce the supply and usage of illegal opioids in the District of Columbia.

Strategy	Lead/ Supporting Agencies	Action Steps	Targeted Completion Date	Measures of Success	Funding

IC.1 (6.1 Strategy Expansion)
Engage and collaborate with the drug court for diversion of individuals with substance use disorder who are arrested.
	CJCC
	USAO
	OAG
	PSA
	Drug Court Committee
		• Ensure that appropriate LLDC stakeholders are participating on Drug Court Steering Committee meetings to engage in information sharing between drug court and LLDC efforts.
		  ○ Review and share criteria for admission to drug court so that stakeholders have a clear understanding of who is eligible to participate.
		  ○ Improve awareness of, and lend support to, screening process.
			10/31/21	• Participation from LLDC stakeholders at Drug Court Steering Committee meetings.
				• Increased utilization of drug court.
					In-Kind

		○ Review utilization rates and share outcomes. • Educate stakeholders on what drug court is and the criteria for admission.	10/31/21		
IC.2 (6.2 and 6.3 Expansion/Combination) **Conduct targeted education and awareness campaigns to law enforcement and criminal justice agencies and stakeholders including, but not limited to, judges, prosecutors, defense attorneys and supervision officers focused on reducing the use of incarceration as a means of accessing substance use disorder treatment and accepting MOUD as a treatment option for offenders.**	DBH Court MPD PSA CJCC DOC CSOSA	• At quarterly Substance Abuse Treatment/Mental Health Services Integration Taskforce (SATMHSIT) meetings, plan (timing and content) education activities for criminal justice, law enforcement, and public safety staff as well as judges, prosecutors, and defense attorneys. • Conduct at least two trainings annually to educate Criminal Division judges and Pretrial Services Agency, CSOSA, Offender Supervision Agency staff as well as others to understand OUD and MOUD as an alternative to incarceration. • Collaborate with District agencies on social marketing campaign and develop messages targeted to criminal justice agencies.	Quarterly Twice per year Ongoing	• Planning about content, audience, and timing for trainings occur at quarterly SATMHSIT meetings. • Delivery of a minimum of two trainings annually. • Implemented education and awareness campaigns focused on reducing the use of incarceration as a means of accessing SUD treatment.	In-Kind
IC.3 (6.4 Strategy Expansion) **Ensure individuals incarcerated with the Department of Corrections (DOC) continue to receive MOUD as prescribed at the time of arrest, or MOUD is made available to individuals in need.**	DOC DBH	• Continue to provide all DEA-approved MOUD and explore the use of all forms (e.g., injectable buprenorphine). • Establish two SUD treatment units at the jail. Establish SUD treatment units at the jail and hire and train staff. • Create individual plans for inmates being released into the community. • Provide naloxone to individuals with OUD upon discharge from jail.	Ongoing 9/29/21 Ongoing Ongoing	• Naltrexone injections, methadone, and buprenorphine available onsite at DOC. SUD units established at the jail. • Two units are established, one for males and one for females and they are operating at 75% capacity annually. • Each inmate with SUD has an individualized plan upon release. • Every individual with OUD is provided a naloxone kit upon release.	$2,842,739
IC.4 (6.5 Strategy Expansion) **Coordinate with the DOC, Pretrial Services Agency, Court Services and Offender Supervision Agency (CSOSA), the Federal Bureau of**	CJCC CSOSA DOC BOP	• Continue work started at Justice Professionals conference and Sequential Intercept Model mapping workshops to identify gaps in the system and implement solutions that support justice-	12/31/21	• Comprehensive approach to working with individuals involved with the criminal justice system with OUD is developed with all relevant stakeholders, being mindful of each individual's unique	$2,232,289

Prisons (FBOP), and other relevant stakeholders to develop a wraparound approach to reintegrate individuals with substance use disorder and a history with MOUD into the community upon release.	Parole Commission DBH	involved individuals with SUD with a focus on OUD. • Develop communication and informational materials for DOC Ready Center to provide to individuals with an SUD reentering the community. • Establish peer navigator program to support individuals re-entering the community by providing them training, resources, and creating a cohort model to share lessons learned. • Develop a wraparound plan to connect individuals with community services (e.g., treatment, Medicaid, employment services, etc.) before they are discharged from jail or prison. • Engage the FBOP on planning for those individuals returning through DOC. • Enhance planning and opportunities for individuals transitioning from FBOP to DOC.	4/30/21 5/31/21 Ongoing Ongoing Ongoing	circumstances or partners' relationships with the individual. • Informational materials about services and supports distributed to individuals with an SUD reentering the community. • Peer navigator program established and a minimum of 20 individuals participate. • A wraparound service plan is established for residents who are in contact with the READY Center 30-days prior to discharged from jail.	
IC.5 (6.6 Strategy Expansion) **Explore developing forums or mechanisms for people to discuss their road to recovery with individuals with substance use disorder, the community, and criminal justice stakeholders.**	DBH CJCC	• Identify and use existing forums (e.g., monthly/quarterly meetings at DBH with peer specialists and recovery coaches) for individuals to discuss their road to recovery.	Twice a year	• At least two forums are established and available for individuals to discuss their road to recovery.	In-Kind
IC.6 (Formerly Strategy 6.7) **Establish effective and coordinated communication channels between justice and public health agency partners to improve continuity of care.**	CJCC DBH	• Leverage CJCC SATMHSIT to ensure issues are regularly addressed.	Quarterly	• The SATMHSIT is used to discuss and address issues between all relevant partners.	In-Kind
IC.7 (New Strategy) **Create a common and accurate understanding of how each agency**	Deputy Mayors Agency heads	• Develop common understanding about the landscape of the justice system that is broader than interdiction (e.g., interplay between public	12/31/21	• A journey map is created and shared with the stakeholders to educate about	In-Kind

of the District's public safety, justice system, and Health and Behavioral Health system works and interfaces, with a focus on how to best serve PWUD and achieve desired public health and public safety outcomes.		health, public safety and justice) by bringing together agency leaders to discuss current interactions, issues, and opportunities.		the ecosystem, including each agency's philosophy (beyond issues/gaps).	
IC.8 (New Strategy) **Monitor the screening of substance use disorders prior to arraignment and provide immediate handoff to treatment after arraignment.**	PSA	• Develop a process to screen and identify who is doing the screening (assuming we do not know what are the legal outcomes of detainees). ○ Hire 24/7 nurse practitioners available at the clinic to do quick screenings within the central cell block. • Map the pathways to treatment based on the disposition at arraignment. • Develop resource list for criminal justice partners.	12/31/21 12/31/21 9/29/21	• Screening is occurring and 50% of individuals are successfully connected to treatment. • Resource list is developed and distributed.	TBD
IC.9 (New Strategy) **Encourage and support ongoing training for dispatchers and first responders around crisis and outreach services to encourage pre-arrest diversion.**	MPD Office of Unified Communications	• Provide annual training for first responders to help them accurately understand what is possible using a pre-arrest diversion approach. • Provide training around crisis and outreach services to Office of Unified Communications to educate around options and who to call for responses. • Stakeholders meet bi-annually to discuss progress on strategy.	10/31/21 10/31/21 Twice per year	• Fifty individuals trained annually. • Biannual meetings occurring.	In-Kind
IC.10 (7.1 Strategy Enhancement) **Enhance surveillance program and data collection efforts in order to determine and characterize the status of the regional supply of illegal drugs.**	DFS MPD FEMS	• Continue to collect data characterizing drug supply by conducting surveillance testing of opioids. • Continue to build surveillance program to be fully functioning by adding additional contract staff. • Share findings with stakeholders (hospitals, clinicians, FEMS, staff at homeless shelters, etc.).	Ongoing 6/30/21 Monthly	• Increased testing capacity via surveillance of synthetic opioids in the District, both to discover new synthetic opioids as well as characterize those currently present. • Successful testing and reporting on at least 50% of submitted heroin evidence items in the District.	$445,500

		• Increase testing on individuals with OUD to get a better understanding of what is in the drug supply.
		  ○ Test clients on MOUD for clinical purposes and share urinalysis results to understand what drugs are in an individuals' system.
		  ○ Collect and analyze demographic and geographic information on current users in addition to drugs detected at MOUD.
		  ○ Ensure this is a care-based initiative rather than a police-based initiative.
		  ○ Reduce stigma surrounding the testing to ensure more testing.
		  ○ Increase capacity for analyzing and tracing seized opiates/drugs.
		• Create city-wide alert system based on community-level assessment of problem.
			6/30/21
			
			9/29/21
				• Determination of composition of opioids distributed in DC.
				• Discovery of new compounds to share with partners and stakeholders.
				• A city-wide alert system is created.	

IC.11 (Formerly Strategy 7.2) **Identify and fill resource gaps preventing law enforcement efforts from using existing laws to reduce the supply of illegal opioids.**	MPD	• Appropriately staff units addressing opioid issues.	Ongoing	• Units restructured to address staffing issues.	In-Kind
IC.12 (7.6 Strategy Enhancement) **Continue to collaborate with the Metropolitan Police Department (MPD) and federal efforts to identify locations where opioids are illegally sold (street level trafficking) as well as individuals who traffic opioids to direct enforcement efforts toward these targets.**	MPD DFS FBI DEA	• Continue collaboration between MPD and federal law enforcement agencies. • Target areas where opioids, including synthetics, are the prominent drug being sold and identify individuals selling them. • Provide MPD narcotics division with DFS reports and other information so they can utilize it in their interdiction strategies. • Train MPD Narcotics division on ODMAP.	Ongoing Ongoing Monthly 12/31/21	• Decreased the presence of opioids in the District. • MPD Narcotics division and other MPD units are trained on ODMAP. • Decrease in opioids in the District.	In-Kind

IC.13 (Formerly Strategy 7.7) **Coordinate with federal law enforcement agencies including the Department of Homeland Security Customs Enforcement and United States Postal Inspector to target opioid trafficking through the United States Postal Service. and other parcel shipping companies.**	MPD HSCE USPS	• MPD will establish relationship with other federal law enforcement entities to identify and intercept packages being shipped through the US Postal Service and being trafficked other parcel shipping agencies.	Ongoing	• Successfully identified and intercepted packages being shipped through the US Postal Service and other parcel shipping agencies.	In-Kind

Appendix: LLDC Strategy Update

New Plan Strategy	Former Strategy	Description	Status
GOAL ONE: REDUCE LEGISLATIVE AND REGULATORY BARRIERS TO CREATE A COMPREHENSIVE SURVEILLANCE AND RESPONSE INFRASTRUCTURE THAT SUPPORTS SUSTAINABLE SOLUTIONS TO EMERGING TRENDS IN SUBSTANCE USE DISORDER, OPIOID-RELATED OVERDOSES, AND OPIOID-RELATED FATALITIES.			
RD.1	**1.1**	Convene Opioid Fatality Review Board (OFRB) to review all opioid related deaths that occur in Washington, DC and develop recommendations to reduce opioid-related fatalities.	Complete but Expanding
	1.2	Coordinate with Washington, DC and federal regulators to revise laws and regulations that currently impose restrictions on the prescribing of medication-assisted treatment (MAT).	Complete
	1.3	Coordinate with federal regulators to reverse policies and practices that restrict access to MAT to District residents while in the custody of the Federal Bureau of Prisons (FBOP).	Complete
RD.2	1.4	Strengthen the infrastructure for data and surveillance to understand the scope of opioid-related overdoses (fatal and nonfatal) and the demographics of the population with opioid use disorder (OUD).	Complete but Expanding
TR.8	1.5	Establish payment incentives for providers and organizations that implement models that improve patient outcomes, improve the patient experience, and decrease healthcare cost.	Not Started
RD.3	1.6	Expand Department of Behavioral Health's Assessment and Referral (AR) sites to establish multiple points of entry and expedite access into the system of care for substance use disorder treatment services.	Complete but Expanding
RD.4	1.7	Build the capacity of substance use disorder treatment providers by maximizing the use of Medicaid funds to support prevention, treatment, and sustained recovery; and seeking the alignment of payment policies between the Department Health Care Finance (DHCF) and other local agencies.	Complete but Expanding
GOAL TWO: EDUCATE DISTRICT RESIDENTS AND KEY STAKEHOLDERS ON THE RISKS OF OPIOID USE DISORDERS AND EFFECTIVE PREVENTION AND TREATMENT OPTIONS.			
PE.1	2.1	Train youth and adult peer educators, in conjunction with people in recovery, to conduct education and outreach activities in schools and other community settings.	Complete but Expanding
PE.2	2.2	Provide age-appropriate, evidence-based, culturally competent education and prevention initiatives in all Washington, DC public schools regarding the risk of illegal drug use, prescription drug misuse, and safe disposal of medications.	Complete and Ongoing

New Plan Strategy	Former Strategy	Description	Status
PE.3	2.3	Conduct outreach and training activities in community settings (e.g., after-school programs, summer camps, churches, and community centers) to engage youth, parents, educators, school staff, and childcare providers on ways to effectively communicate regarding substance use disorder to engage and support those impacted.	Complete but Expanding
PE.4	2.4	Create multiple social marketing campaigns, including anti-stigma campaigns, using a variety of media with clear messages to multiple target audiences (e.g., youth and young adults, current users) to increase awareness about opioid use, treatment, and recovery.	Complete but Expanding
PE.5	2.5	Increase the targeted advertisement of treatment and recovery programs throughout the District.	Complete but Expanding
PE.6	2.6	Educate and promote the Good Samaritan Law (laws offering legal protection to people who give reasonable assistance to those who are, or who they believe to be, injured, ill, in peril, or otherwise incapacitated) for community and law enforcement.	Complete but Expanding
PE.7	2.7	Provide education and/or seminars about maintaining sobriety to patients receiving opioid medications and individuals in recovery.	Complete and Ongoing
GOAL THREE: ENGAGE HEALTH PROFESSIONALS AND ORGANIZATIONS IN THE PREVENTION AND EARLY INTERVENTION OF SUBSTANCE USE DISORDER AMONG DISTRICT RESIDENTS.			
PE.8	3.1	Expand the use of Screening, Brief Intervention, Referral, and Treatment (SBIRT) programs among social service agencies that conduct intake assessments.	Complete and Ongoing
TR.3	3.2	Create 24-Hour intake and crisis intervention sites throughout the District.	Complete but Expanding
	3.3	Mandate that all licensed providers in Washington, DC who are permitted to prescribe and/or dispense controlled substances be required to register with the Prescription Drug Monitoring Program (PDMP) and PDMP integration into health management system.	Complete
	3.4	Encourage the use of physician-pharmacist collaborative practice agreements to provide appropriate pain management to patients with chronic pain as well as palliative care patients, and to integrate pharmacists into methadone and buprenorphine/naloxone (Suboxone) treatment programs.	Will Not Implement
PE.9	3.5	Develop a comprehensive workforce development strategy to strengthen the behavioral health workforce's ability to provide services in multiple care settings including peer support specialists/recovery coaches, holistic pain management providers, and those trained to treat patients with co-occurring mental health diagnosis and substance use disorder.	Complete but Expanding

New Plan Strategy	Former Strategy	Description	Status
PE.10	3.6	Encourage provider continuing education on evidence-based guidelines for the appropriate prescribing and monitoring of opioids and other evidence-based practices such as warm hand-offs, 12-step model programs, Acceptance and Commitment Therapy, and SBIRT.	Complete but Expanding
TR.4	3.7	Encourage provider continuing education on evidence-based guidelines for the appropriate prescribing of MOUD, with a target audience of addiction treatment providers and primary care providers who are most likely to encounter patients who are seeking this therapy.	Complete and Ongoing
HR.6	3.8	Encourage provider continuing education on increasing prescriptions of naloxone for persons identified with OUD or those at risk.	Complete and Ongoing
GOAL FOUR: SUPPORT THE AWARENESS AND AVAILABILITY OF, AND ACCESS TO, HARM REDUCTION SERVICES IN THE DISTRICT OF COLUMBIA CONSISTENT WITH EVOLVING BEST AND PROMISING PRACTICES.			
HR.1	4.1	Increase harm reduction education to families and communities, including naloxone distribution for those most affected.	Complete but Expanding
HR.2	4.2	Make naloxone available in public spaces in partnership with a community-wide training initiative.	Complete but Expanding
HR.3	4.3	Consider safe consumption sites with the following issues to be addressed: medical supervision, the definition of a site, location of a site, requirements for other services, and understanding with local law enforcement.	Complete but Expanding
HR.4	4.4	Continue syringe service program in combination with other harm reduction services and continuous assessment for site selection and safe disposal sites.	Complete but Expanding
	4.5	Permit the use of controlled substance testing kits by members of the general public to screen drugs for adulterants that may cause a fatal overdose	Complete
HR.5	4.6	Use peers with lived experience to engage individuals with substance use disorders in harm reduction programs and services.	Complete but Expanding
GOAL FIVE: ENSURE EQUITABLE AND TIMELY ACCESS TO HIGH-QUALITY SUBSTANCE USE DISORDER TREATMENT AND RECOVERY SUPPORT SERVICES.			
	5.1	Conduct a comprehensive assessment of the availability of treatment services slots/beds per American Society of Addiction Medicine (ASAM) criteria for patients by age, gender, and payer in Washington, DC for adequacy, and develop a plan for building capacity as may be required. In addition, assess the efficiency and effectiveness of the District's referral system and develop protocols (including training) that	Complete

New Plan Strategy	Former Strategy	Description	Status
		are patient-centered and practical for both the referring and receiving facility.	
RD.2	5.2	Evaluate the effectiveness of programs providing MAT to identify opportunities for enhancing treatment and recovery.	Not Started
	5.3	Explore ways to draw down federal dollars for stays in residential or inpatient treatment programs.	Complete
TR.1	5.4	Develop and implement a model for initiating in emergency departments (ED), ensuring a direct path to ongoing care that is patient-centered, sustainable, and takes into consideration the demographics of the implementing health system.	Complete but Expanding
TR.2	5.5	Incorporate emphasis on physical health (including health screenings) and mental well-being in SUD treatment and programming.	Partially Completed but Expanding
RE.1	5.6	Increase the presence of peer support groups/programs (e.g., 12-step programs, clubhouse, 24-hour wellness centers, sober houses, peer-operated centers) throughout the community (e.g., faith-based institutions, community centers, schools) for people in recovery and monitor the quality and effectiveness of programming.	Partially Completed but Expanding
RE.2	5.7	Improve the quality and quantity of support services (e.g.., education, employment, community re-entry, recovery coaching, transportation, dependent care, and housing) that are available to individuals in recovery.	Partially Completed but Expanding
GOAL SIX: DEVELOP AND IMPLEMENT A SHARED VISION BETWEEN THE DISTRICT'S JUSTICE AND PUBLIC HEALTH AGENCIES TO ADDRESS THE NEEDS OF INDIVIDUALS WHO COME IN CONTACT WITH THE CRIMINAL JUSTICE SYSTEM. PROMOTE A CULTURE OF EMPATHY FOR ARRESTEES, INMATES, RETURNING CITIZENS, AND THEIR FAMILIES AS THEY NAVIGATE THE VARIOUS ENTITIES IN THE CRIMINAL JUSTICE SYSTEM.			
IC.1	6.1 Expansion	Engage and collaborate with the drug court for diversion of individuals with substance use disorder who are arrested.	Not Started
IC.2	6.2 and 6.3 Expansion/ Combination	Conduct targeted education and awareness campaigns to law enforcement and criminal justice agencies stakeholders including, but not limited to, judges, prosecutors, defense attorneys and supervision officers focused on reducing the use of incarceration as a means of accessing substance use disorder treatment and accepting MOUD as a treatment option for offenders.	Complete and Ongoing
IC.3	6.4 Expansion	Ensure individuals incarcerated with the Department of Corrections (DOC) continue to receive MOUD as prescribed at the time of arrest, or MOUD is made available to individuals in need.	Partially Completed but Expanding

New Plan Strategy	Former Strategy	Description	Status
IC.4	**6.5 Expansion**	Coordinate with the DOC, Pretrial Services Agency, Court Services and Offender Supervision Agency (CSOSA), the Bureau of Prisons (BOP), and other relevant stakeholders to develop a wraparound approach to reintegrate individuals with substance use disorder and a history with MOUD into the community upon release.	Partially Completed but Expanding
IC.5	**6.6 Expansion**	Explore developing forums or mechanisms for people to discuss their road to recovery with individuals with substance use disorder, the community, and criminal justice stakeholders.	Complete and Ongoing
IC.6	6.7	Establish effective and coordinated communication channels between justice and public health agency partners to improve continuity of care.	Complete and Ongoing
	6.8	Develop educational and motivational programs for individuals in the custody of the DOC with a history of substance use to encourage treatment and recovery.	Complete
GOAL SEVEN: DEVELOP EFFECTIVE LAW ENFORCEMENT STRATEGIES THAT REDUCE THE SUPPLY OF ILLEGAL OPIOIDS IN THE DISTRICT OF COLUMBIA.			
IC.10	**7.1 Enhancement**	Enhance surveillance program and data collection efforts in order to determine and characterize the status of the regional supply of illegal drugs.	Complete and Ongoing
IC.11	7.2	Identify and fill resource gaps preventing law enforcement efforts from using existing laws to reduce the supply of illegal opioids.	Complete and Ongoing
	7.3	Identify any legislative gaps that may exist preventing or hampering law enforcement "best practices" to reduce the supply of illegal opioids.	Complete
	7.4	Coordinate investigative efforts with the United States Attorney's Office and Drug Enforcement Administration to utilize federal laws in cases involving individuals who sell opioids (heroin/fentanyl) that cause the death or injury of another.	Complete
	7.6	Identify existing federal task force assets and ensure efforts are in place to investigate and disrupt the flow of illegal opioids into Washington, DC.	Complete

New Plan Strategy	Former Strategy	Description	Status
IC.12	**7.6 Enhancement**	Continue to collaborate with the Metropolitan Police Department (MPD) and federal efforts to identify locations where opioids are illegally sold (street level trafficking) as well as individuals who traffic opioids to direct enforcement efforts toward these targets.	Complete and Ongoing
IC.13	7.7	Coordinate with federal law enforcement agencies including the Department of Homeland Security Customs Enforcement and United States Postal Inspector to target opioid trafficking through the United States Postal Service and other parcel shipping companies.	Complete and Ongoing

FY 2024-2025

COMBINED BEHAVIORAL HEALTH ASSESSMENT AND PLAN

Community Mental Health and
Substance Use Prevention, Treatment, and
Recovery Services Block Grant
(MH & SUPTRS BG)

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

District of Columbia
Department of Behavioral Health

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

Overview of the District of Columbia Department of Behavioral Health

The District of Columbia Department of Behavioral Health (DBH) envisions a thriving community where prevention is possible, and recovery from mental health and substance use disorders is the expectation. DBH helps support healthier and stronger communities by working to prevent the onset of mental health and substance use disorders and providing a range of community-based treatment services and recovery supports. DBH also provides crisis services, operates adult and child urgent care clinics, and manages Saint Elizabeths Hospital for 24-hour psychiatric inpatient care.

The mission of DBH is to develop, manage and oversee a public behavioral health system for adults, children and youth and their families that is consumer driven, community based, culturally competent and supports prevention, resiliency and recovery and the overall well-being of the District of Columbia.

The Department of Behavioral Health is leading the District's work to ensure residents have access to high-quality, behavioral health services and the opportunity to lead healthy and fulfilling lives. The strategic goals[1] of the DBH are:

- Goal 1: **Prevention and Early Intervention** promotes behavioral health wellness through prevention and early intervention services and supports.
- Goal 2: **Access to Quality Services** ensures that individuals and families receive high-quality services to meet their unique needs, resulting in access to the right services, at the right time, in the right amount.
- Goal 3: **Recovery and Resilience** builds and supports a community that promotes recovery and resilience to help individuals and families thrive.
- Goal 4: **Partnership, Integration, and Coordination** strengthens community partnerships to better integrate and coordinate services towards a sustained and shared vision of excellence.
- Goal 5: **Leadership, Innovation and Accountability** will transform the District's behavioral health system into a nationally recognized, results-based model of care by promoting a common vision, accountable collective action, research, training and education, transparency, and innovative programs.

Demographically, the District of Columbia is 61.05 square miles and is divided into eight Wards. The Community Mental Health Services Block Grant (MHBG) and Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRS or SUD BG) will be utilized across the

[1] DBH Strategic Plan 2019, https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/DBH%20Strategic%20Plan.%202019.pdf

entire jurisdiction.

As of April 1, 2020, the District had a population of 689,545 that was 45.8% Black or African American, 45.9% White, 0.6% American Indian/Alaska Native, 4.5% Asian, 0.2% Native Hawaiian/Other Pacific Islander, 11.5% Hispanic/Latino, and 3.0% selecting two or more races.[2]

Nearly 22% of District of Columbia residents are aged 25-34 (148,977) with 16% aged 35-44 and 11% aged 45-54. Females represent 52% and males 48% of the District's population. The female median age is 35.2 and the median age for males is 34.7.[3]

There are 313,594 households and 129,345 families. The average household size is 2.03 persons and 62,787 or 20% of household include children. The average household income is $156, 367 with a median household income of $104,110. [4]

The median household income by race/ethnicity is $161,812 (White). $147,727 (Native Hawaiian/Pacific Islander, $122,201 (Asian), $111,087 (2+ Races), $105,386 (Non-Hispanic/Latino), $94,484 (Hispanic/Latino), $72,268 (Some Other Race), $54,401 (Black/African American), and $50,611 (American Indian/Alaskan Native). [5]

Ten percent or 13,006 of District families fall below poverty with 9,298 (7%) of families below poverty with children. [6]

Additionally, 15% of the District's population is living below the poverty line, with Wards 7 and 8 having the highest levels of poverty at 26% and 30% respectively in 2023. [7] The District's 2023 data on homelessness shows an estimated 4,922 people experiencing homelessness. [8]

Provider and Consumer Landscape

Mental Health

DBH provides an array of mental health services and supports through Health Homes and Mental Health Rehabilitation Services (MHRS) options.

DBH contracts with 53certified providers to deliver mental health services. Four of these providers

[2] U.S, Census Bureau QuickFacts: District of Columbia, https://www.census.gov/quickfacts/fact/table/washingtoncitydistrictofcolumbia,US/PST045222

[3] DC Health Matters 2023 Demographics, https://www.dchealthmatters.org/demographicdata?id=130951&sectionId=943#sectionPiece_281

[4] Ibid

[5] Ibid

[6] Ibid

[7] Poverty by ward: DC KIDS COUNT data center: Ward Snapshots, https://dckidscount.org/ward-snapshots/ward7/, https://dckidscount.org/ward-snapshots/ward8/

[8] Homelessness in DC, Results from January 25, 2023 Point-in-Time Count, https://community-partnership.org/homelessness-in-dc/

are classified as only a Free-Standing Mental Health (FSMH) clinic; 30 are classified as MHRS-only providers; and 17 are both MHRS and FSMH providers. Ten mental health providers are also certified to provide SUD treatment. In addition, DBH operates adult and child clinics that provide urgent care and crisis emergency services.

Outreach and treatment services related to both mental health and substance use are also provided through the Community Response Team (CRT), outreach contractors funded through the District's State Opioid Response (SOR) grant and locally funded Community Engagement Team.

Substance Use

DBH also contracts with 29 certified providers to deliver treatment and recovery supports for adolescents to adults with substance use disorders (SUD). Seventeen of these providers also are certified to provide mental health treatment. Individuals who want to obtain SUD services go through the Access and Referral Center (ARC) or community intake sites operated by DBH certified treatment providers. In FY 20, all SUD providers were required to provide assessment, intake and referral services, unless a waiver exemption is approved. During the intake process, clients receive an assessment to determine the appropriate level of treatment.

A comprehensive continuum of substance abuse recovery and treatment services, including outpatient, intensive outpatient, residential, detoxification and stabilization, and medication assisted treatment is available within the system of care.

SUD services for adolescents are provided through the Adolescent Substance Abuse Treatment Expansion Program (ASTEP). Two certified substance use disorder treatment providers offer these specialized services. Screening, assessment, outpatient and in-patient treatment, and recovery services and support are provided.

DBH supports four Prevention Centers that conduct community education and engagement activities related to substance use prevention across all eight wards. This includes youth empowerment training, social media outreach and Prevention Centers capacity-building efforts. DBH has developed the Prevention Policy Consortium made up of more than 15 District agencies and national leaders to bolster the substance use prevention infrastructure and system of care.

Consumers

In FY 22, 43,637 individuals obtained mental health or substance use disorder services. DBH experienced a 24 percent increase in mental health services from FY 20 during the height of the pandemic, driven in part by greater use of telehealth. There also was a six percent increase in the number of people who received substance use disorder services compared to FY 21. Of those individuals, 3,188 were served by both MH and SUD providers.[9]

[9] DBH Reports,"MHEASURES Annual FY 22 (Oct 1, 2021-Sept 30, 2022)"

A total of 5,265 residents participated in treatment, primarily in person. Significantly, 61 percent of people who received treatment for substance use disorder services also received mental health treatment.[10] Though there was an increase in utilization, total expenditures for substance use services decreased by eight percent.

A similar proportion of males (47%) and females (53%) received mental health services in FY 22; however, males are a larger share (nearly two-thirds) of consumers received substance use disorder services, and/or both mental health and substance use disorder services.[11]

DBH is transforming publicly funded behavioral healthcare into a whole-person, culturally competent, integrated behavioral health system that ensures services for those who need them, and embracing our role as the state authority responsible for improving population behavioral health outcomes and advancing health equity.

Additionally, DBH is addressing the same challenges facing our country today to strengthen the behavioral health system including addressing workforce shortages, expanding access to care, improving health equity, enhancing child and family well-being, the opioid epidemic, and addressing the mental and emotional impact of the pandemic. We are making meaningful progress on these priorities.

Behavioral Health Transformation and Integration with Managed Care

DBH and Department of Healthcare Finance (DHCF), the District's Medicaid authority, are collaborating through a multi-year plan to fully integrate behavioral health services into the District's Medicaid managed care program.

DBH and DHCF are now in the Provider Planning and Readiness phase of our multi-year plan to fully integrate behavioral health services into the District's Medicaid managed care program. We first surveyed providers so they could identify their challenges and are responding with multiple technical assistance opportunities and provider forums. One example of the support provided was the development of a Business and Administrative Operations Best Practices Manual. We are working very closely with providers to identify and implement changes in how they will conduct business in the managed care environment. The integration of services will standardize certain operational processes and reduce administrative burdens.

The foundation for whole person care is timely access to both physical and behavioral health data. DBH will require that a provider have a certified electronic health record to capture and enable the transfer of health information. DBH worked with DHCF to obtain grant funding to support providers to implement, enhance or optimize their electronic health records.

[10] Ibid.
[11] Ibid.

In addition, DBH is in the second year of implementation of its Integrated Technology Engine (ITE). The ITE is a technology solution aligned with DBH's business process that will consolidate accurate and timely health data, enabling DBH managers and staff to make informed data-driven decisions supporting the District's vision of population health and whole-person care.

Overview of Mental Health Services

Comprehensive Community-Based Mental Health Service System

DBH has a range of treatment and support services for children, youth, and their families available, including specialized evidence-based practices for youth and families recovering from trauma, emergency care, and ongoing treatment primarily through certified, **community based mental health providers**. Ongoing treatment includes individual, group, and family counseling, diagnostic assessment, medication management, and family support.

In addition, community-based providers are certified to provide **substance use disorder treatment.** The Department also operates a children's clinic, provides services in public and public charter schools, and manages an alcohol, tobacco, and drug prevention and awareness campaign called **DrugFreeYouthDC**.

DBH is invested in supporting a clinician in every public and public charter school within the District. Using a public health approach, the School-based Behavioral Health Program provides a range of prevention, early intervention and treatment services to students in the DC public and public charter schools. The are a total of 253 schools.

DBH has trained providers to offer evidence-based practices with a focus on trauma support proven to improve functioning at home, in school and in the community. In FY 22, DBH added training in three new Evidence-Based Practices (EBPs) for early childhood and youth substance use disorder treatment for infants and youth to age 18 to support families.

For **youth with SED**, DBH continues to offer Community Based Intervention Services which are time-limited, intensive, mental health services delivered to children and youth. CBI services are intended to prevent the utilization of an out-of-home therapeutic resource or a detention of the consumer. In FY 22, the Department provided funding to support workforce stabilization and development initiatives assisting CBI providers to retain and recruit staff required to provide in-person care to children, youth, and their families with social disturbances. Funding was provided in the amount of up to $35,000 for each CBI provider to assist with recruitment and retention efforts to increase capacity to service youth and families in crisis.

To address the **ESMI/FEP population**, DBH implements a Navigate Team approach to address ESMI/FEP treatment. Navigate is a comprehensive intervention program for people who have experienced the first episode of psychosis. This treatment promotes shared decision-making and

uses a team of specialists who work with the client to create a personal treatment plan. It has been used as the foundation for the District's coordinated specialty care (CSC) program.

The number of Transition Age Youth (TAY) aged 16-25 years old in the District of Columbia is approximately 35,924, which is 6% of the overall population. Of the District's young adult population, 54% identify as black, 32% as white, 11% as Hispanic, and the remainder 3% identify as other, while 19% of the overall TAY population aged 18 -24 years old identify as LGBTQ. In 2020, NIMH reported that young adults ages 18–25 had the highest prevalence (21.0%) of any mental illness (AMI), including mental, behavioral, or emotional disorders. NIMH also reported that young adults ages 18-25 (17.0%), had the highest prevalence of experiencing a major depressive episode. National Data indicates that in the U.S., 1 in 10 young adults aged 18-25, experienced a SMI.

In FY 20, 8.1% of the TAY population received treatment and/ or support for a SMI. In FY 20, among 16–25-year-olds seeking services through DBH, 1,997 TAY received a primary diagnosis of major depressive disorder and an additional 902 TAY seeking services through DBH received a primary diagnosis of bipolar disorder, schizophrenia and/or schizoaffective disorder. Of the 2,901 TAY who were diagnosed with a SMI, 40% received treatment. In FY 20, 41% of the TAY youth diagnosed with a SMI were hospitalized and 17% experienced 2+ more hospitalizations due to treatment for a SMI.

The purpose of the FEP Treatment Program for Transition Age Youth is to change the long-term prognosis for young adults coping with schizophrenia by providing an early and effective treatment intervention program for individuals who have experienced their first episode of psychosis. The FEP treatment team consists of a Case Manager, Medication Manager, Individual Resiliency Trainer, Family Education Clinician, Supported Employment and Education Specialist and Peer Specialist.

Specific to FEP, DBH implements:

- NAVIGATE Services: NAVIGATE is a comprehensive intervention program for people who have experienced a first episode of psychosis. Treatment is provided by a team of mental health professionals who focus on helping people work toward personal goals and recovery. More broadly, the NAVIGATE program helps consumers navigate the road to recovery from an episode of psychosis, including supporting efforts to function well at home, on the job, at school, and in the social world.

- Individual Placement and Support/Supported Employment/Education: 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.

- Cognitive Behavioral Therapy for Psychosis (CBTp): Cognitive Behavioral Therapy for Psychosis (CBTp) is an evidence-based treatment approach shown to improve symptoms

and functioning in patients with psychotic disorders. CBTp aims to enhance function despite difficult symptoms and experiences such as hallucinations, negative symptoms, thought disturbances, and delusions. CBTp forms a collaborative treatment alliance in which the patient and therapist can explore distressing psychotic incidents and the beliefs the patient has formed about these experiences, with the goal of reducing distress and disability caused by these experiences.

- 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.

- TIP and Assertive Community Treatment (TACT): The integration of TIP and ACT has proven very successful with Transition-Aged Youth.

Other EBP that support services to young adults experiencing their first episode of psychosis include:

- Adolescent Community Reinforcement Approach (A-CRA) is a behavioral intervention targeted to transition-age youth with co-occurring mental health and SUD. Research has indicated that A-CRA results in abstinence and recovery from substance use, increased social stability, and improved linkages and participation in continuing care.

- Appreciative Inquiry (AI) *is* differentiated from other change management processes as it begins with interviews in which participants reflect on their positive experiences and discover their capacity to make a difference. Sharing the stories that emerge from the interviews builds appreciation for the value and potential to contribute that is inherent in all human resources. Accumulating positive stories has the effect of changing the grand narrative or self-image of a system.

- TAY Trauma Recovery and Empowerment Model (*TREM)* is a fully manualized 24-to-29 session group intervention for transition-age youth (TAY) who survived trauma and have substance use and/or mental health conditions. This model draws on cognitive–behavioral, skills training, and psychoeducational techniques to address recovery and healing from sexual, physical, and emotional abuse.

- Seeking Safety is an evidenced-based present-focused counseling model to help people attain safety from trauma and/or substance abuse. It can be conducted in group (any size) and/or individual modality.

- Trauma Systems Therapy- A comprehensive, phase-based model for treating traumatic stress in children and adolescents ages 6-18 that adds to individually based approaches by specifically addressing the child's social environment and/or system of care.

- Trauma-Focused Cognitive Behavioral Therapy- A psychotherapeutic intervention designed to help children ages 3-18, working with their parents or caregivers, overcome the negative effects of traumatic life events.

- Multi-Systemic Therapy- an intensive community-based treatment for youth ages 12-17 and their families with antisocial behaviors putting them at risk of out-of-home placement, who are living with or returning to a parent/caregiver with whom the youth have a long-term relationship and who is willing to participate in treatment.

- Functional Family Therapy: A family-focused intervention for at-risk and juvenile justice-involved youth ages 11-18.

- Family Supports: Social support from family provides patients with practical help and can buffer the stresses of living with illness.

For **adults with SMI**, the District also delivers Assertive Community Treatment (ACT) to approximately 2300 consumers annually through nine (9) providers running twenty-six (26) teams. ACT teams are expected to function as the full-service care coordination team for medical, psychiatric, vocational, and housing services and support for enrolled consumers. Consumers are identified for care using PATH homeless engagement teams, by providers of outpatient mental health and substance use disorder care, in patient providers and by the individuals themselves and their informal support networks.

DBH is working with mental health providers who manage Assertive Community Treatment (ACT) teams. In FY 22, the District also made available grants up to $58,000 per ACT team to support staff recruitment, retention, and training. As we reshape and better coordinate the components of our crisis services, we are working to ensure ACT teams are part of crisis response and that crisis management is part of treatment planning. DBH will begin implementation of the TMAC protocol in FY 2024. Providers will receive a significant increase in the Medicaid rate for the delivery of ACT using this protocol.

In FY 23 the District developed and implemented the Intensive Care Coordination Team. This team, led by a registered nurse, is comprised of six (6) community behavior support specialists, two (2) registered nurses, and two (2) peer support specialists.

DBH is actively working to realign and expand **crisis services** in alignment with the SAMHSA guidelines. It is important to note, the vast majority of behavioral services in the District of Columbia are provided by community-based organizations that are certified by DBH. In contrast, crisis services, including **someone to talk to** (Access Helpline), **someone to respond** (mobile crisis and the Community Response Team or CRT), and **a place to go** (the Comprehensive Psychiatric Emergency Program or CPEP) are currently provided directly by employees of the Department of Behavioral Health.

DBH's expansion and realignment of crisis services began in earnest in 2020 and 2021 when the nation found itself at a crossroads concerning behavioral health. The COVID-19 pandemic shined a bright light on system vulnerabilities as new mental health challenges have emerged owing to the collective trauma, loss, and stress brought on by the pandemic. Longstanding inequities in access to quality mental health care and services for substance use disorders are ever more apparent. Simultaneously, the nation's reckoning with racial injustice and persistent calls for police reform have highlighted the need to dramatically realign how we respond to individuals experiencing behavioral health crises. DC's Mayor Muriel Bowser launched a 911 call diversion program on June 1, 2021, amidst nationwide calls for police reform prompted us to redouble efforts to move away from an automatic law enforcement response to a health first and clinician led approach to behavioral health crisis.

Here in the District, as with many other jurisdictions across the country, DBH is working to meet the demands of the new behavioral health landscape. To that end, DBH has created a new executive level Chief of Crisis Services and a Deputy Chief position to support the reorganization and expansion of crisis prevention and alternative response options to improve clinical outcomes for individuals experiencing behavioral health crises. Programs that previously sat in different administrations are being brought under a single reporting line to assure optimal alignment and to improve patient experience and outcomes throughout the service continuum. The goal is to ensure that crisis services and the larger system-of-care can achieve the following:

- Prevent crises wherever possible,
- Resolve crises quickly and effectively when they do occur,
- To make the recurrence of a crisis unlikely, and
- To effectively manage crisis services to ensure they are comprehensive, well-coordinated and data driven.

In addition to assuring a high level of coordination within the various crisis program components within Crisis Services there is a desire to enhance collaboration with other DBH program elements "upstream" before crises occur and "downstream" at the end of a discrete crisis episode.

It is incumbent on the District's system to do everything possible to securely connect individuals to continuing care driven by a person-centered plan that reflects an ever deepening and shared understanding of the individual's needs.

DBH implements several 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, and adults.

Mental Health System Data Epidemiology

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	38,410	36,700
2. Children with SED	4,903	4,860

DBH supervises the operation of all behavioral health providers and set standards for the provision of clinical care throughout the public behavioral health system, which is community-based. DBH provides prevention, intervention, and treatment services and support for children, youth, and adults with mental and/or substance use disorders including emergency psychiatric care, community-based outpatient, and residential services. We are committed to developing innovative and effective person-centered practices that promote community integration, enhance communications with family and peers, and reinforce natural supports for recovery and resilience.

To increase consumers'/clients' ability to successfully integrate into their community, maximize independence, and participate fully in their environment, DBH has several strategic initiatives to facilitate treatment in the least restrictive environment possible:

- Enhanced engagement of community employers to support consumers/clients in securing and maintaining meaningful employment.
- Integration of Free-Standing Mental Health Clinics (FSMHC) into DBH and the District broader service system.
- Supporting treatment interventions that reduce rates of incarceration, when appropriate.
- Conducting regular level of care assessments for consumers in community residential facilities (CRF) to support independence and integration into the community.
- Requiring regular level of care assessments for Assertive Community Treatment (ACT) consumers to ensure access to the appropriate level of placement.
- Conducting Community Integration Team meetings to improve the outcomes for consumers experiencing multiple hospitalizations or other poor treatment outcomes

Additionally, DBH oversees involuntary commitment at community hospitals, and coordinates services that assist individuals transitioning from psychiatric hospitals and nursing homes to community-based behavioral health services.

The Access Helpline is the central point for accessing all DBH community-based services, and Behavioral Health Services Division provides same day urgent care with services including assessments, counseling, medication management, and psychiatric evaluations. Residents can also enroll in services at the offices of certified providers.

DBH monitors a comprehensive array of prevention, early intervention, and community-based behavioral health services and supports for adults, children, youth, and their families that are culturally and linguistically competent, and supports resiliency and recovery. A network of community-based mental health and SUD providers delivers a range of treatment services including crisis services, residential, outpatient treatment, counseling, and community supports.

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

Children's Services

To address **children with SED and their families**, the Early Childhood Mental Health Consultation Project, known as the Healthy Futures Program, operates in 107 child development centers located throughout the District. Consultation focuses on improving the overall quality of the program and assisting staff to solve a specific issue that affects more than one child, staff member, or family. The Healthy Futures Program offers child and family-centered consultation services to care providers and family members. In FY 22 and FY 23, Healthy Futures began a treatment pilot for young children and families in eight child development centers. Clinicians were trained in early childhood evidence-based treatments to build capacity to implement treatment in child development centers based on needs identified by center directors and parents.

In FY 22, as part of the Healthy Futures Pilot Initiative funded by America Rescue Plan Act (ARPA) to implement within early childhood programs, DBH invested funding to cover training, consultation, and equipment to implement the Attachment Biobehavioral Catchup (ABC) model, a home visiting model for toddlers and infants 6 months to 2 years of age and their parents who have experienced early adversity such as caregiver mental illness, chemical dependence, or neglect.

To promote the integration of behavioral health and primary care, DBH developed the Quality Improvement Mental Health Learning Collaborative and the DC Mental Health Access in Pediatrics (DC-MAP) program. There are two primary initiatives: 1) annual, universal mental health screening through the pediatric primary care provider and 2) DC Mental Health Access in Pediatrics (DC MAP), a children's mental health consultation program for pediatricians and primary care physician practices.

Through the DCMAP, DBH works with pediatricians to identify problems early and conduct an annual mental health screening within a primary care visit. This initiative promotes the integration of behavioral health and primary care for children and recognizes mental wellness as part of good health. To support the program, DHCF issued a new billing code for mental health screening during

an annual well-child visit. This unique code also allows the collection of data on the number of screens completed and the number of positive screens across the District. Participating practices serve children in all wards and cover approximately 80 percent of the children enrolled in Medicaid. Practices also have access to an on-call child psychiatrist, psychologist, social worker, and a care coordinator for behavioral health consultation regarding diagnosis or medication management.

Targeted Services to Rural and Homeless Populations and to Older Adults

Rural Population

The District of Columbia is an urban setting with a population of 689,545 residents living within 61.05 square miles between the states of Virginia and Maryland. The District does not have any rural populations.

Homeless Populations and Older Adults

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. The director of the Department of Behavioral Health serves as a member of the ICH. The ICH **Homeward DC 2.0 Strategic Plan (2021-2025) envisions ending long-term homelessness and creating a system that quickly stabilizes households that do experience housing loss and connects them back to permanent housing and quickly as possible**. 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.

The District's CoC provides persons experiencing homelessness 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.

Homeward DC 2.0[12], the Interagency Council on Homelessness' second iteration of the District's Strategic Plan (FY 2021 – FY 2025), lays out a community vision:
Homelessness in the District of Columbia will be rare, brief, and nonrecurring. We will eliminate

[12] DC Interagency Council of Homelessness (ICH), Homeward DC 2.0 Strategic Plan (FY2021- FY2025) https://ich.dc.gov/sites/default/files/dc/sites/ich/page_content/attachments/Homeward-DC-Report_FY2021-2025%5B1%5D.pdf

racial inequities in the homeless services system and create systemic fair treatment for all people.

The plan consists of 4 major components. *Homeward DC 2.0*:

- Summarizes the Homeless DC Plan and lessons from the last five years;
- Provides the vision, guiding principles, and building blocks of Homeward DC 2.0;
- Outlines system modeling and housing inventory needs; and
- Shares 100+ strategies supported by twelve strategic goals.

In 2015, Mayor Bowser released *Homeward DC*, a bold vision and strategic plan to end long-term homelessness in Washington, DC. Since its initial release, the District has made significant progress and investments in sustainable solutions to reduce homelessness, especially with regard to family homelessness.

Using a comprehensive approach, the District scaled homelessness prevention services for families; reformed the family shelter system – closing DC General and launching small, service-enriched Short-Term Family Housing programs throughout the city; and expanded rental subsidies for families. This work has led to a reduction in family homelessness in the District, from a peak of nearly 1,500 families experiencing homelessness on any given night as the District began Homeward DC implementation, to just over 400 families as of January 2021 – a 73% decrease.

Homeward DC 2.0 builds on this progress, with a strong focus on realizing similar progress with unaccompanied adult homelessness. Homeward DC 2.0 is the result of a highly collaborative process led by the District of Columbia Interagency Council on Homelessness (ICH), the Community Partnership for the Prevention of Homelessness (TCP), and the ICH's Strategic Planning Committee, including persons with lived experiences of homelessness. The plan presents data collected through the District's Homelessness Management Information System (HMIS) and is supplemented by data from other agencies and systems that play a direct or indirect role in the District's response to homelessness and housing insecurity.

District of Columbia Point-in-Time Count of People Experiencing Homelessness is conducted by the Community Partnership for the Prevention of Homelessness (TCP), a requirement for all jurisdictions receiving federal homeless assistance funding on behalf of the District of Columbia since 2001. This year's count took place on January 25, 2023 and shows an estimated 4,922 people experiencing homelessness.

After several consecutive years of declining PIT counts, the 2023 count data showed an overall 11.6% increase from 2022. This includes a 10.2% increase among unaccompanied individuals and a 12.1% increase among families.

Despite the increase, the 2023 count is lower than the count recorded in 2020 which was the last PIT count held prior to the COVID-19 public health emergency (PHE). **Overall homelessness has**

decreased nearly 23% since prior to the PHE and family homelessness decreased nearly 50%, showing that the District has emerged from the public health emergency with fewer people experiencing homelessness than going into the public health emergency.

The SAMHSA Projects for Assistance in Transition from Homelessness (PATH) grant funds services for adults with SMI experiencing homelessness. DBH administers the grant and funds are utilized to support DBH's Homeless Outreach Program (HOP) and the Housing Subsidy Program.

The HOP conducts street outreach and case finding of consumers who reside in locations unfit for human habitation (e.g., streets, abandoned properties, vehicles); in low barrier shelters; in transitional housing programs; and other temporary living arrangements. HOP provides crisis services, case management, transportation, and services to link individuals to appropriate mental health and substance use treatment.

The HOP will also provide assistance in housing consumers by providing three individuals who are experiencing homelessness with first month's rent and/or a security deposit.

The HOP intends to serve at minimum 450 adult consumers who are literally homeless during the year. The HOP anticipates enrolling 70% of these literally homeless adult consumers (315) during the award year. Services include outreach, case finding, interim case management, assistance in obtaining benefits, SOAR (SSI/SSDI Outreach, Access, and Recovery**)** connection, linkage to comprehensive mental health services and substance use services as well as transportation to initial mental health, medical, or substance use appointments.

Management Systems

A priority topic for SAMHSA is **increasing access to treatment for SMI and SUD using telehealth modalities**. Telehealth is the use of telecommunication technologies and electronic information to provide care and facilitate client- provider interactions.

Currently, DBH is in the process of implementing a Telehealth pilot to distribute smart phones and devices to our most vulnerable and clinically at-risk consumers. This initiative, initially scheduled to be launched last year, was delayed as we explored and resolved legal concerns to ensure compliance with Federal anti-kickback laws. We are now at the point of distributing 300 smart phones to selected consumers to ensure they are connected to a provider and fully engaged in care. We will be tracking the impact of this initiative regarding clinical results and other outcome metrics of those individuals participating in this initiative and make future operational adjustments as necessary.

In addition, the DBH has **developed the Integrated Technology Engine** (ITE). The ITE is a technology solution aligned with DBH's business process that **will consolidate accurate and timely health data**, enabling DBH managers and staff to make **informed data-driven decisions**

supporting the District of Columbia's vision of population health and whole-person care.

The ITE, driven by DBH's operational needs and strategic goals, will integrate and host behavioral health related data from multiple systems, providing DBH staff with a user-friendly and secure platform that will promote data validation, data democratization and ownership, utilization of meaningful data, and predictive analytics. The ITE is a data hub that will ingest source data from DBH electronic health records and databases (grants management and certification), DBH certified provider electronic health records (EHRs), DHCF claims data and MCO encounters, the District's eligibility data and will integrate with CRISP DC.

Information from DBH certified providers EHRs will be transmitted to the DBH ITE through a secure provider gateway. DBH has developed at standard provider data extract called the Behavioral Health Supplemental Data (BHSD) set of 86 data elements which augments provider data from other sources to ensure DBH can meet federal reporting requirements and to drive data informed decisions. The BHSD is supported by a comprehensive BHSD Companion Guide which details needed information to submit the extract. The BHSD Companion Guide and subsequently the file extract will be updated annually so that DBH can have the required data to support reporting needs.

Overview of Substance Use Disorder Services

Statewide Plan for Substance Use Primary Prevention, Treatment, and Recovery Services for Individuals, Families and Communities

DBH is targeting support to providers of substance use disorder services with extensive training and technical assistance on person centered care and treatment planning, using nationally recognized medical necessity criteria. DBH worked with the Department of Health Care Finance to provide additional funds to help offset revenue lost during the pandemic.

DBH is on course to open the **new Sobering and Stabilization Center** in late 2023 to support individuals under the influence of alcohol or drugs who require stabilization services and support but do not need to be transported to a hospital emergency department. The District believes the new Sobering Center **will be a low barrier, stepping-stone to ongoing treatment and sustained recovery**. A second Center is planned for development in FY 2024.

The Assessment and Referral Center (ARC), under the Adult Services Administration, provides same day substance use assessments and referral services for adults (21 years and older), seeking publicly funded treatment for substance use disorders and other services. The ARC is a walk-in based facility which conducts treatment assessments, pregnancy screening, **tuberculosis (TB) screening and testing**, **HIV counseling**, **testing and linkage to treatment**. ARC registered nurses and clinicians conduct medical and treatment placement assessments to determine the most appropriate level of care for individuals seeking treatment.

Also, DBH utilizes a mobile van that provides behavioral health outreach and engagement services. The mobile van visit's multiple locations around the District of Columbia, targeting areas with identified increased rates of fatal and non-fatal overdoses, as well as substance use.

The mobile unit is in the process of hiring a registered nurse and a social worker who will have the ability to provide same day assessments and referrals to substance use treatment. **Testing for TB, HIV** and pregnancy will be offered as part of the overall assessment process. To provide greater access to care, the MARC van will also assess for and prescribe buprenorphine.

Primary Prevention

The Substance Use Disorder Prevention, Intervention & Treatment 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**.

We continue to use its Drug Free Youth DC (**www.drugfreeyouthdc.com**) website as the primary method for disseminating information throughout the District of Columbia and beyond in addition to the DBH Prevention Centers. Included within the site is information on the District's laws as it pertains to substances such as the legalization of marijuana for recreational use and the increase in the age to legally purchase tobacco products from 18 to 21. The website also provides links to all of the District's social marketing strategies aimed at preventing substance use. These social marketing strategies focus on underage drinking, opioid misuse for youth and adults, synthetic drug use for youth and adults, and marijuana use.

During FY 2023, the SUD Prevention Team used discretionary funding to support the redevelopment of social marketing strategies. These newly revised strategies will be housed on the Drug Free Youth DC websites and will be available during information dissemination activities. The DBH Community Engagement Team Manager will continue to serve as the lead for information dissemination along with a team of other individuals supported by the Substance Use Block Grant.

Pregnant Women and Women with Dependent Children

Pregnant Women and Women with Dependent Children have priority access to SUD treatment and are given preference in admission to treatment facilities. In the event the treatment facility requested is at capacity and cannot accept an admission, the assessment center will refer the woman to another program that has the capacity. If no such facility can admit the woman, the assessing provider will make interim services available no later than forty-eight (48) hours after the woman seeks treatment.

DBH has one certified provider specializing in **pregnant and parenting women with children in treatment**. Samaritan Inns' Clark Inn provides 12 beds for women and 16 beds for children as a residential treatment program for women and children. Samarian Inns' Lazarus House is certified

to provide Level 3.1 clinically managed medium-intensity residential, and Mozart Inns is certified to provide Level 3.5, clinically managed high-intensity residential and medication management substance use disorder treatment services to adults.

To ensure the families stay together during the SUD treatment process, Samaritan Inns provides continuity of care with Elisha House, a certified Recovery Support program to include spiritual support services and environmental stability. An array of childcare and support services for women's children are included in the duration of SUD treatment services.

Persons Who Inject Drugs

In 2022, DBH assumed efforts that focus on stopping the spread of HIV/AIDS, hepatitis, and connecting individuals to the health services they need. DBH supports comprehensive harm reduction programs for **persons who inject drugs** (PWID).

Specifically, this includes:

- Syringe services programs (SSPs) that work to **reduce the numbers of PWID who are infected with HIV** in the District.
- Helping to increase the number of District residents who know their HIV and Hepatitis C status.
- Ensuring individuals with **HIV and Hepatitis C have access to care and treatment**.

In calendar year 2022, the four SSPs continued to engage in syringe exchange activities in all eight wards of Washington, DC. In addition to those services, they continued the robust naloxone education and use schema as well as curated services such as the women's wellness initiatives that target women who are experiencing homelessness. They regularly assess the community's concerns by holding routine listening sessions called Community Conversations. Three providers operate mobile units, which help to expand the reach throughout the entire District. Two of the SSPs are operating harm reduction vending machines, which are primarily being managed through a grant by DC Health. There are currently seven operational vending machines that are located in overdose hotspots throughout the District and provide naloxone, fentanyl test strips, safer drug use supplies, condoms and PPE.

Tuberculosis Services

All DBH certified providers including the DBH Assessment and Referral Center (ARC) are required to complete the assessment and referral process for those seeking substance use treatment. As part of the assessment process, **all consumers are screened for tuberculosis** and based on the screening are tested or referred for chest x-rays.

Those consumers that do test positive for TB exposure are linked to either DC Health for further testing and treatment or a local community based medical provider. All consumers seeking residential treatment or withdrawal management are required to be tested for tuberculosis prior to

referral.

Early Intervention Services Regarding HIV

All consumers seeking **SUD treatment at the ARC** or a **certified SUD provider are offered HIV testing as part of the assessment process**. The ARC employs three staff that are trained to provide early intervention HIV services for consumers seeking treatment.

At a minimum all consumers receive HIV education to ensure they are aware of how HIV is transmitted, possible risk factors and options for testing. If the consumer opts for testing, pre and posttest counseling is provided as well as linkage to HIV treatment if they test positive. Staff follow the DC Health protocol for red carpet service for those that test positive.

Group Homes for Persons in Recovery from SUD

In 2023, DBH began providing the low barrier recovery housing to persons or in recovery from opioid use disorder (OUD) and stimulant use disorder (STUD). This housing operates in compliance with Level III/IV National Alliance for Recovery Residences (NARR) standards. In these recovery residences, intensive case management is provided to residents along with access to treatment and other recovery support services. Residents are also supported through restorative policies that allow for residents who have returned to using substances to be held accountable for their actions while not only responding by enforcing punitive actions such as eviction or discharge.

Referrals to Treatment

In 2021, DBH the implementation of a medical necessity protocol in conjunction with DHCF to ensure that individuals seeking residential treatment were assessed appropriately. To that end, DBH trained our four residential providers on the use of the ASAM Continuum assessment tool. Additionally, to support the determination of an initial level of care, all SUD providers were trained to utilize the ASAM Co-Triage assessment tool.

In 2023, DBH officially mandated that all certified SUD providers utilize the ASAM Co-Triage and Continuum assessment tools. DBH will provide ongoing training on the implementation and use of the tools as well as training on the ASAM criteria to ensure all providers are versed in the criteria and how to utilize the tools.

Independent Peer Review

DBH has begun the process of developing an independent peer review process. Initially, DBH will review all SUD providers to determine their true level of functioning and programmatic need. Based on this assessment, providers shall be paired to review each other's programs and provide feedback in a written and verbal format.

We are awaiting our Quality Assessment Review (QAR) final report and look forward to working with SAMHSA to ensure proper implementation of the peer review requirement.

Professional Development

In FY 23, the District funded training for current youth SUD providers for Motivational Enhancement Treatment Cognitive Behavioral Therapy (MET-CBT). This initial training equipped staff with techniques and strategies to implement individual and group sessions for youth with SUD.

In FY 24, the District is slated to fund training for the youth SUD providers in the Adolescent Community Reinforcement Approach (A-CRA) to ensure that there are a variety of tools to meet the diverse needs of youth seeking SUD treatment.

Each of the aforementioned trainings include an administrative track for DBH staff to also be trained in order to provide oversight and to support the implementation of evidence-based practices by the youth SUD treatment providers.

Current Organization of Mental Health/Substance Use Disorder System

The Department of Behavioral Health (DBH) plans and develops:

- Mental Health and Substance Use Disorder services;
- Certifies all providers of behavioral health services;
- Ensures timely access to services;
- Monitors the service system;
- Provides on-going technical assistance and training in evidence-based, evidence-informed and best practices to support the delivery of quality care;
- Supports service providers by operating the DBH Fee for Service (FFS) system;
- Provides grant or contract funding for services not covered through the FFS system;
- Regulates the providers within the District's public behavioral health system; and
- Identifies the appropriate number and mix of programs, services, and supports necessary to meet the behavioral health needs of District residents.

The Behavioral Health Authority serves as the State Mental Health Administration (SMHA) and Single State Authority (SSA) for substance use disorders for the District of Columbia. DBH is led by the director, Barbara J. Bazron, Ph.D. who with the executive leadership team oversees approx. 1,250 employees.

The **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 approached to enhance access to services that support recovery and resilience. Included in the Office of the Director are the chief of staff, legislative affairs, human resources, communications, office of the Ombudsman, public engagement and outreach and consumer and family affairs.

The **General Counsel's Office** provides legal advice to the Director on all aspects of DBH operations and activities; drafts, research, and reviews legislation, regulations, and policies that affect the DBH mission and programs; and formulates strategic advice on DBH program development, compliance, and oversight activities.

The Chief Operating Officer leads the **Agency Operations Administration** by providing operational support to DBH programmatic and administrative areas. This Administration is responsible for the business services, including budget and financial management; information technology, claims and billing operations, grants management, including the MH & SUD BG Program; facilities management, records management; and general administrative support.

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.

Crisis Services was created to support the reorganization and expansion of crisis prevention and alternative response options to improve clinical outcomes for individuals experiencing behavioral health crises. Operated directly by DBH employees, responsibilities include Access Helpline, mobile crisis and the Community Response Team (CRT), the Comprehensive Psychiatric Emergency Program (CPEP) and disaster behavioral health and support collaboration.

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. Licensed by DC Health, the District's Department of Health, the hospital meets all conditions of participation promulgated by the federal Centers for Medicare and Medicaid Services.

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

The **Policy, Planning, & Evaluation Administration** coordinates DBH's strategy development and performance improvement processes to help advance the mission: to develop, manage and oversee a public behavioral health system for adults, children and youth, and their families that is consumer-driven, community-based, culturally competent and supports prevention, resiliency, and recovery and the overall well-being of the District of Columbia.

The **Adult and Children's Services Administrations** develop, implement, and monitor a comprehensive array of prevention, early intervention, and community-based behavioral health services and supports for adults, children, youth, and their families that are culturally and

linguistically competent and support resiliency and recovery. The components are described below.

The **Adult and Transition-Aged Youth Services Administration** supervise the operation of clinical programs and set standards for the provision of clinical care throughout the public behavioral health system. This includes all services as overseen by DBH as the Health Care Authority (HCA) for the Managed Care Organization (MCO) contract: directly provided assessment, referral, and clinical services; forensic services; the comprehensive emergency psychiatric program; and the disaster behavioral health program.

The **Child, Adolescent & Family Services Administration** offers a range of treatment and support services for children, youth and their families, including specialized evidence-based practices for youth and families recovering from trauma, emergency care and ongoing treatment primarily through certified, community-based mental health providers. Within the CAFS Division, is early childhood services and supports, evidence-based practices, school-based behavioral health, linkage and assessment, crisis services, and youth SUD prevention, treatment, and recovery services.

Under the strategic direction of Deputy Mayor for Health and Human Services, DBH partners with agencies within the **Health and Human Services cluster (Department on Aging and Community Living, Child and Family Services, Department of Disability Services, Department of Health, Department of Health Care Finance, and Department of Human Services)** and throughout government to integrate information and access to behavioral health care and normalize behavioral health treatment as essential to daily living as housing or a job.

Child and youth and adult behavioral health service partners include but not limited to, **Office of the State and Superintendent of Education, D.C. Public Schools**, **D.C. Public Charter Schools**, **Child and Family Services Agency**, **Department of Youth Rehabilitation Services**, **D.C. Superior Court Juvenile Division**, **Court Social Services, the Metropolitan Police Department, Office of Unified Communications (District-wide 311 and 911 all center), DC Department of Fire & Emergency Services, Department of Employment Services, Office of the Deputy Mayor for Planning and Economic Development, Office of the Attorney General, D.C. Interagency Council on Homelessness, D.C. Housing Authority, D.C. Medicaid MCOs, Department of Corrections, Criminal Justice Coordinating Council, Department of Forensic Sciences, Office of the Chief Medical Examiner, All D.C. acute care hospitals and EDs for psychiatric and medical surgical admissions, the (number) providers in the network of care for both substance use and mental health conditions, and the free standing and Federally Qualified Health Centers (FQHC) provider networks.**

Addressing the Needs of Diverse and Minority Populations and Priority Populations

DBH is a recipient of the SAMHSA Community Program for Outreach and Intervention with Youth

and Young Adults at Clinical Risk for Psychosis (CHR-P) grant award. There is an additional focus on closing the gap/disparity for the LGBTQ who in 2016, the National Institute on Minority Health and Health Disparities identified the LGBTQ+ community as a health disparity population.

For **LGBTQ TAY**, the preventable gaps in physical and mental health stem from continued social stigma, discrimination, and denial of civil and human rights based on sexual orientation and gender identity.

In 2020, LGBTQ young adults aged 18 to 25represented the highest percentage of those with SMI, followed by adults aged 26-49, then by adults aged 50 or older. Of the individuals reporting SMI, about one-third have not received mental health treatment of any kind in 2020.

Further data by the 2022 Trevor Project survey[13] of 34,000 LGBTQ youth garnered new LGBTQ youth mental statistics. Here is a summary of the findings.

- 50 percent of LGBTQ teens seriously considered suicide during the past year.
- 18 percent made a suicide attempt—twice the average rate of teen suicide attempts in the United States.
- 75 percent of LGBTQ teens experienced symptoms of anxiety in the past year.
- 61 percent experienced symptoms of depression.
- 82 percent of LGBTQ youth wanted mental healthcare in the past year, but 60 percent of those youth were unable to access care.

Lastly, statistics from the Substance Abuse and Mental Health Services Administration (SAMHSA) and the CDC's Youth Risk Behavior Surveillance Survey show that LGBTQ teens have a higher risk of substance abuse than their peers. LGBTQ high school students abuse alcohol at 25 percent higher rates than peers. They are also significantly more likely to report recent alcohol and marijuana use. In addition, LGBTQ teens report using cocaine, ecstasy, meth, and heroin at triple the rates of their peers.

DBH partners with Supporting and Mentoring Youth Advocates and Leaders (SMYAL) to provide **resources and support to LGBTQ youth**. Services include case management (development of personal action plan, weekly check-in meetings, and crisis navigation), supportive services (medical and mental health services, and self –care support), skill development (education, job readiness, and life skills), social support (community outings and access to LGBTQ youth networking), and after care (open line of post program communication between the youth and their case manager for up to 12 months).

The **988 Lifeline** initiated a pilot program in the autumn of 2022 to provide **LGBTQI+** adolescents and young adults with specialized phone, text, and chat support services. People under the age of 25 who contact the 988 Lifeline and desire the option of connecting with a counselor who is

[13] 2022 Trevor Projects survey, https://www.thetrevorproject.org/survey-2022/

especially focused on addressing the needs of LGBTQI+ kids and young adults. Calling, texting, or chatting with a crisis counselor who is trained to assist LGBTQI+ clients and is accessible around the clock is one way to access the specialized services that are now available.

Every episode of victimization in the course of an LGBTQ+ person more than doubles the chance of self-harming behavior, and more than 80% of LGBTQ+ youth have been attacked or threatened at some point in their lives.

Additionally, the **deaf community** has been left out of the conversation on **mental health crisis services**. Understanding how to support this community is essential. AHL call takers get training on how to deal with deaf and hard of hearing who are at a greater risk of suicide utilizing a variety of approaches. AHL are supporting an endeavor to bridge the mental gap with the deaf population by participating in training.

AHL will use a public health approach, to enhance and expand current deaf suicide prevention efforts facilitated by AHL, significant clinical supports and community base outreach and education to internal and external stakeholders.

The CBI-CB model expands capacity to engage in community-based suicide prevention efforts. AHL and internal stakeholders will collaborate in the community to implement CBI-SP through facilitation of community coalitions and local universities such as Gallaudet in the District of Columbia. AHL collaboratively works with key internal and stakeholders to develop, facilitate, and strengthen CBI-CB at community, state, and local levels to advertise 988 to the deaf community.

The Healthy Futures program staff includes five **Spanish bi-lingual** early childhood clinical specialists that serve 22 Spanish speaking early childhood development centers.

Two members of the Healthy Futures leadership team attended the **national Equity in Early Childhood Mental Health Consultation series** presented by Georgetown University. In addition to this series and the Health Futures program's two-year training and consultation on **Equity in Early Childhood** with national leader Lisa Gordon, the Healthy Futures leadership team along with input from clinical staff is creating a **plan to integrate equity trainings for early childhood development center** staff and families to increase awareness of **equity and implicit bias** issues that impact early childhood mental health.

Healthy Futures provides early childhood mental health consultation to child development centers and home providers that accept subsidy and currently serve 107 centers and homes throughout the District. Among the centers that are served include a domestic violence center and centers that include a neurodiverse population.

FQHCs are community-based, and patient directed primary care centers that serve individuals with limited access to healthcare, including **low-income individuals**, the **uninsured and**

underinsured, **immigrants**, those who are **homeless**, and those who live in **public housing**.

FQHCs deliver behavioral health services to their patients to include Community of Hope, which services populations to include homeless, La Clinica Del Pueblo, which serves the **Latino and immigrant populations**, and Mary's Center which is also a DBH-certified Mental Health Rehabilitation Services (MHRS) provider which also serves the Latino and immigrant populations.

The DBH Access Helpline (AHL) has collaborated with the Veteran's Administration (VA) to develop training for local crisis line operators in the management of **Veteran-specific crises calls and education on VA services**. Additionally, AHL has reached out to DC VAMC Suicide Prevention, which offers community-based trainings on the following topics: Understand the Suicide Phenomenon, gain an understanding of the Epidemiology of Suicide Prevention, Identify the Crisis Warning Signs of a Veteran, Understand the Importance of Reviewing the Clinical Record and Veterans in Crisis Management.

The Veterans Crisis Line was also established concurrently with the 2007 Suicide Prevention Act. AHL's training focus is identifying service members, veterans, and their families, promoting connections and enhancing care transitions, and increasing lethal means safety and safety planning are the focus areas. AHL's CoP mission, goal, and task comprehensively aligns with Zero Infrastructure recommendations.

Strengths and Needs of Current System

Strengths

DBH provides a **comprehensive range of treatment and support services for children, youth and their families** including **specialized evidence-based practices** for youth and families recovering from trauma, emergency care and ongoing treatment primarily through certified, community based mental health providers.

In addition, community-based providers are certified to **provide substance use disorder treatment**. The Department also operates a children's clinic, provides services in public and public charter schools, and manages an **alcohol, tobacco and drug prevention and awareness campaign** called DrugFreeYouthDC.

In partnership with the Office of the State Superintendent of Education, DC Public Schools, and DC Public Charter Schools, the Department continues to **expand behavioral health services in public and charter schools** in the District to include prevention, early intervention, and treatment services with the goal to have a school-based clinician at each public and charter school in the District. In school year 22-23, the total landscape is 253 schools.

As a part of the LIVE. LONG. DC., the District's Strategic Plan to Reduce Opioid Use, Misuse, and Related Deaths (LLDC), the District's goal is to **implement naloxone training into each school** as one of the harm reduction strategies. Naloxone is now available in all DC Public Schools and 67%

of Public Charter Schools. In addition, we are establishing partnerships with private schools.

LLDC provides a blueprint for the opioid work and has multiple stakeholders, both public and private, who work together in Opioid Strategy Groups (OSGs) to implement the plan. The OSGs have developed a revised plan (LLDC 3.0) that includes: 1) a greater focus on saving lives from opioid overdoses by increasing harm reduction activities; 2) developing the peer workforce and a stronger integration of peers with lived experience within organizations, which has proven to be effective in encouraging individuals to get into and stay in treatment; 3) better coordination of treatment and supports to sustain recovery tailored to individual needs, including better coordination of treatment with the criminal justice system; and, 4) engagement with vulnerable populations including pregnant and parenting individuals, youth and young adults, and residents of skilled nursing facilities. LLDC 3.0 continues to emphasize a targeted approach at the community level using data to address the needs at hotspots, which includes the deployment of a mobile unit to meet individuals where they live. LLDC 3.0 consists of six Opioid Strategy Groups (OSGs), each with subsequent strategies related to that area of focus, with a total of 38 strategies.

LLDC will continue to:

- Educate District residents and stakeholders on opioid use disorder, its risks, and prevention and harm reduction approaches through coordinated community efforts;
- Support the awareness and availability of, and access to, harm reduction services in the District of Columbia;
- Ensure knowledge of, and equitable access to, high-quality, trauma-informed, recovery-oriented, equity-based SUD treatment;
- Expand reach and impact of the highest quality recovery support services available and promote a recovery-oriented system of care;
- Implement a shared vision between justice and public health agencies to address the needs of individuals who come in contact with the criminal justice system.
- Strengthen the District's opioid response by cultivating a skilled workforce, advancing professional development opportunities, and implementing strategic communication methodologies to drive meaningful change.

DBH is on course to open the **new Sobering and Stabilization Center** to support individuals under the influence of alcohol or drugs who require stabilization services and support but may not need to be the intervention of the hospital emergency room. The goal is to be a l**ow barrier, stepping-stone to ongoing treatment and sustained recovery**.

We offer a **comprehensive array of crisis services** to include someone to talk to (Access Helpline (AHL)), someone to respond (Community Response Team (CRT)), and a place to go (the Comprehensive Psychiatric Emergency Program (CPEP)). As a part of the District's crisis redesign, the Access Helpline has implemented the national 988 dial code for the National Suicide Prevention Lifeline; in collaboration with the District's Office of Unified Communication's (OUC) 911 call center, AHL is currently working to ensure that behavioral health calls received by law

enforcement, but are appropriate for diversion, are transferred from OUC to AHL. In addition, to support the full implementation of the 911 Behavioral Health Call Diversion, DBH has been funded to add an additional 41 staff positions, including 14 new AHL call center staff and 27 new CRT staff.

Furthermore, our Children and Adolescent Mobile Psychiatric Service (ChAMPS) provides **on-site immediate help to children facing a behavioral or mental health crisis** whether in the home, school or community. Services are geared toward children and youth 6-21 years of age. The goal is to stabilize them and avert inpatient hospitalization or placement disruptions in the case of foster children. The mobile crisis teams also make follow up visits and connect family to needed support services.

DBH has a **robust array of outreach and engagement services** through the Office of the Director's Community Engagement team which conducts outreach to the behavioral health community, District residents, and behavioral health providers in the District. In addition, the Community Response Team engages with individuals not connected to care, but not actively engaged with services due to other providers.

In addition, the **youth SUD prevention team** participates in community and health events, gives presentations to organizations and agencies, and responds to requests for training and technical assistance.

DBH has **expanded access to SUD services** through the update of regulations to require **all certified SUD treatment providers to provide assessment and referral services**. Providers must be able to assess and determine the most appropriate treatment level of care based on American Society of Addiction Medicine (ASAM) criteria and refer the consumers upon completion. This change in regulation has decentralized the assessment and referral process from the DBH Assessment & Referral Center (ARC) being the only point of entry to establishing multiple points of entry in the District of Columbia.

We have a **comprehensive array of access points for urgent care** to include our two Urgent Care Clinic located at Howard Road and 35 K Street. Our Howard Road location **services children and young adults ages 4-21 with complex emotional, behavioral, and mental health challenges**. Our 35K location offers **psychiatric assessment, evaluation, counseling, and medication management to adults**. These two locations function as psychiatric safety-net services for those consumers that either cannot access their psychiatrist in a timely manner or need emergency same-day psychiatric services.

Also, the 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.

Court Urgent Care Clinic (D.C. Superior Court) **identifies and provides immediate services to persons in need of mental health and/or substance abuse assistance who become involved with the Court** as a result of criminal, civil, probate, and/or family proceedings and to **connect them to appropriate mental health**, **substance abuse**, and housing services. Anyone who is directly or indirectly involved with the court, adults/juveniles, housed/unhoused, those with matters before the criminal, civil, family, probate courts, are eligible to receive services.

Based on many years of program operation, the principal recipients in need of this service are adults who walk-in for assessment and short-term care, as well as a small number of juveniles who are court-ordered for emergency evaluation. The ultimate objective is to support D.C. residents who are court involved, minimize recidivism within the criminal justice system, augment justice diversion programs, and triage the behavioral health needs of the consumers served there so they will be connected to appropriate long-term care.

Year	Initial Clinical Services	Subsequent Clinical Services
2022	205	1288
2023 (6 mos.)	101	612

In FY 23 DBH added **Intensive Care Coordination Teams** (ICC) to the Integrated Care Division. These teams are in-person and telephonic engagement teams that work with **consumers who are not enrolled with a DBH mental health or substance use service delivery provider**. The goal is to connect consumers to care within 30 days of the referral. Referrals can come from community stakeholders, family members, other D.C. agencies like the Executive Office of the Mayor, or internally from other DBH departments like the community response teams. Consumers can continue with the Intensive Care Coordination Team past 30 days until they select and begin care with a provider, or until they decide they no longer want the services of the ICC team.

DBH partners and collaborates with sister district agencies via a MOU/MOA to coordinate and provide behavioral health services and resources to better serve district residents who are **impacted by unaddressed behavioral health concerns**.

This collaboration includes the **co-location of mental health clinicians** at designated agencies and/or in the community to assure individuals have access to a full continuum of quality behavioral health services and support. These partnerships promote a No Wrong Door approach to accessing behavioral health services in the District.

Needs

There continues to be a **gap in substance use treatment and recovery services for youth**. One of the District's FQHCs, as well as Children's National Hospital, report that they are seeing an increase in youth experiencing substance use challenges, especially youth of Hispanic descent who are relatively new to the country and are addicted to fentanyl.

DBH currently has two certified youth SUD treatment providers. These two providers provide outpatient treatment services for youth up to age 21. However, the District has not been able to establish higher levels of care for substance use treatment. With the support of COVID Supplemental Block Grant funding as well as ARPA funding, the District is looking to **establish a residential substance use treatment program** in late 2023.

DBH currently has one First Episode Psychosis (FEP) Program that will discontinue programming and treatment services at the end of September 2023. FEP consumers will be transferred with wrap around supportive services and treatment. The District will be **seeking a new FEP provider** which is anticipated to be awarded in October 2023 with the support of MHBG and ARPA funding.

As the District is establishing and building a system of care to addressing early serious mental illness, the District through SAMHSA funding has recently awarded a provider to establish a Clinical High Risk for Psychosis (CHR-P) program for transition-age youth (TAY) or young adults aged 16–25-year-olds, who are at high clinical risk for their first episode of psychosis (FEP), but who have not yet fully experienced psychotic symptoms. The CHR-P Provider will have a stepped care approach, where treatments of differing intensity will be offered, and young adults will learn to manage stress, anxiety, and uncertainty associated with early signs of psychosis. The CHR-P provider will work in close partnership with the newly identified FEP Provider to provide ESMI treatment and supportive services for youth and young adults, ages 16-25, in the District.

The District has **one of the highest rates of opioid fatalities** when compared to States. Through the State Opioid Response (SOR) grant, we are focused on **increasing access to medication for opioid use disorder** (MOUD), **reducing unmet treatment needs**, and **reducing opioid and stimulant overdose-related deaths** in the District through the provision of prevention, treatment, and recovery support services (RSS) to individuals with opioid use disorder (OUD) and stimulant use disorder (STUD). The blueprint for this work is LLDC.

As noted above, we are in the process of revising the LLDC plan and within the plan, we have **outlined 38 strategies and their related activities that we need to implement to continue to fight the opioid crisis**. Some of those strategies are **increasing access to harm reduction tools** and **low-barrier recovery housing**, **facilitating collaboration amongst stakeholders**, and **training the workforce to be better equipped to meet the needs** of this vulnerable population.

We continue to experience workforce shortages. In general, behavioral health providers need additional training on ASAM, trauma-informed care, and addressing co-occurring issues.

The District **provides low barrier recovery housing to residents with OUD and STUD**. This housing operates in **compliance with Level III/IV National Alliance for Recovery Residences (NARR) standards**. In these recovery residences, intensive case management is provided to residents along with **access to treatment and other recovery support services**. Residents are also supported through restorative policies that allow for residents who have returned to using substances to be held accountable for their actions while not only responding by enforcing punitive actions such as eviction or discharge.

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 systems, 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, including for 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 data-driven processes. This could include data that is available through a number of different sources such as SAMHSA's National Survey on Drug Use and Health (NSDUH), Treatment Episode Data Set (TEDS), National Survey of Substance Use Disorder Treatment Services (N-SSATS), the Behavioral Health Barometer, **Behavioral Risk Factor Surveillance System (BRFSS)**, **Youth Risk Behavior Surveillance System (YRBSS)**, the **Uniform Reporting System** (URS), and state data. Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States with current Partnership for Success discretionary grants are required to have an active SEOW.

This narrative must include a discussion of the unmet service needs and critical gaps in the current system regarding the MHBG and SUPTRS BG priority populations, as well as a discussion of the unmet service needs and critical gaps in the current system for underserved communities, as defined under **EO 13985**. States are encouraged to refer to the **IOM reports**, *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement* and ***The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding***[1] in developing this narrative.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

FY 2024-2025

COMBINED BEHAVIORAL HEALTH ASSESSMENT AND PLAN

Community Mental Health and
Substance Use Prevention, Treatment, and
Recovery Services Block Grant
(MH & SUPTRS BG)

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

District of Columbia
Department of Behavioral Health

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

Unmet Service Needs and Critical Gaps

Mental Health Services

There continues to be a gap in mental health services for **children with SED and their families**. Community-based Intervention (CBI) services are time-limited, intensive, mental health services and is the highest level of care for children with SED prior to Psychiatric Residential Treatment Facility (PRTF) placement. Once youth have met maximum benefit of CBI, youth are transitioned to a PRTF. In FY 23, the District received an increased number of reports for youth being admitted to inpatient hospitals who do not meet criteria for PRTF and have met maximum benefit for CBI. There is a need for intensive outpatient, day treatment and partial hospitalization programs to stabilize youth and transition them back into the community.

The Assessment Center needs a psychologist who specializes in sexual offenses and another psychiatrist to meet the increasing demands of the juvenile justice involved youth requiring psychiatric evaluations. A bilingual person to fill these two positions is preferred but not required. Under court mandate, DBH has been identified as the entity under the Family Court to provide court ordered evaluations. For the past three years, the court, the child welfare system and the juvenile justice system has requested and sought a psychologist that specializes in sexual offender behaviors.

Currently, the Assessment Center has two psychiatrists to conduct psychiatric evaluations for children, youth and adults involved in the child welfare and juvenile justice system. For the past two years, there has been an increase in court order psychiatric evaluations for youth involved in the juvenile justice system. We presently have a 12% increase from this time last year. With the current increase in juvenile involved crimes, this need will continue to grow. Despite having two psychiatrists, one doctor who is bilingual and has limited availability and the other has exhausted funds to continue evaluations for the remainder of the year. This limitation impacts the timeliness of reports before the next court date which can delay recommendations and conditions of court on community release and detainment. This is another critical gap regarding the availability of services for **children with SED and their families**.

Substance Use Disorder Services

There are critical gaps within the system of care for youth SUD services. This critical gap does impact **adolescents with a substance use disorder or a substance use disorder with a co-occurring mental health problem**. The District currently has two youth SUD providers providing outpatient services. The District of Columbia Youth Risk Behavior Survey (YRBS) 2019 data reported that on a national level 22% of youth used marijuana in the last 30 days. In the District, 29% of youth reported using marijuana in the last 30 days, which is higher than the national average.

Additional providers are needed to implement **comprehensive community-based services for youth with SUD**. When youth meet criteria for a higher level of care, youth are sent to residential treatment facilities outside of the District of Columbia. To enhance the local level of care, youth residential and SUD Withdrawal Management for adolescents is needed. This is underscored by Children's Hospital and youth providers reiterating the District of Columbia does not possess robust treatment services for youth.

In the last six years, the District has seen a **32% decrease in the number of adults receiving residential substance use treatment services**. In 2017, the District had seven providers; in 2023 that number has decreased to four providers. This decrease in provider has caused a decrease in access to treatment to the highest level of community-based care for substance use.

Behavioral Health Workforce

As previously mentioned, DBH is addressing the same challenges facing our country today when it comes to **strengthening the behavioral health system and addressing workforce shortages**. DBH continues to have challenges in hiring and retaining nearly 300 licensed social workers.

The District of Columbia has made significant investments in increasing access to high quality behavioral health supports in public schools across the city. The expansion of those services has leveraged a complex and dynamic public-private partnership, requiring coordination across numerous government agencies and community-based organizations (CBOs).

The current workforce shortage has continued to result in a challenge in hiring and retaining school behavioral health providers. Over the past school year, there was a DBH or CBO provider in approximately 63 percent of our public schools. And, in this continued time of recovery and restoration in our schools, DBH continues to innovate and implement strategies to increase the consistency and retention of school behavioral health providers in schools, all in the service of the important work of building a relationship of trust with the students and their families.

In FY 22, DBH awarded Assertive Community Treatment (ACT) and CBI providers funding to **support work force stabilization and development initiatives** to retain and recruit staff required to provide in-person care to adults with SMI and children, youth and their families with SED.

The National Council for Mental Wellbeing recently reported that 83% of the nation's behavioral health workforce believe that without public policy changes, provider organizations won't be able to meet the demand for mental health or substance use treatment and care. [1] The Department of Health and Human Services, Health Resources and Services Administration released Behavioral Health Workforce Projections, 2020-2035[2] in which the primary function is to assess the adequacy

[1] *New Study: Behavioral Health Workforce Shortage Will Negatively Impact Society*, April 25, 2023, National Council for Mental Wellbeing. https://www.thenationalcouncil.org/news/help-wanted/

[2] Department of Health and Human Services, Health Resources and Services Administration, Behavioral Health Workforce Projections 2020-2035, Fact Sheet, https://bhw.hrsa.gov/sites/default/files/bureau-health-

of the nation's projected workforce supply to meet the demand. There are shortages in 6 out of the 12 behavioral health professions reported, which included adult, child and adolescent psychiatrists, addiction counselors and mental health counselors. These professions are critical to behavioral health.

Additionally, the utilization of **peer specialists** is needed to **support the behavioral health workforce**. Peer specialists are self-identified people who are successful in the recovery process and who help others who are living with mental and/or substance use disorders. Through mutual respect and shared understanding based on similar experiences, peer specialists help people get into treatment and meet the challenges to sustain recovery.

The DBH Peer Specialist Certification Training Program builds on the experience of people in recovery with training in foundational competencies required by anyone who provides peer support in behavioral health services. DBH is currently exploring national certification for the training program, as well as including specialty professional (i.e., youth, forensic) and wellness tracks.

Integrated Technology Engine

In order to **maintain the necessary data to make informed data-driven decisions** supporting the District's vision of **population health and whole-person care**, DBH will need to support its certified providers to be able to pass the additional information through the BHSD. Certain system configuration costs are incurred with these updates as well as maintaining the ITE file and reporting structures.

Crisis Services

DBH recognizes the **importance of technology** as an essential component of a **reorganized crisis system**. A best practice crisis system receiving a great deal of national attention for their strong and critical role in call centers is Georgia's Behavioral Health Links. The software utilized "captures crisis call clinical information, quality management documentation, mobile crisis assessment data and to manage bidirectional, electronic referrals to outpatient services, mobile crisis teams, crisis stabilization units, and inpatient facilities, track the progress of referrals and availability of resources in real time, and provides interactive dashboards and complex reporting solutions designed to measure the efficiency and the effectiveness of the process."

This need is also emphasized in **SAMHSA's Crisis Now model**, which describes four core elements for transforming crisis services, the first being "High-Tech Crisis Call Centers." "These programs use technology for real-time coordination across a system of care and leverage big data for performance improvement and accountability across systems. At the same time, they provide high-touch support to individuals and families in crisis."

workforce/Behavioral-Health-Workforce-Projections-Factsheet.pdf

State Plans to Address Unmet Service Needs and Critical Gaps

Mental Health Services

To address the **gap in mental health services for children with SED and their families**, this District plans to continue to support the needs of current CBI providers through funding trainings, consultations, human resources, and technical assistance to meet the evolving needs of the youth with SED population. There are currently 5 providers within the CBI network. The District continues to keep the application process open for new providers to apply for certification to increase capacity to serve youth.

As part of the Behavioral Health Transformation and integration with Managed Care, DBH and DHCF have embarked on a **rate study to determine the need for an increase in rates** for behavioral health services in the District. In addition, DBH and DHCF have discussed service gaps and identifying rates for services to enhance the behavioral health system. DBH continues to work with DHCF to care in needed behavioral health services for youth that address critical gaps.

Substance Use Disorder Services

In FY23/FY24, the District plans to fund trainings for current youth SUD providers to include the GAIN-I assessment, Motivational Enhancement Treatment Cognitive Behavioral Therapy (MET-CBT), and Adolescent Community Reinforcement Approach (ACRA) to enhance the continuum of services for adolescents with SUD.

As a part of system redesign efforts and transition to managed care, a **comprehensive rate study** was conducted by DHCF's contractor, PCG. MET-CBT and ACRA were included in the rate study. Rates were developed that adequately reflected training costs, staffing, required technology, inflation, turnover, and other factors contributing to the implementation of the models.

DBH will continue to work with DHCF and providers to ensure rates are reflected in regulations, policies, and procedures. In addition, DBH is currently putting out a solicitation for a 3.5 SUD residential facility to support youth who need more intensive inpatient SUD services.

DBH continues to accept **certification applications for potential residential providers**. COVID-19 was difficult for many providers so to address this, DBH worked with the Department of Health Care Finance (DHCF) to provide supplemental funds to providers during this time. To continue to support providers, DBH and DHCF are currently engaged in a rate study that will increase reimbursement for services and supports that complement residential treatment (e.g., recovery support services, therapy, clinical care coordination, medication management). The goal is to have these new rates effective October 1, 2023.

Behavioral Health Workforce

The FY24 budget maintains funding to **support our workforce development initiatives** as well as participate in the new workforce development fund proposed by the Mayor to support our recruitment. This includes implementing a telehealth pilot to increase the availability of licensed staff to support school based behavioral health services. DBH is also exploring strategies to better

utilize the existing licensed staff by pairing them with trained mental health clinicians that can provide prevention services while they focus on the delivery of intervention and treatment services.

DBH reinstated Peer Specialist training in January 2023 and has held three classes and successfully certified 30 new peers. The program is working to provide more trainings, implement specialty professional and wellness tracts, and explore areas such as family support and training for peer supervisors. This will provide an increase in the number of peer specialists to supplement the workforce shortage.

We also anticipate hosting additional peer and recovery coach job fairs in the upcoming fiscal year. The initial job fair was a success allowing providers, peers and recovery coaches to network and provide on-the-spot job offers.

Integrated Technology Engine

DBH collaborated with the Department of Health Care Finance (DHCF) eHealth DC Technical Assistance (TA) Program to deliver customized and tailored TA to support DBH certified providers. The program provides incentive payments to providers satisfying defined milestones to supplement costs for implementation. Ongoing maintenance costs will need to be incurred by the Provider; however, DBH will need to facilitate training, produce behavioral health service guidance, provide resources and support for future system configuration changes for providers EHRs and DBH's ITE.

Crisis Services

DBH intends to allocate both local appropriations and block grant dollars to **enhance the integration of the call center** with our partners at the Office of Unified Communications (OUC) and the Metropolitan Police Department (MPD) and will also pursue additional technologies to move us toward the "Air Traffic Control" model described in the guidelines. Specifically, we will evaluate, procure and implement technology tools that will allow call-takers to track mobile teams and Co-Response teams in the field in real time in order to optimize the deployment of the full range of resources.

State Epidemiology Workgroup

DBH closed out the Strategic Prevention Framework Partnership for Success (SPF-PFS) grant in January 2020, therefore DBH is not required to have a State Epidemiological Outcomes Workgroup. The primary prevention efforts have continued by utilizing the DC Office of the State Superintendent for Education (OSSE) Youth Risk Behavior Survey (YRBS) results. Additionally, the four DC Prevention Centers funded by SUBG conduct Community Conversations, which is an evidence-based approach of sharing quantitative data in exchange for qualitative data.

DBH currently is working with a contractor for the completion of an epidemiological report to guide the continued development of the District's system of care for the behavioral health needs of children, youth, and their families. The report's insights will assist DBH in continued implementation of a comprehensive, proactive approach towards behavioral health - one that

prioritizes prevention and early identification of needs alongside robust community-based treatment and support. Drawing from the report's findings, the Department will work towards enhancing the accessibility of services to address behavioral and social determinants of health needs, ensuring that services are readily available to all families regardless of their socio-economic circumstances. Simultaneously, DBH will continue its efforts to improve provider cultural and linguistic competency, thus ensuring that services effectively respond to the diverse needs of the community. Informed by the report, DBH will continue to support various treatment and support services. These services are a range of treatments, including specialized evidence-based practices for families recovering from trauma, emergency care, ongoing therapy, diagnostic assessment, medication management, and family support. Moreover, recognizing the importance of substance use disorder treatment, DBH will continue to certify community-based providers to provide this service. The epidemiological report serves as a crucial roadmap for DBH and its partners, informing our actions, helping us to improve existing services, and guiding the development of new ones. Its findings will assist DBH in continuing to build a system of care that is comprehensive, community-based, and responsive to the multiple and changing needs of the District’s children, youth, and their families.

OSSE

District of Columbia

YOUTH RISK BEHAVIOR SURVEY

2019

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

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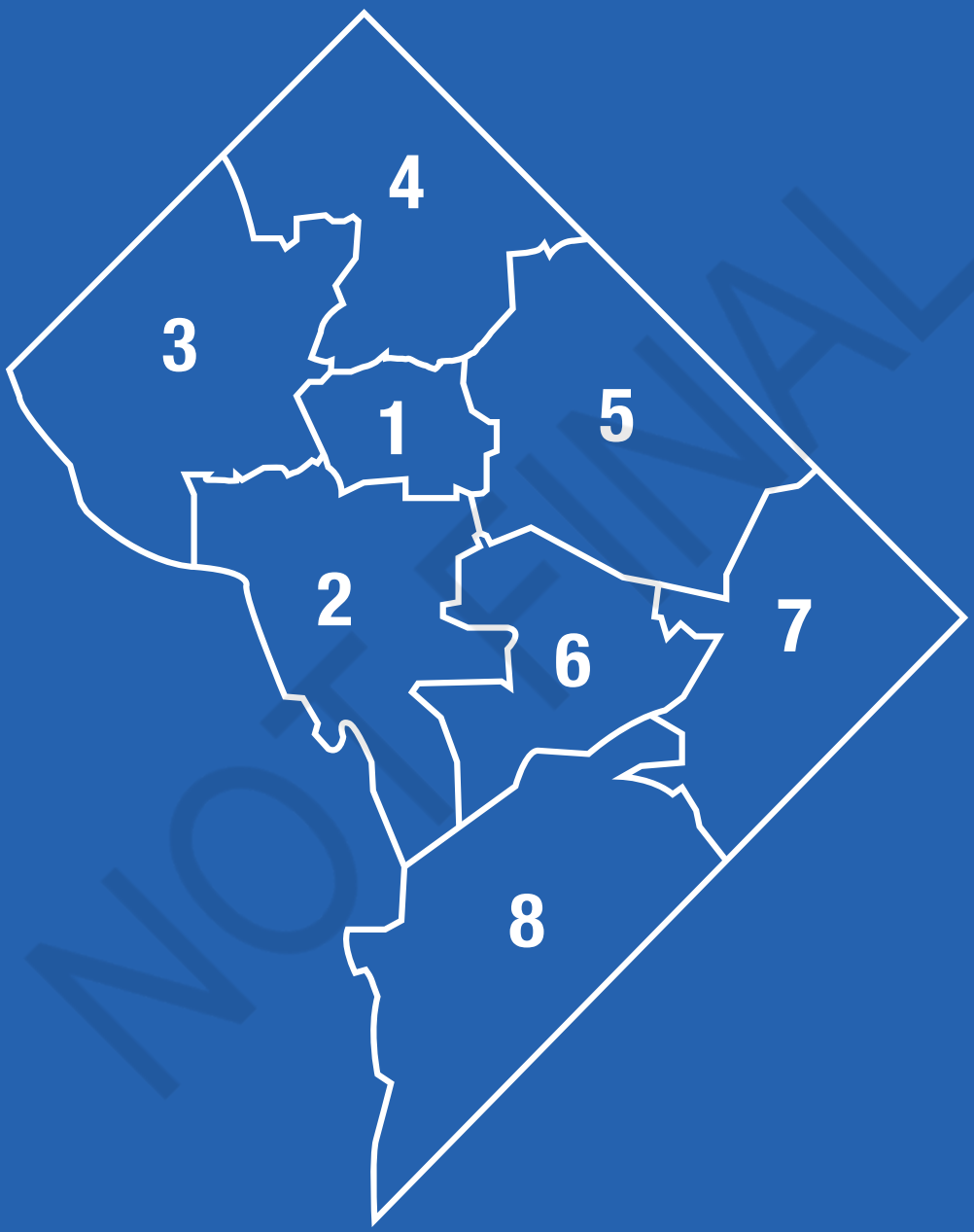
YOUTH RISK BEHAVIOR SURVEY 2019



Letter from the

STATE SUPERINTENDENT

At the Office of the State Superintendent of Education (OSSE), we know that healthy bodies and healthy minds are the foundation of academic success. As we grapple with the largest public health emergency in a century, our school communities' health and wellbeing are front and center. The public health crisis has impacted not only the health and wellness of our students, educators and communities, but also our students' ability to access and thrive in their education. This is a dramatic, but not unique, example of what the Youth Risk Behavior Survey (YRBS) has long shown us: that the health and wellbeing of our students is intimately related to their ability to succeed in school and in life.

The District of Columbia's biennial YRBS results describe health-related risk and protective factors as reported anonymously by middle and high school students from DC public and public charter schools. OSSE uses its YRBS results to inform how we support our adolescent students and remove health barriers to learning and instruction.

Unique among the states, the District's YRBS employs a census-level data collection methodology that generates a deep and broad data set that enables us to identify trends within and among specific groups of students. In addition to analyses based on transgender identity, sexual orientation, and race/ethnicity, for the first time, the 2019 YRBS Report includes a ward-level analysis.

The 2019 YRBS Report shows success in several areas compared to the first report in 2007. Alcohol, tobacco, and illegal drug use have declined. Violence victimization and violent behaviors among high school students are trending downward, and membership of high school males in gangs and crews has decreased from 21.6 percent in 2012 to 16.2 percent in 2019.

Despite these encouraging trends, the 2019 YRBS report also identifies areas of serious and persistent concern. Lesbian, gay and bisexual (LGB) middle school students were more likely to go hungry than their heterosexual peers. High school students whose gender expression is different from their assigned sex are more than three times as likely to have attempted suicide, compared to students whose gender expression matches their assigned sex. Condom usage at both the middle school and high school levels continues to decline.

We will continue to work with schools, our sister agencies, and community partners to ensure that students are prepared to succeed in school and in life. These data are a valuable tool for helping OSSE and our partners effectively direct our resources. We hope that all schools and community partners use these results to make evidence-based decisions to inform professional development needs, drive intervention efforts, and guide investments in student supports.

Thank you to our schools and students for participating in this process. We are committed to continuing to engage all middle and high school students as we work to ensure that students of all backgrounds are prepared to succeed in school and life.

Sincerely,

Hanseul Kang
State Superintendent of Education

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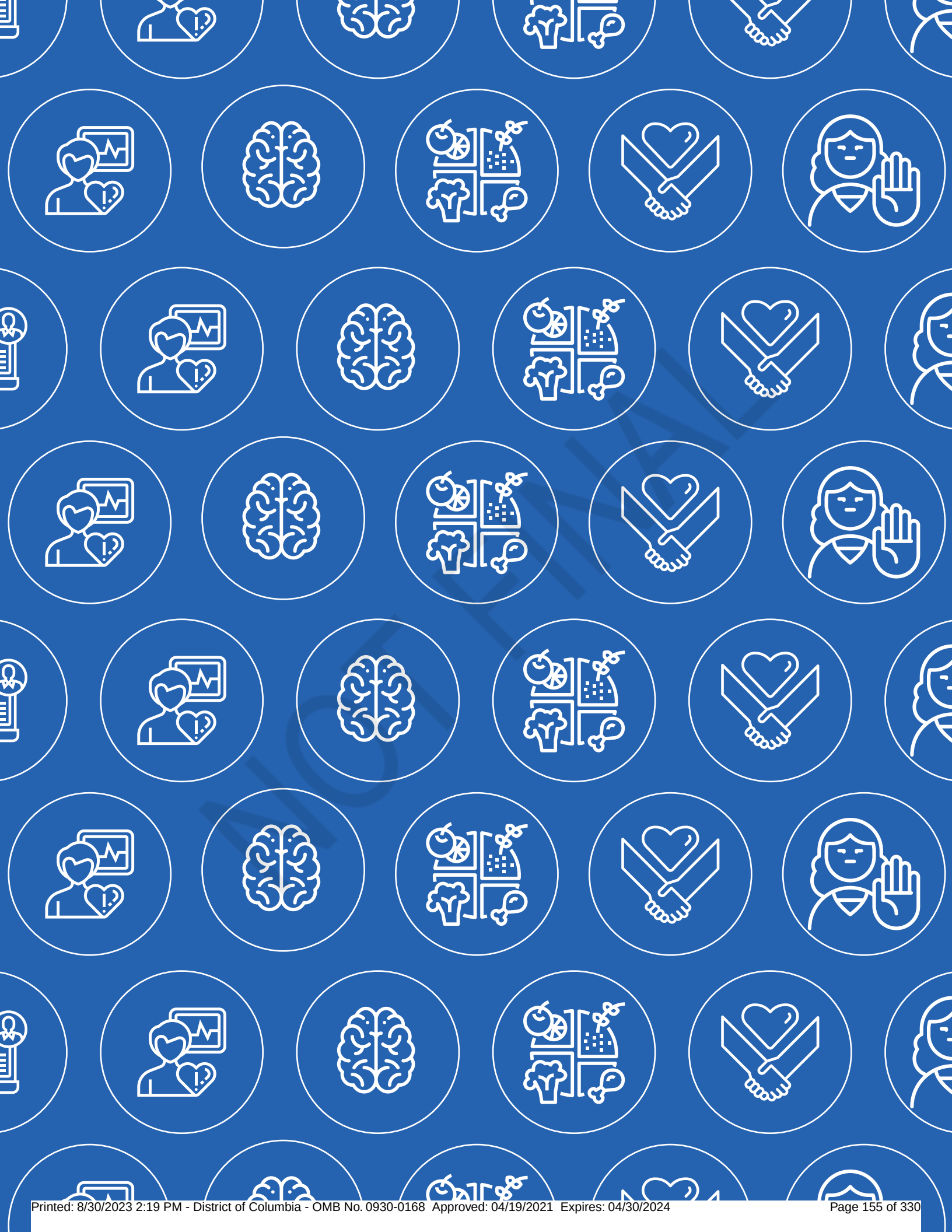


HOW TO UNDERSTAND THIS REPORT

This report presents data from the District of Columbia Youth Risk Behavior Survey (YRBS) for 2019 and covers the following risk behavior categories, which coincide with the categories of OSSE's Health Education Standards:

- Alcohol, Tobacco and Other Drugs
- Mental and Emotional Health
- Nutrition and Physical Activity
- Disease Prevention / Sexual Health
- Violence and Safety

The report finds significant differences between and within specific groups of students in the District of Columbia youth population (e.g., sex, grade, race and ethnicity) for various health behaviors and describes behaviors that have undergone significant changes since the YRBS was previously administered in 2007, 2012, 2015, and 2017. When data are reported separately for different groups (e.g., males and females), the data shown apply only to those groups and should not be added together.

How to Understand Statistically Significant Results

The term "significant" is used throughout the report to denote a change that is statistically significant. Statistical significance refers to differences in data that do not occur by chance, but because an actual difference exists between the groups or years being compared. All comparisons in this report were calculated using a significance level of 95 percent, indicating that there is at least a 95 percent probability that the result did not occur by chance. Significance here does not say anything about the size of the change or difference that has occurred, but rather, it indicates that the change or difference observed has a 95 percent chance of being true and less than a 5 percent chance of not being true.

How to Understand Significance Reported in Tables

Tables are used throughout the report to display changes in the data between the 2007, 2012, 2015, 2017, and 2019 surveys. Trend tables in this report have a respective column for each year in addition to two trend columns, the first indicating whether there was a significant change in students' behavior between the most recent survey administrations (2017 and 2019) and the second indicating whether there is a significant change between 2007 and 2019. Unless otherwise noted, arrows are used in the significance column to denote if there is a significant linear change between the earlier and later year.

When 2007 data is not available for the long-term trend column, only significant change between 2012 and 2019 is measured. The direction of the arrow indicates if the data show a significant increase, a significant decrease, or a non-significant change. Color is used to show if the behavior has improved over time (green) or if it has worsened over time (red). The arrows used are as follows:

↔	No significant change
↑	Significant increase in a positive direction (e.g., significant increase in eating fruit)
↓	Significant decrease in a positive direction (e.g., significant decrease in riding in a vehicle with someone who drank alcohol)
↑	Significant increase in a negative direction (e.g., significant increase in marijuana use)
↓	Significant decrease in a negative direction (e.g., significant decrease in condom use)

DEMOGRAPHICS AND STUDENT CHARACTERISTICS

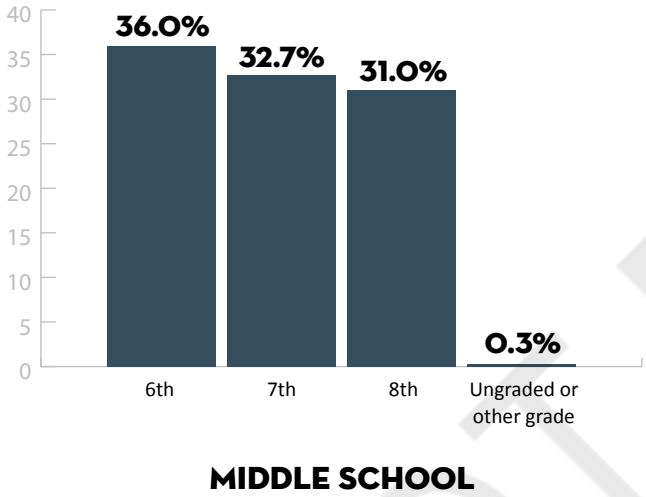
DEMOGRAPHICS AND STUDENT CHARACTERISTICS

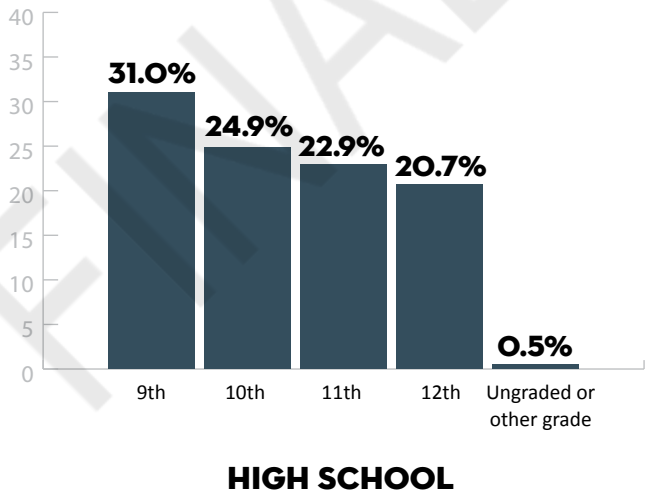
Survey participants had the following characteristics:

Sex

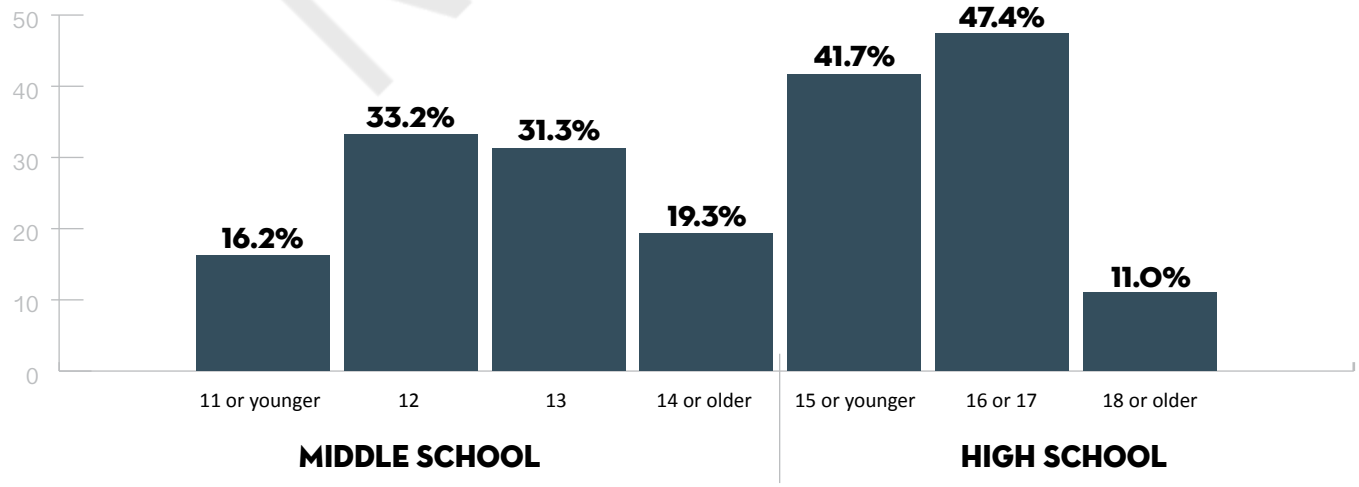
	Middle School	High School
Male	50.0%	49.3%
Female	50.0%	50.7%

Grade

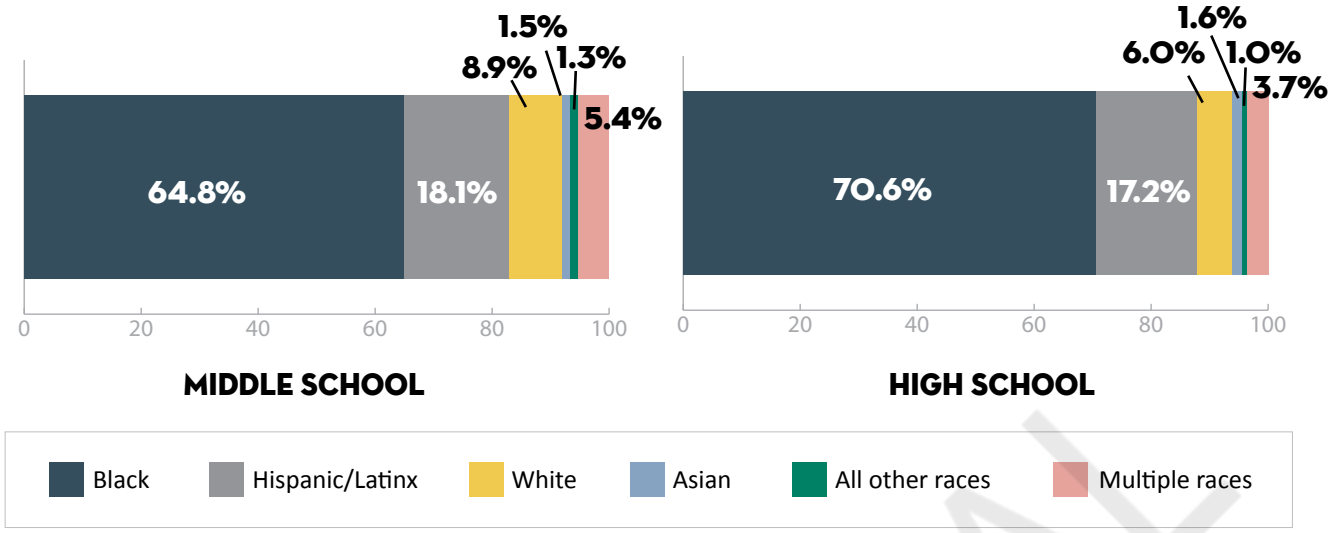




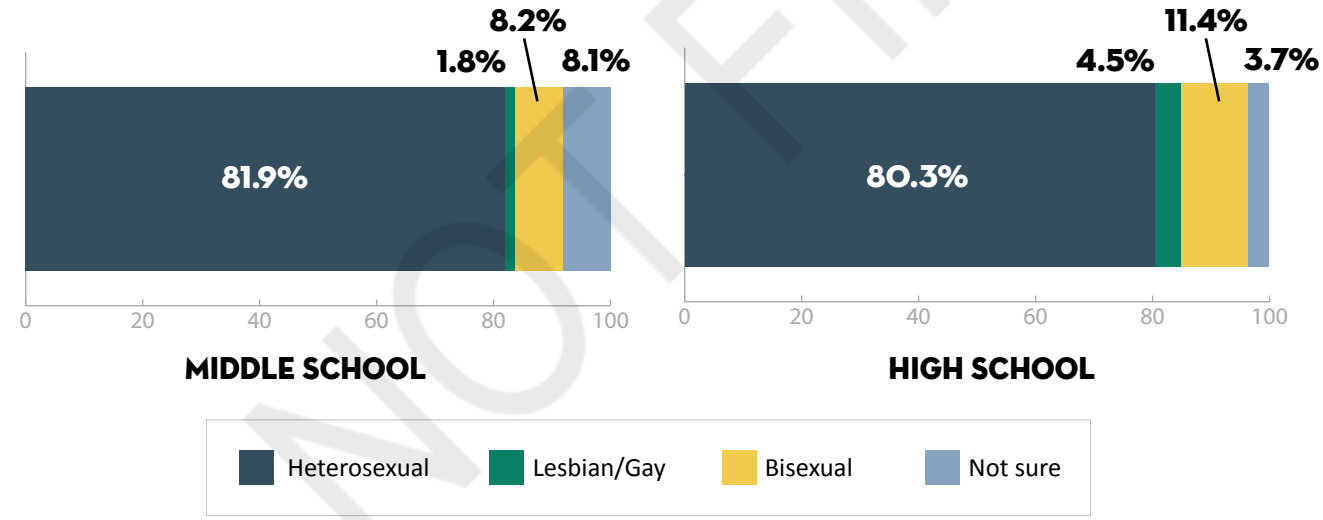
Age



Race/Ethnicity



Sexual Orientation



Throughout this report, analysis that refers to lesbian, gay, and bisexual (LGB) students only includes those who identify as lesbian, gay, or bisexual; students who responded as "not sure" are excluded from analysis that compares heterosexual youth to LGB youth.

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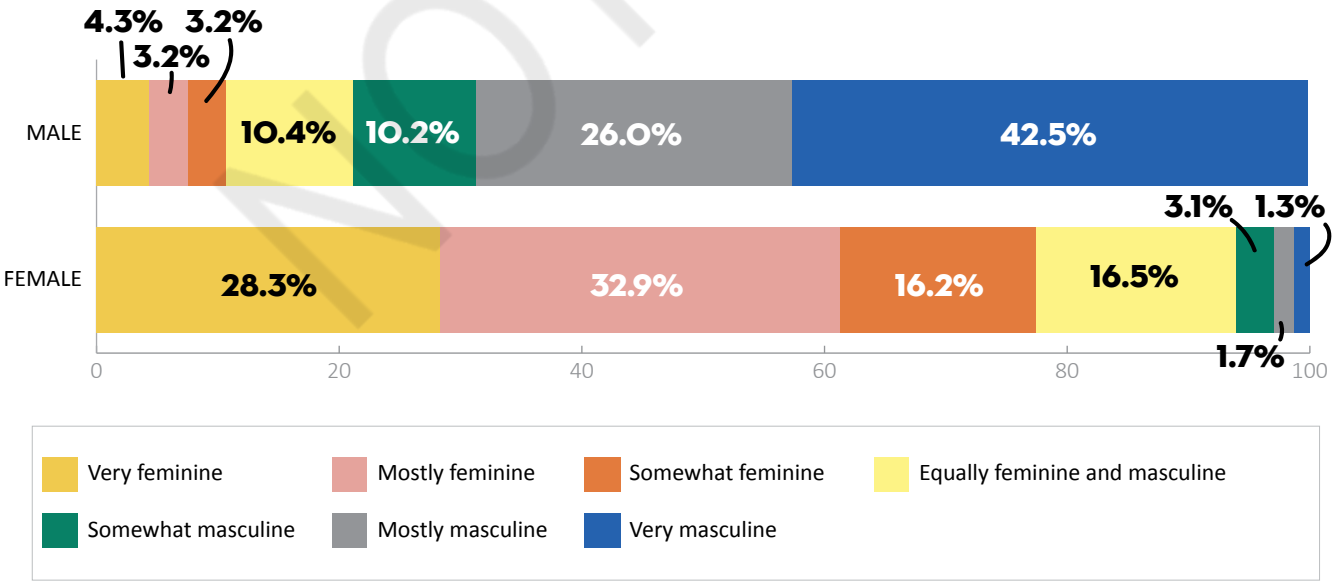
TRANSGENDER

Middle School Percentage	High School Percentage
0.9%	**1.9%**

The Human Rights Campaign defines transgender as an umbrella term for people whose gender identity and/or expression is different from cultural expectations based on the sex they were assigned at birth.[1] Being transgender does not imply any specific sexual orientation.

High school gender expression: Self-reported thoughts on how others at school would describe them based on appearance, style, dress, or the way they walk or talk, by sex

Most students express a gender that aligns with their sex. Percentage of high school students who identified as...



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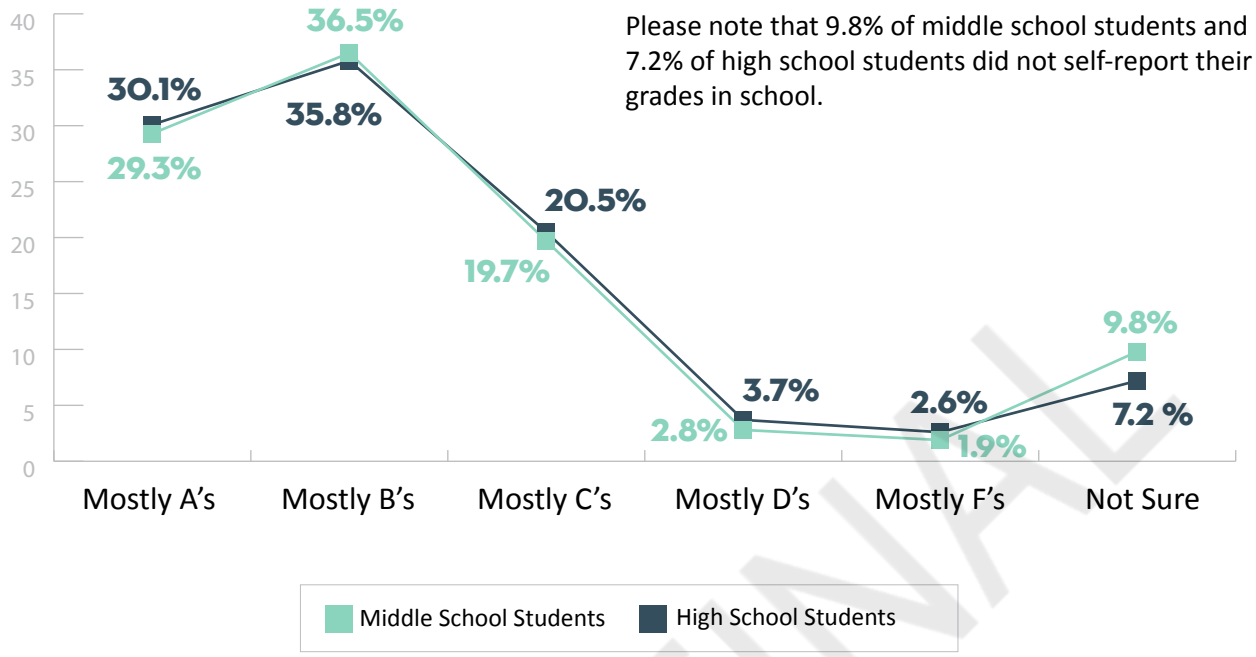
Self-reported academic performance in school during the previous 12 months



Please note that 9.8% of middle school students and 7.2% of high school students did not self-report their grades in school.

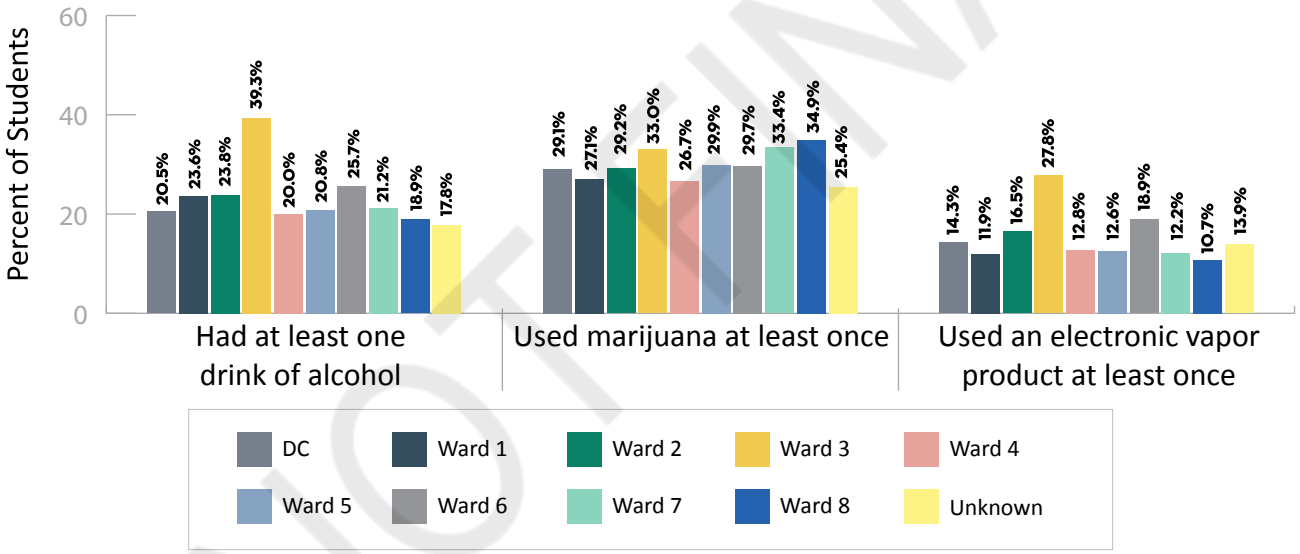
ALCOHOL, TOBACCO AND OTHER DRUGS

According to the Centers for Disease Control and Prevention (CDC), substance use during adolescence affects growth and development, occurs more frequently with other risky behaviors, and contributes to the development of health problems in adulthood.[2] In DC, alcohol and drug use is down overall, but students who identify as LGB remain over-represented in the number of students who report substance use. Similarly, there are major differences in the rates of use of electronic vapor products across race and sexual orientation. Understanding patterns associated with substance use is critical to inform programming to meet the needs of the groups that are most impacted.

Current (past 30-day) substance use	Middle School Average Age of First Use	High School Average Age of First Use
Smoked cigarettes	10.3 years	11.6 years
Had at least one drink of alcohol	10.3 years	12.8 years
Used marijuana	11.4 years	13.5 years

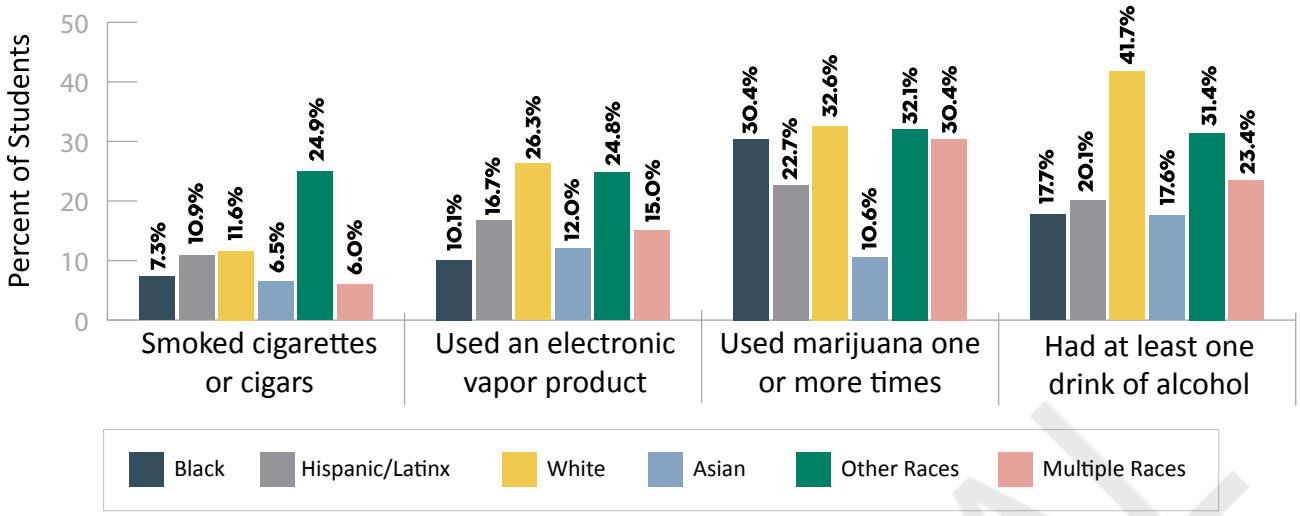
Nearly one in 10 middle school students report having had their first drink of alcohol, other than a few sips, at age 9 or younger.

High school substance use within the last 30 days, by ward of residence*



* Approximately 60 percent of high school students report knowing in which DC ward they live.

High school substance use within the last 30 days, by race/ethnicity



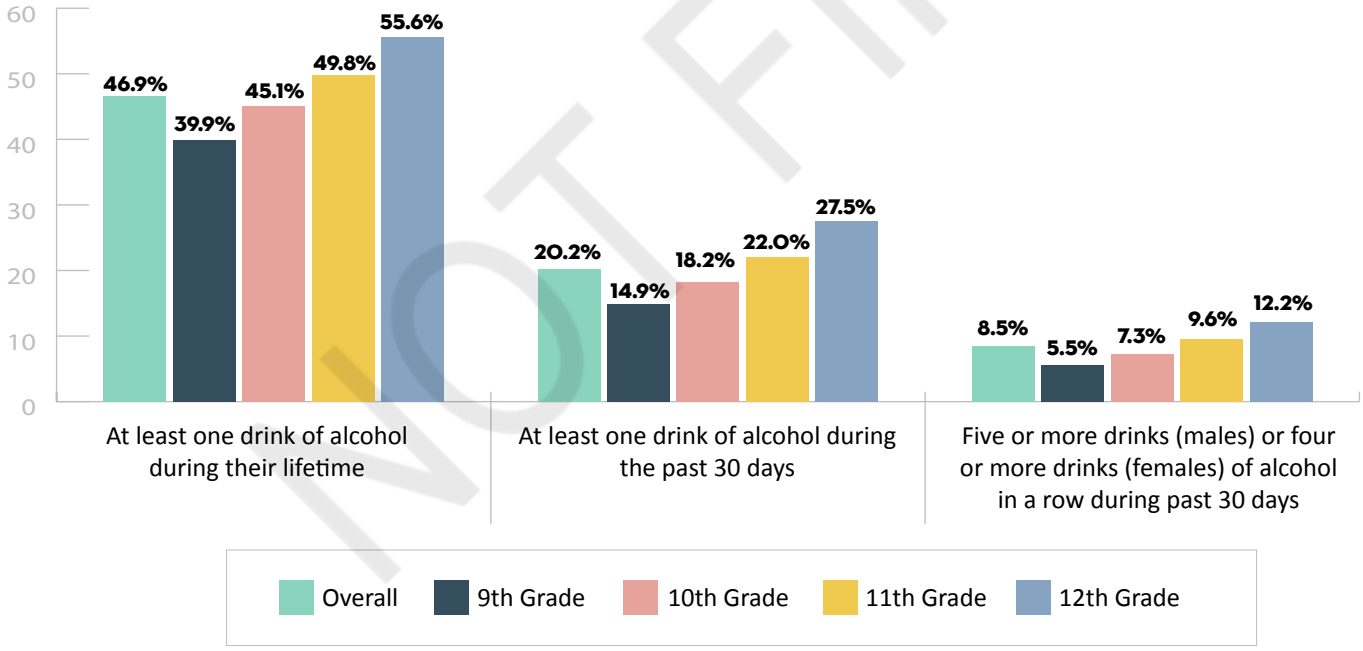
Trends in high school students' current (past 30-day) substance use: 2007 to 2019	2007	2012	2015	2017	2019	2017-2019 Trend	Long-Term Trend (2007-2019)
Smoked cigarettes*	11.0%	13.8%	8.2%	8.1%	5.3%	Down↓	n/a
Smoked cigars, cigarillos, or little cigars	10.4%	16.5%	11.5%	10.5%	6.6%	Down↓	Down↓
Used electronic vapor products	n/a	n/a	13.4%	10.9%	13.0%	Up ↑	No Change ↔
Used marijuana	20.5%	32.2%	28.7%	33.0%	29.2%	Down↓	Up ↑
Had at least one drink of alcohol	34.2%	31.4%	20.1%	20.5%	20.2%	No Change ↔	Down↓
Used illegal drugs	n/a	25.3%	13.3%	14.1%	13.1%	No Change ↔	Down↓

*The wording of this question was altered from "How old were you when you smoked a whole cigarette for the first time?" to "How old were you when you first tried cigarette smoking, even one or two puffs?" in 2017. Therefore, no long-term trend data are available for this question.

Rates of electronic vapor product use have not changed significantly since 2015. However, there is a notable difference in use between DC wards of residence, with Ward 3 students reporting the highest electronic vapor product usage rates of all wards in 2019.

	Trends in alcohol age of initiation: 2007 to 2019	2007	2012	2015	2017	2019	2017-2019 Trend	Long-Term Trend (2007-2019)
MIDDLE SCHOOL	Percentage of students who had their first drink of alcohol other than a few sips before age 11 years	17.6%	14.2%	10.9%	14.4%	13.1%	Down ↓	Down ↓
HIGH SCHOOL	Percentage of students who had their first drink of alcohol other than a few sips before age 13 years	25.4%	22.0%	18.8%	16.1%	17.8%	Up ↑	Down ↓

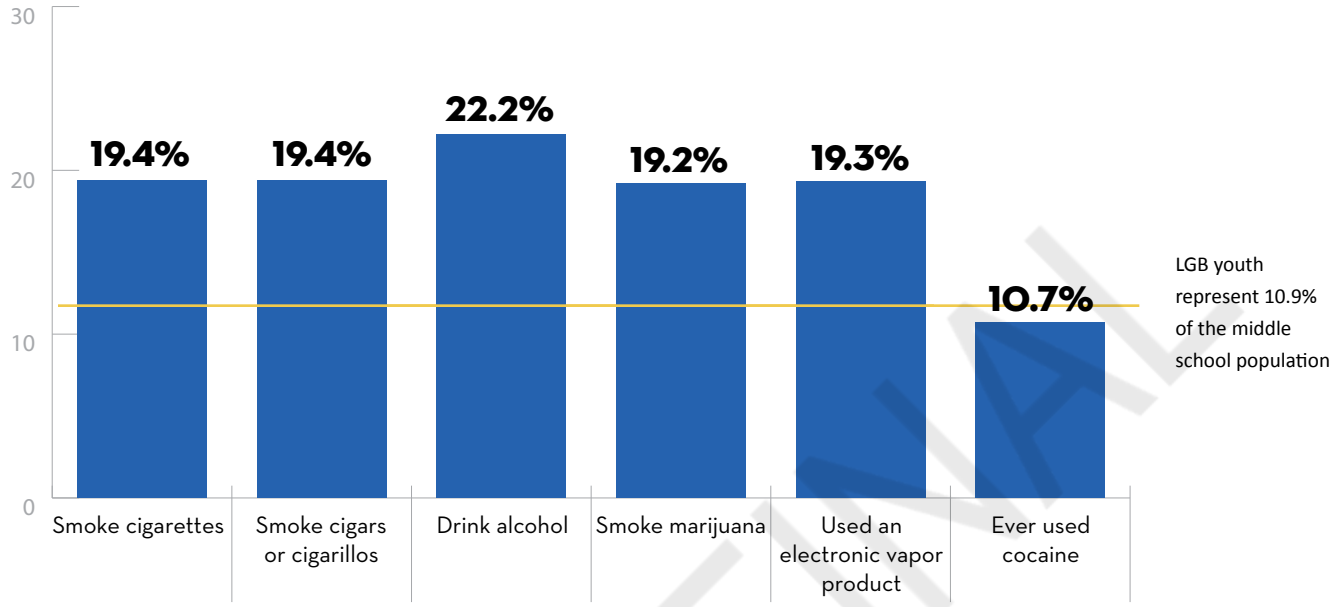
High school alcohol use, by grade



*All three categories of drinking were significantly higher at higher grade levels.

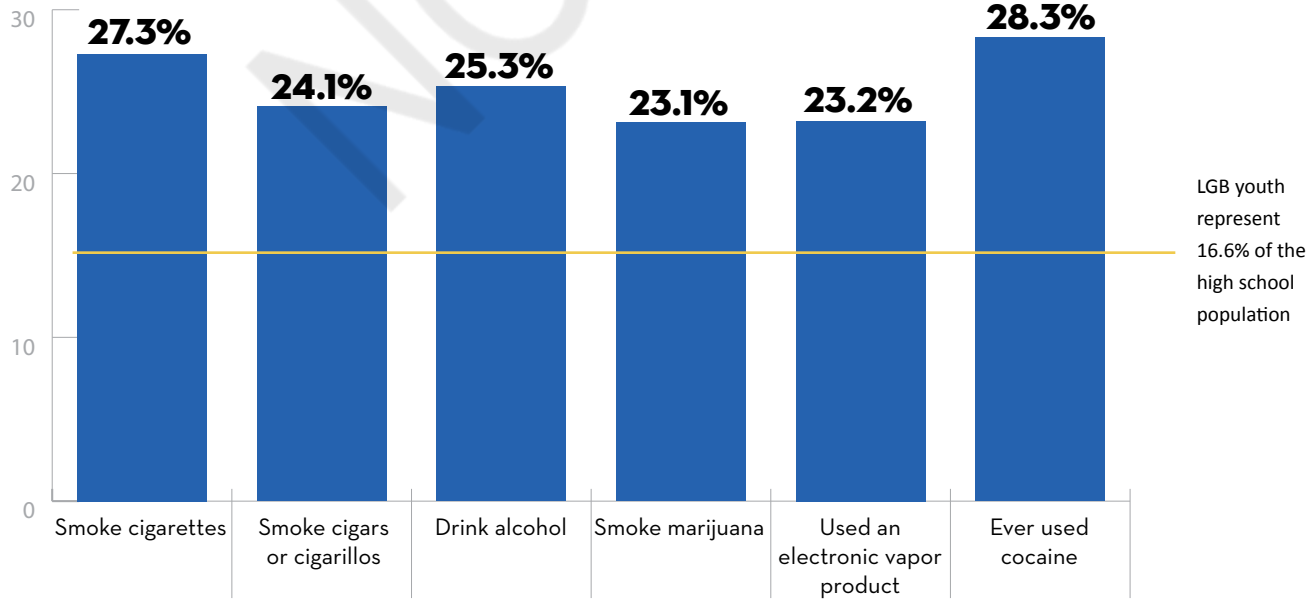
LGB youth are overrepresented in the percentage of students who reported substance use.

Of middle school students who reported substance use, the following shows the percentage who are lesbian, gay, or bisexual:



*Differences are significant between students who identify as heterosexual and students who identify as LGB for all categories except cocaine use.

Of high school students who reported substance use, the following shows the percentage who are lesbian, gay, or bisexual:

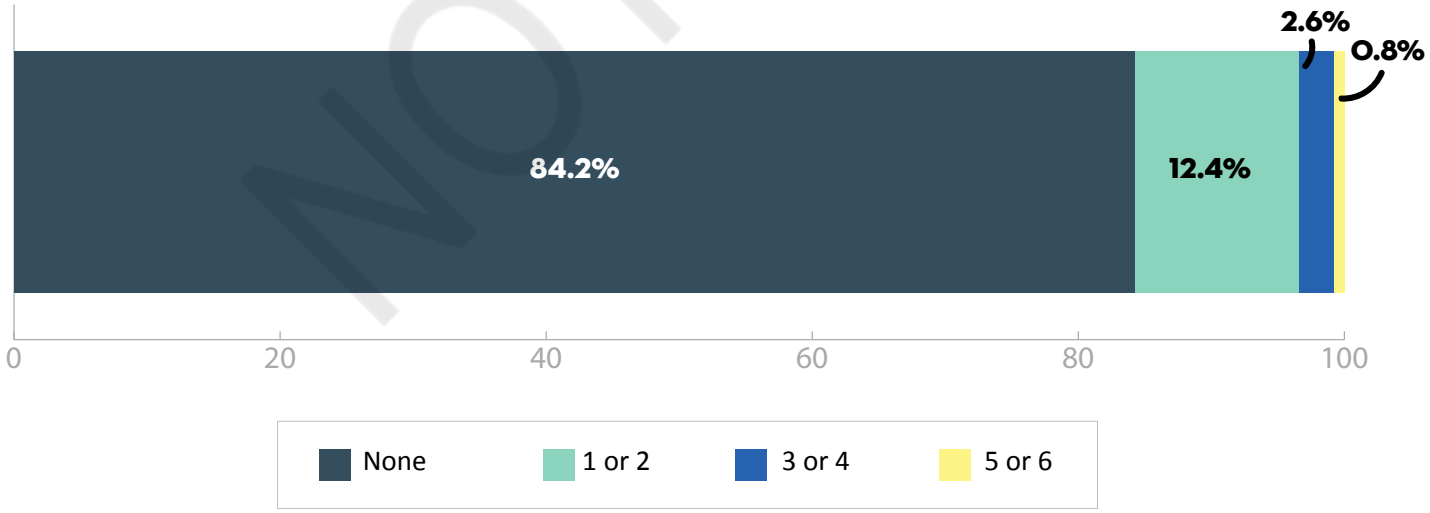


*All differences between students who identify as heterosexual and students who identify as LGB are statistically significant.

Trends in high school students' substance-related behaviors: 2007 to 2019	2007	2012	2015	2017	2019	2017-2019 Trend	Long-Term Trend (2007-2019)
Rode one or more times during the past 30 days in a car or other vehicle driven by someone who had been drinking alcohol	29.0%	25.5%	20.4%	22.1%	20.1%	Down↓	Down↓
Drove a car or other vehicle after drinking alcohol during the past 30 days	n/a	11.2%	7.8%	7.0%	6.6%	No Change ↔	Down↓
Drank alcohol or used drugs before the most recent time they had sexual intercourse during the past three months	17.4%	20.5%	18.1%	19.2%	16.5%	No Change ↔	No Change ↔

Of students who reported drinking and driving, 30 percent did so frequently (on six or more occasions in the past 30 days).

High school students by number of illicit drugs* they have used three or more times



*Illicit drugs include cocaine, inhalants, heroin, methamphetamines, synthetic marijuana, ecstasy, or prescription pain medicine without a doctor's prescription.

Twenty percent of all high school students reported having used prescription pain medicine without a doctor's prescription or differently than how a doctor told them to use it.

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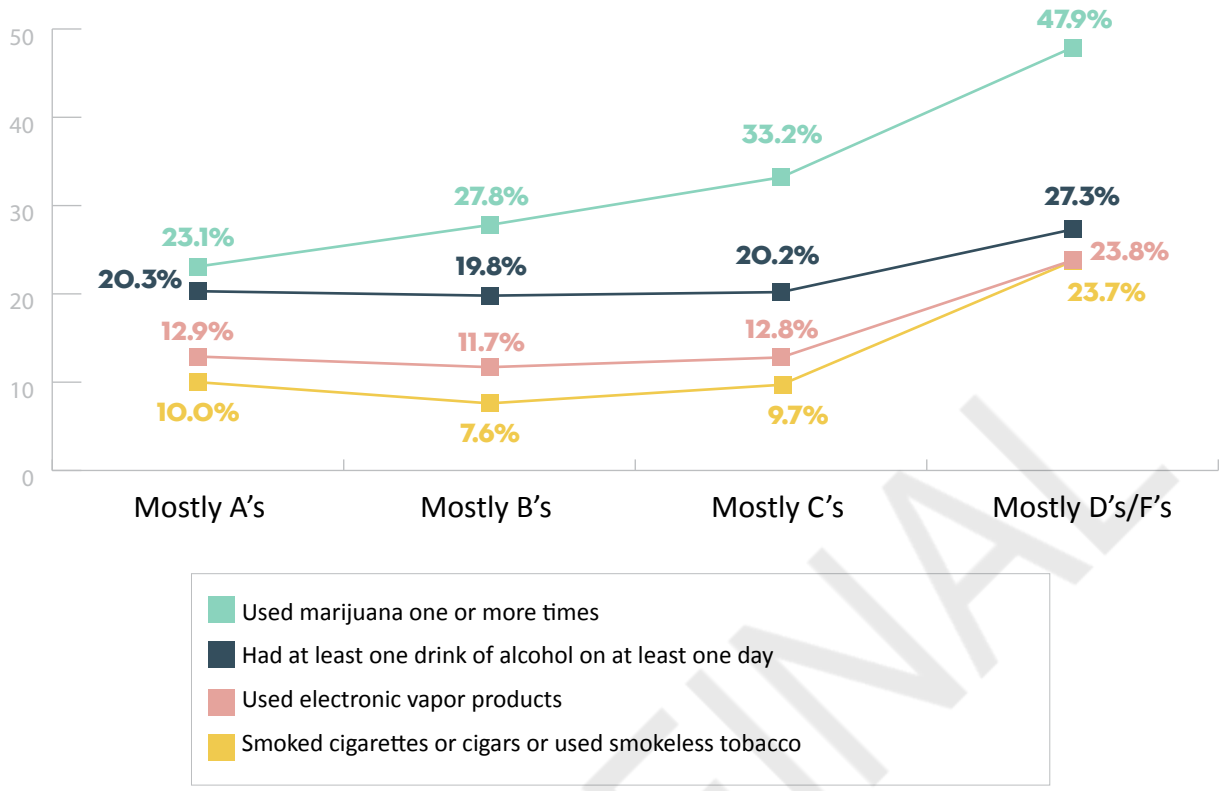
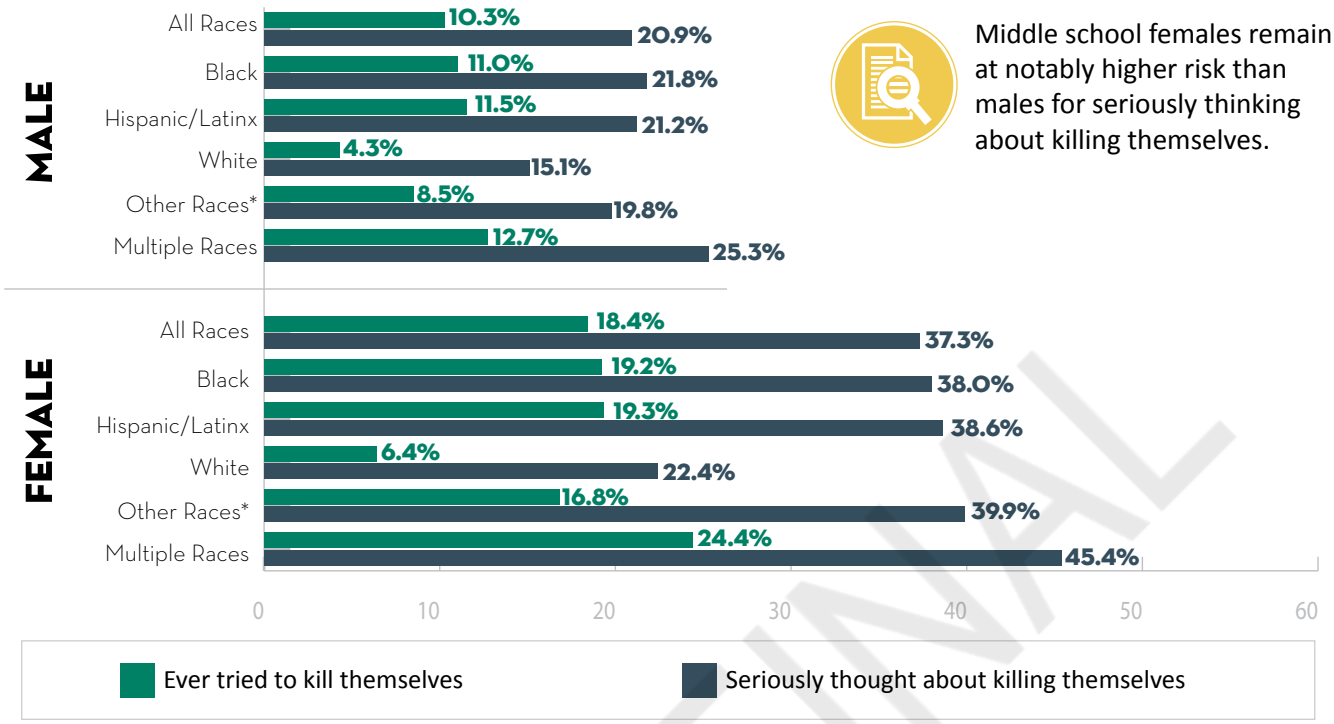
High school substance use within the last 30 days, by academic performance



MENTAL AND EMOTIONAL HEALTH

Mental and emotional health are essential for youth to have a positive quality of life and function well at home, in school, and in their communities.[3] Suicide is among the leading causes of death nationally for youth ages 10-24 years.[4] In DC, youth are contemplating and attempting suicide at alarming rates, with the rates for certain groups, including middle school females and students who identify as LGB or transgender, even more troubling. Amidst concerning findings, our data also demonstrate protective factors, including the presence of a relationship with a school-based trusted adult. OSSE is committed to working with schools and mental and behavioral health partners to develop safe and supportive school environments to identify and respond to these needs.

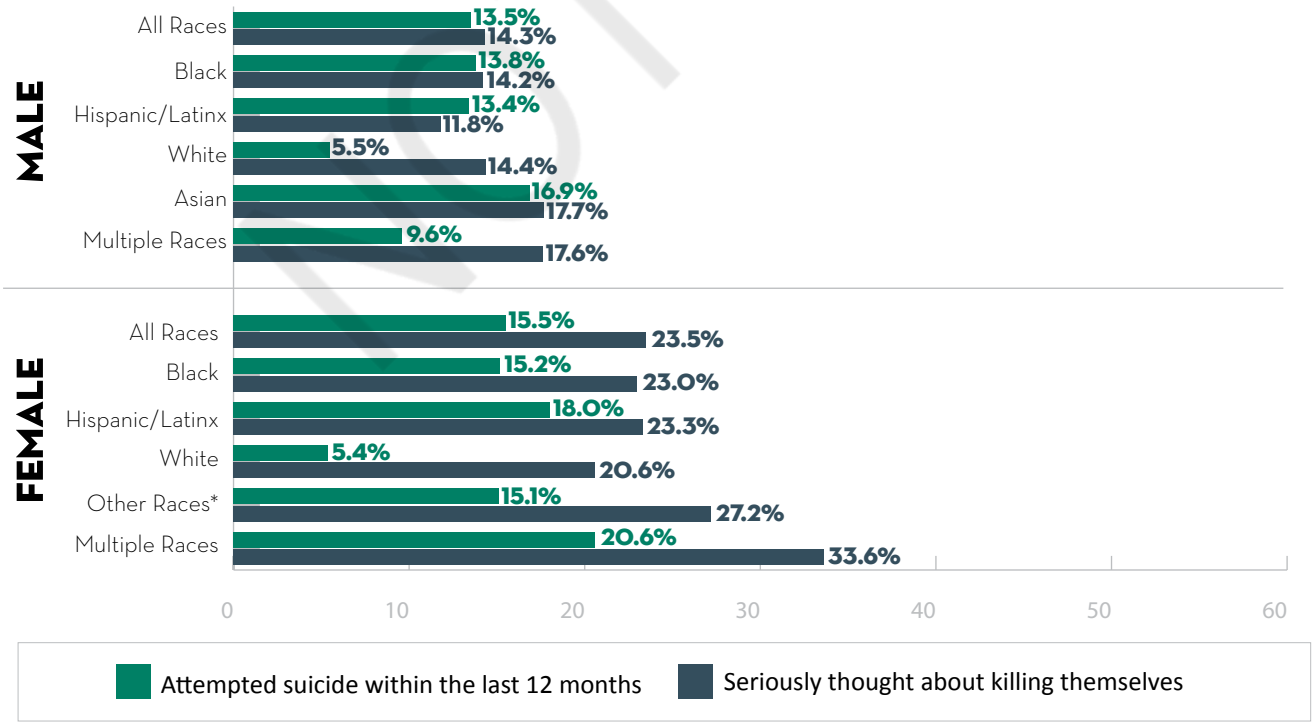
Middle school suicidality, by race and sex



Middle school females remain at notably higher risk than males for seriously thinking about killing themselves.

"Other Races" includes Asian students, as Asian students accounted for fewer than 100 students.

High school suicidality, by race and sex



*Asian females are included with "Other Races" includes Asian females, as Asian females accounted for fewer than 100 students.

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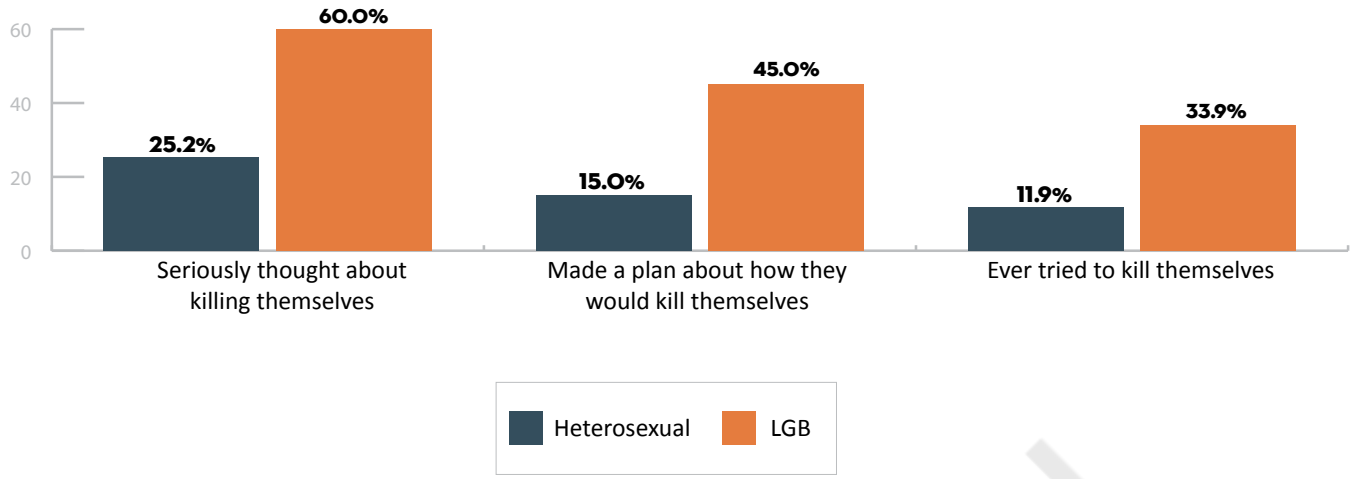
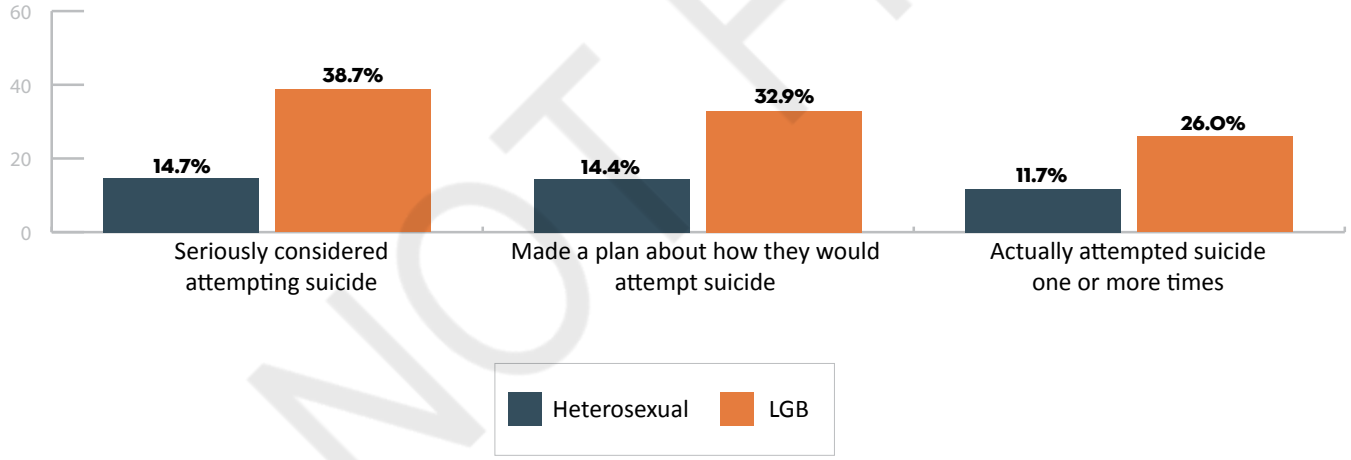
Middle school suicidality, by sexual orientation



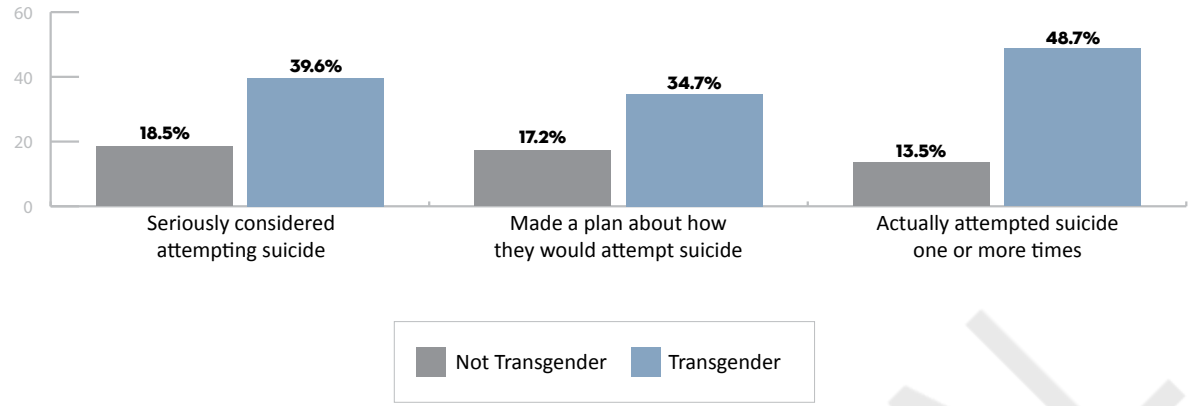
LGB middle school students are two and a half to three times as likely as their heterosexual peers to have seriously thought about, planned to, or ever tried to kill themselves.

High school suicidality, by sexual orientation

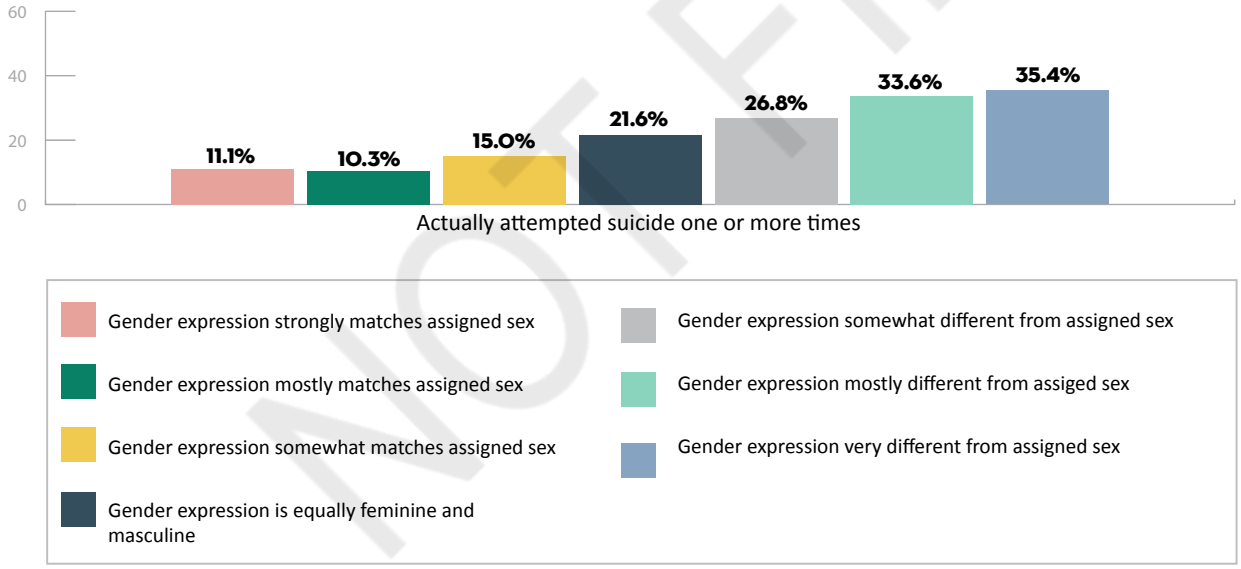


- LGB high school students are more than two times as likely as their heterosexual peers to have seriously thought about, planned to, or attempted to kill themselves.
- One in 10 lesbian, gay, and bisexual high school students has needed medical treatment as a result of an attempted suicide.

High school suicidality, by gender identity

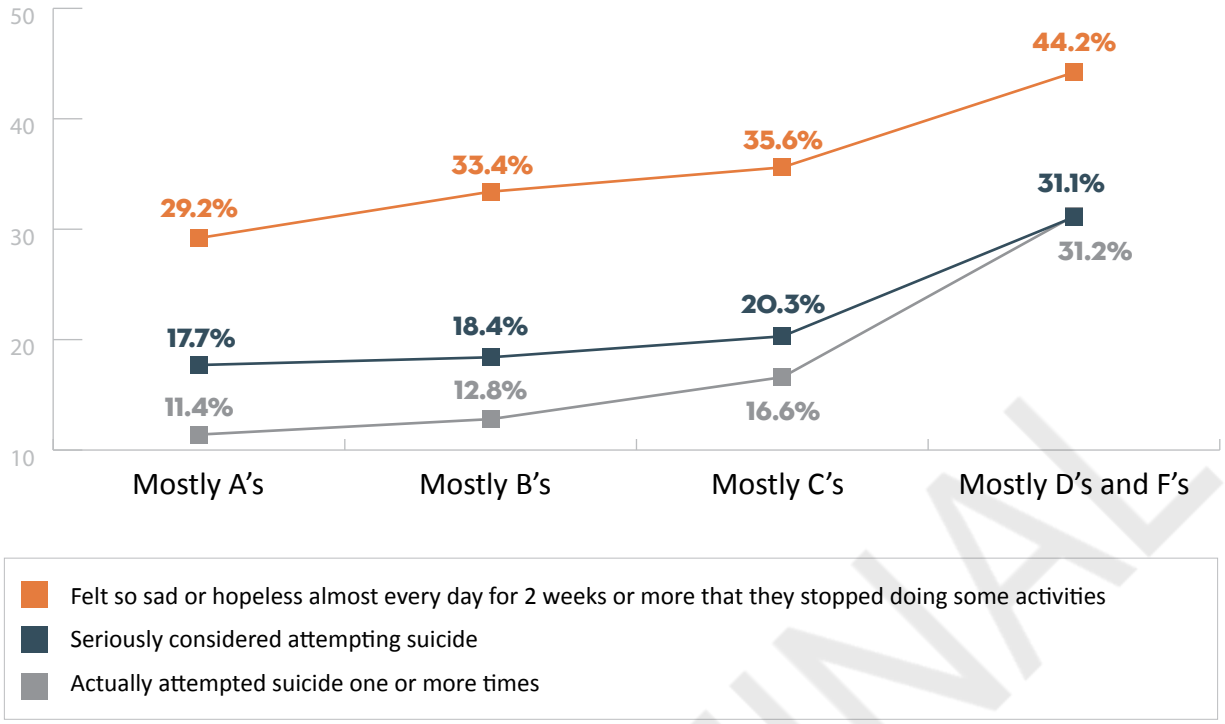


High school suicidality, by gender expression



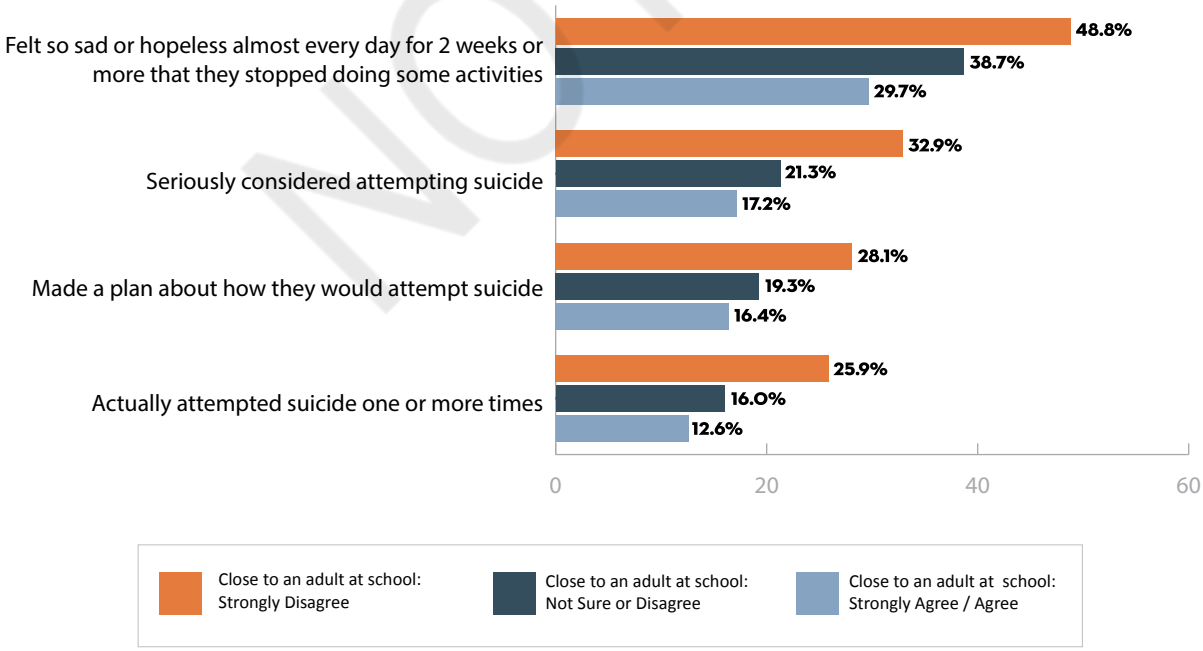
High school students whose gender expression is very or mostly different than their assigned sex (i.e., males who reported a very or mostly feminine gender expression) are more than three times as likely to have ever attempted suicide compared to students whose gender expression strongly or mostly matches their assigned sex.

High school depressed mood and suicidality, by academic performance



Mood and suicidal behaviors were associated with academic performance among high school students. Nearly one third of students receiving mostly D's and F's report having attempted suicide one or more times during the previous 12 months.

High school depressed mood and suicidality, by level of closeness with school-based supportive adult



There is a strong association between high school students' feelings of depressed mood and suicidality and their reported lack of a school-based supportive adult. Among high school students who report lacking a supportive adult at school, one in four students has attempted suicide.

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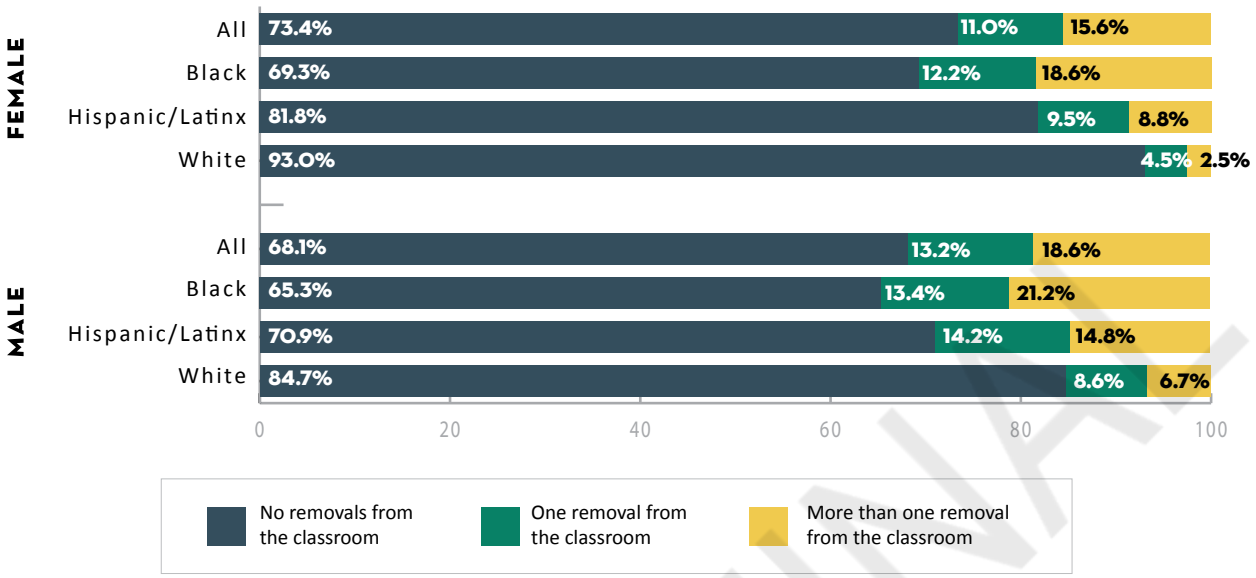
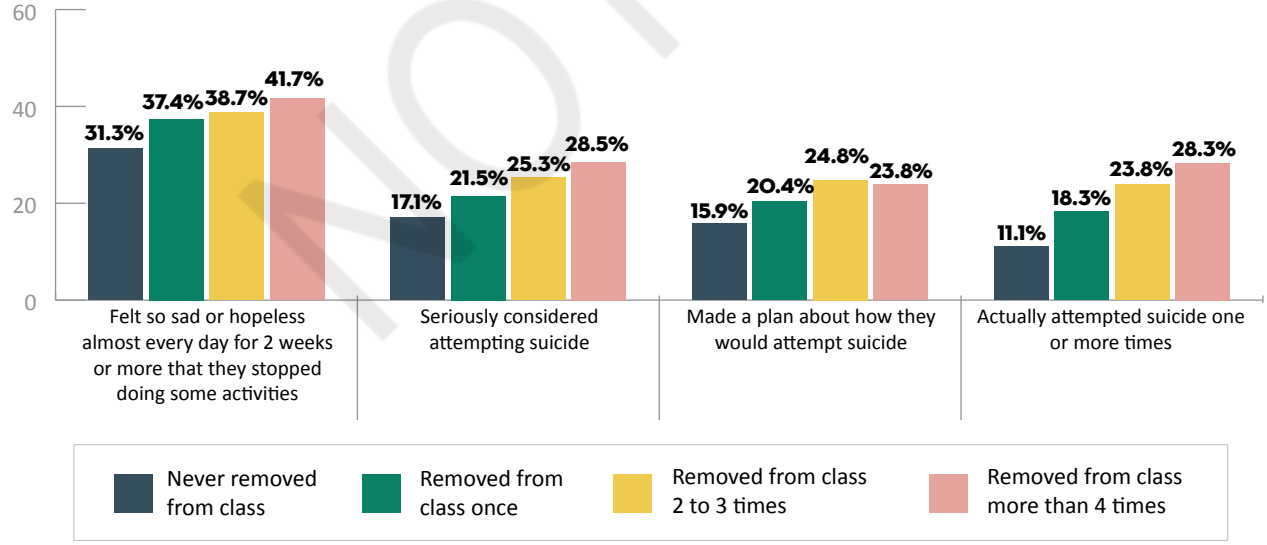
High school discipline experience, by race and sex



*Other racial groups are not shown due to low sample sizes.

High school depressed mood and suicidality, by discipline experience



High school students who have been removed from class for disciplinary reasons four or more times in the past 12 months are nearly three times as likely to attempt suicide as their peers who have never been removed from class.

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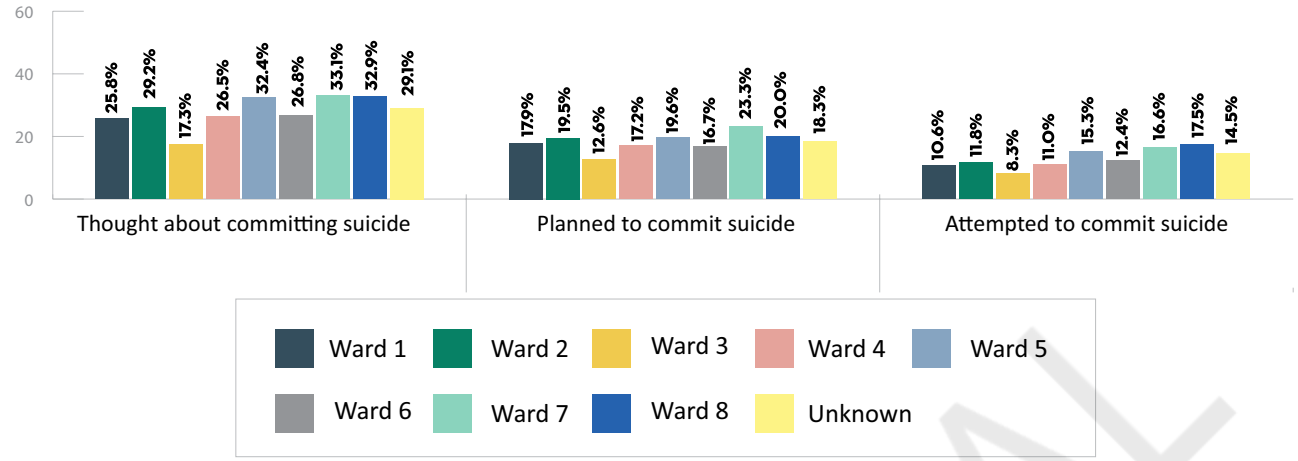
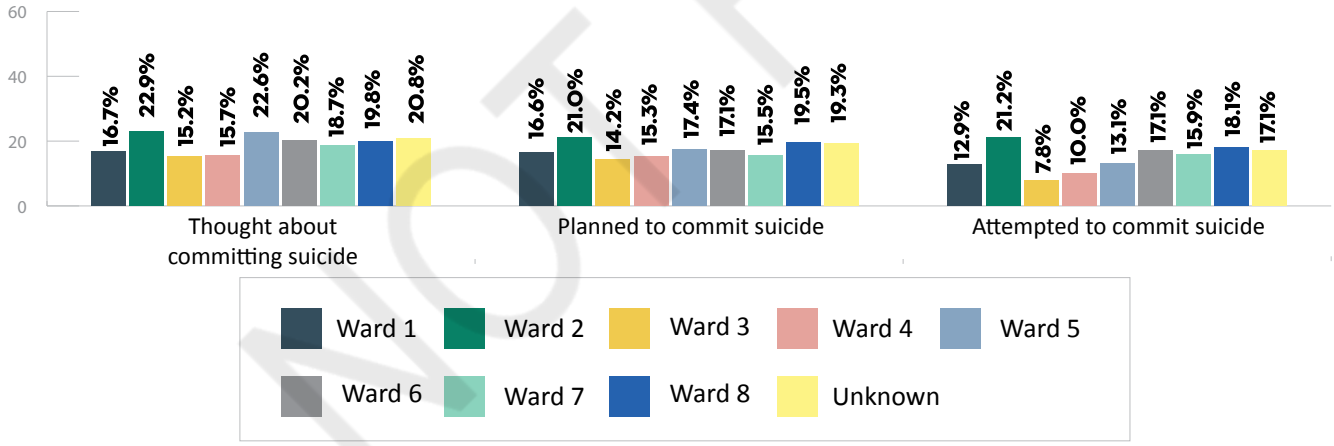
Middle school depressed mood and suicidality, by ward of residence*



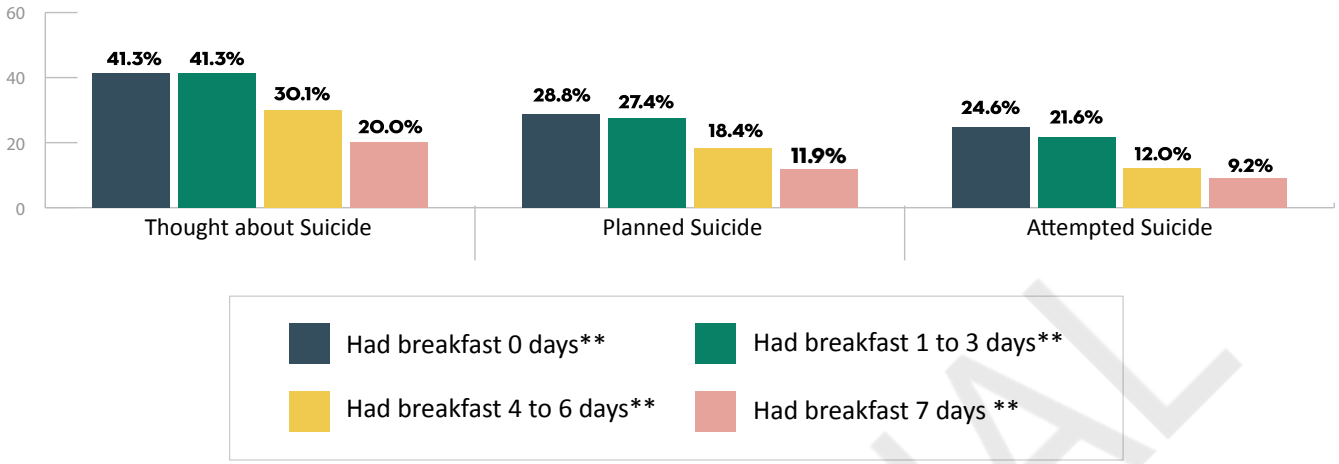
*Approximately 40 percent of middle school students report knowing in which DC ward they live.

High school depressed mood and suicidailty, by ward of residence*



* Approximately 60 percent of high school students report knowing in which DC ward they live.

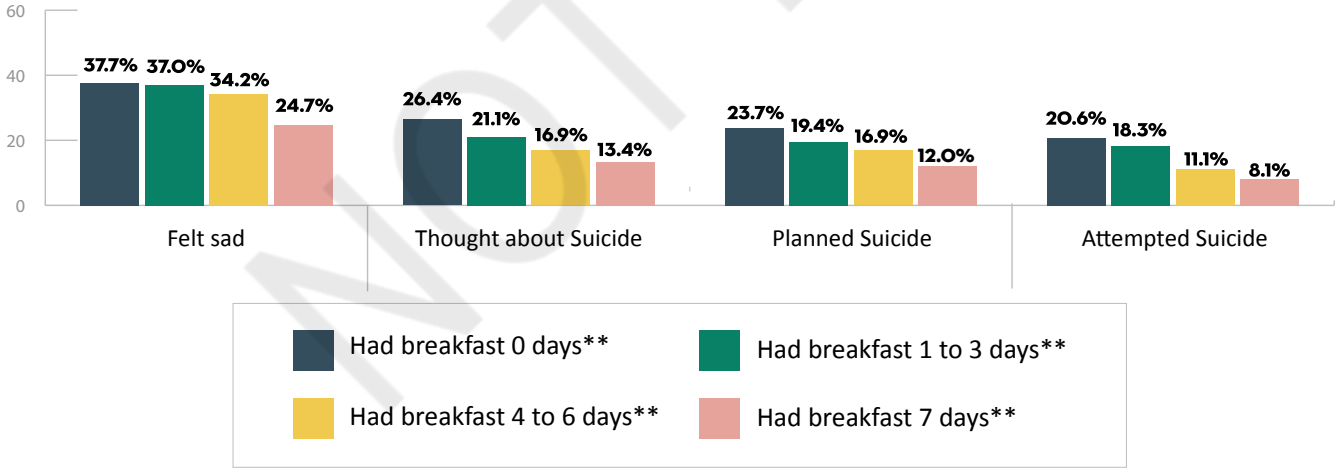
Middle school suicidality, by breakfast consumption*



* Breakfast consumption is any breakfast, not just school breakfast.

**In the seven days prior to the survey.

High school suicidality, by breakfast consumption*



* Breakfast consumption is any breakfast, not just school breakfast.

** In the seven days prior to the survey.

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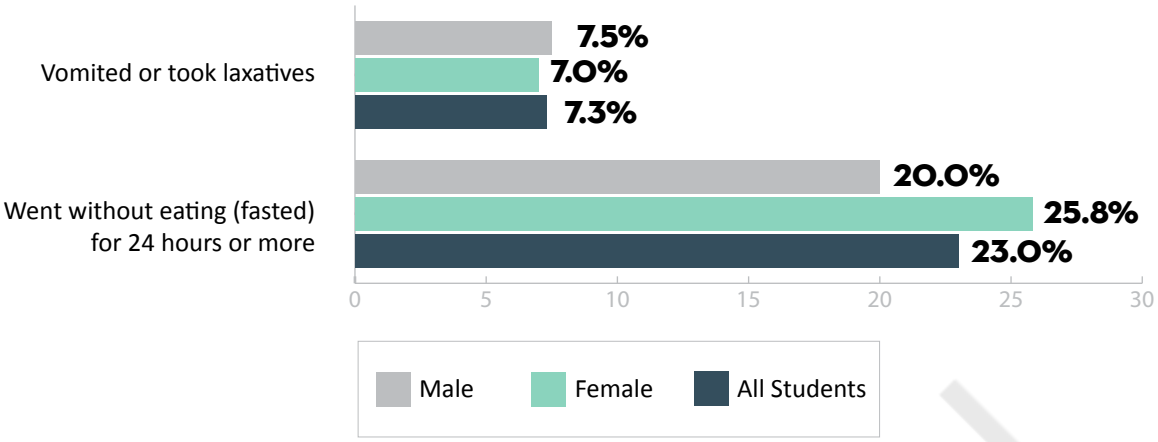
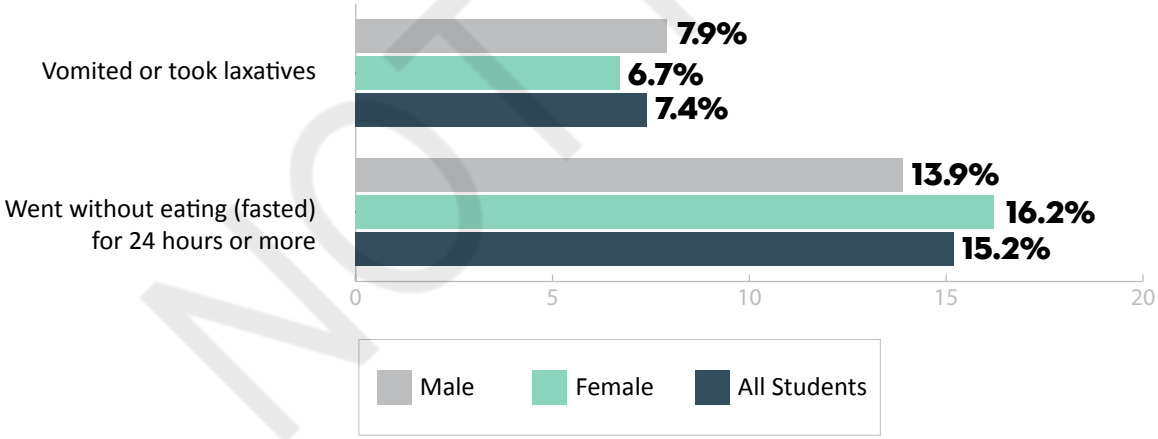
Middle school students' lifetime disordered eating behaviors, by sex



- Significantly more middle school female students than male students report having ever fasted for 24 hours or more to lose weight.
- Male and female middle school students report similar rates of vomiting or taking laxatives to lose weight.

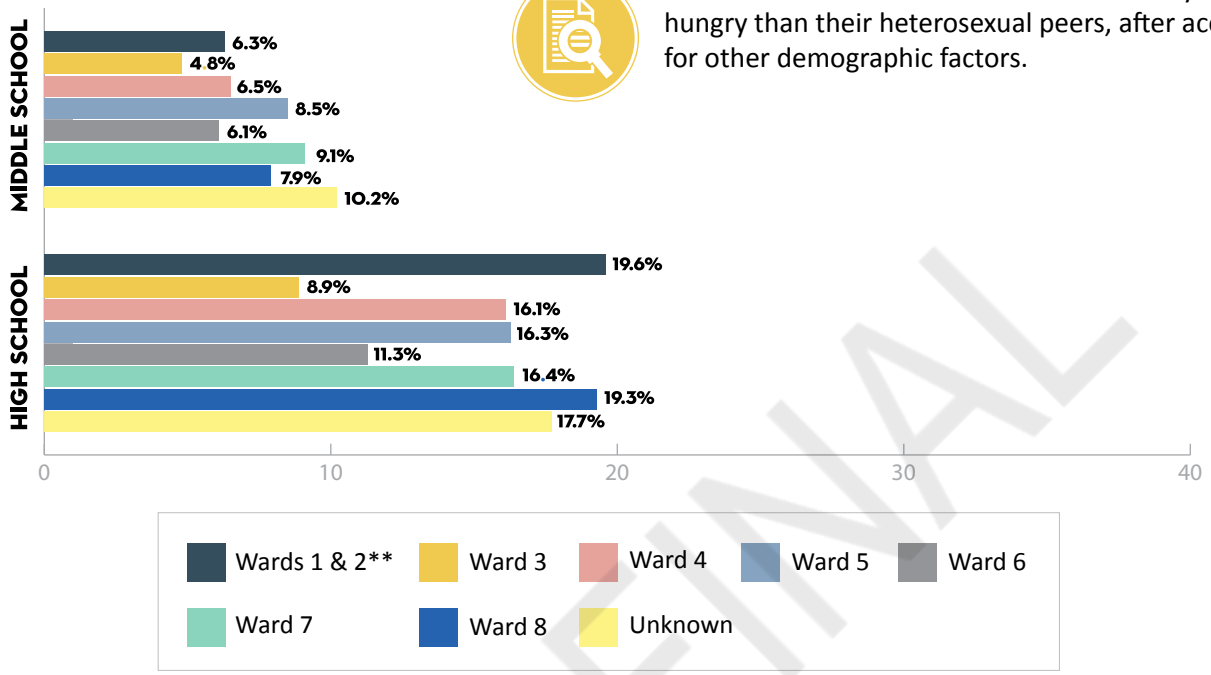
High school students' current (past 30-day) disordered eating, by sex



NUTRITION AND PHYSICAL ACTIVITY

Healthy eating and physical activity contribute to student success in school and life. Not only are poor nutrition and inadequate physical activity significant risk factors for obesity and other chronic diseases,[5] but they also impact students' academics. In DC, students who had gone hungry were more likely to have lower grades in school. On the other hand, students who received mostly A's reported higher rates of physical activity and lower rates of sedentary behaviors. In order to close the achievement gap and ensure students are prepared for success, schools and communities must be supportive of students' food security and physical health.

Students who went hungry sometimes, most of the time, or always, by ward of residence*



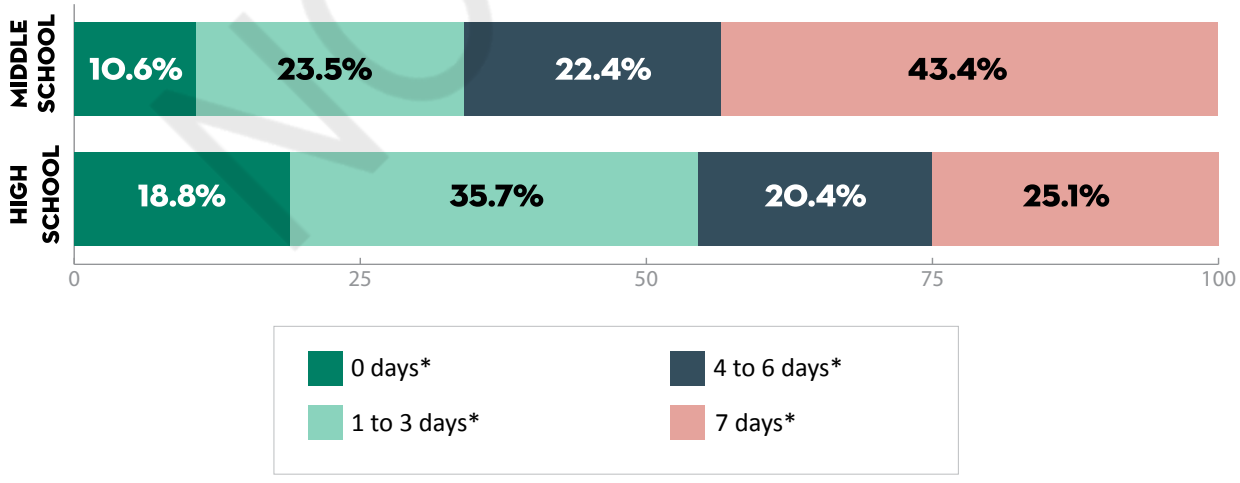
LGB middle school students were more likely to go hungry than their heterosexual peers, after accounting for other demographic factors.

* Approximately 40 percent of middle school students report knowing in which DC ward they live.

* Approximately 60 percent of high school students report knowing in which DC ward they live.

** Wards 1 & 2 combined for data suppression due to low sample size.

Breakfast consumption among middle and high school students



* In the seven days prior to the survey

- Frequency of breakfast consumption is much lower among high school students than middle school students and is the least frequent among high school males age 18 and older.
- High school students who were removed from class for diciplinary reasons were less likely to eat breakfast, after accounting for other demographic factors.

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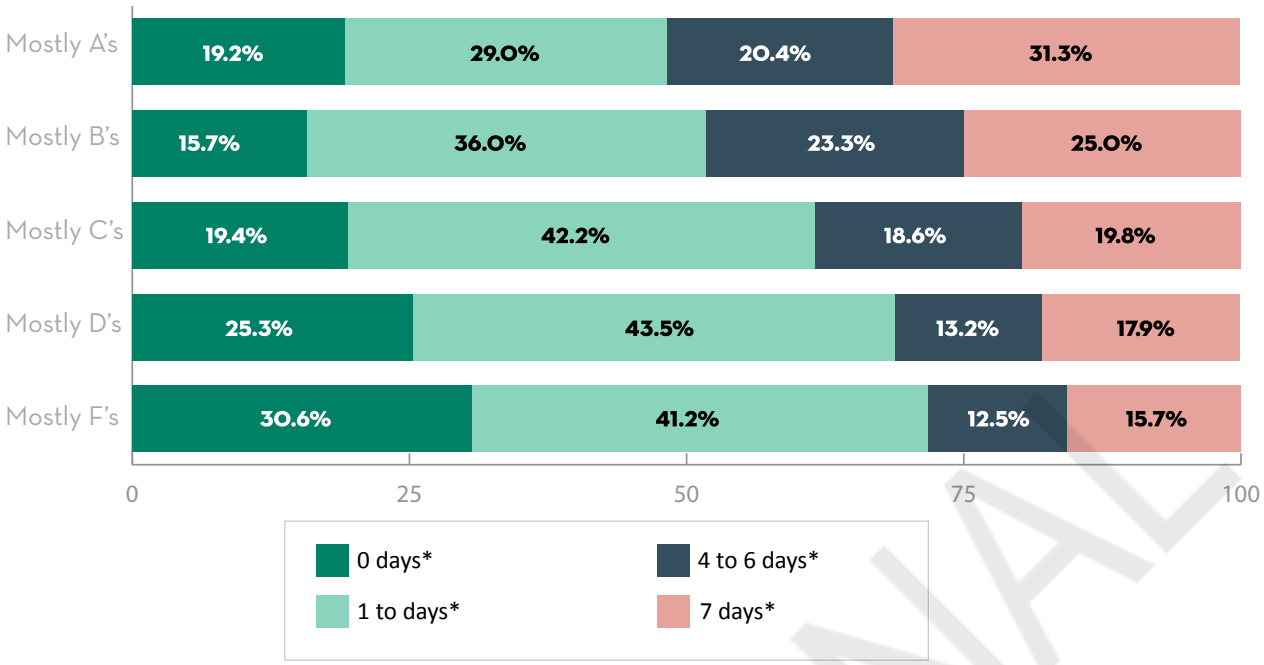
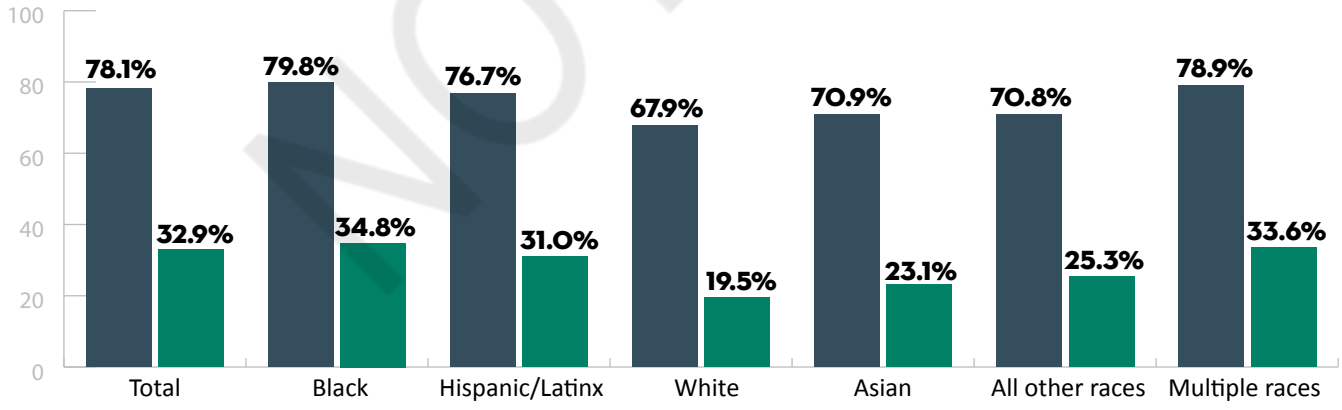
Breakfast consumption among high school students, by academic performance



* In the seven days prior to the survey

Middle and high school students who have gone hungry are more likely to have lower grades in school, after accounting for other demographic factors.

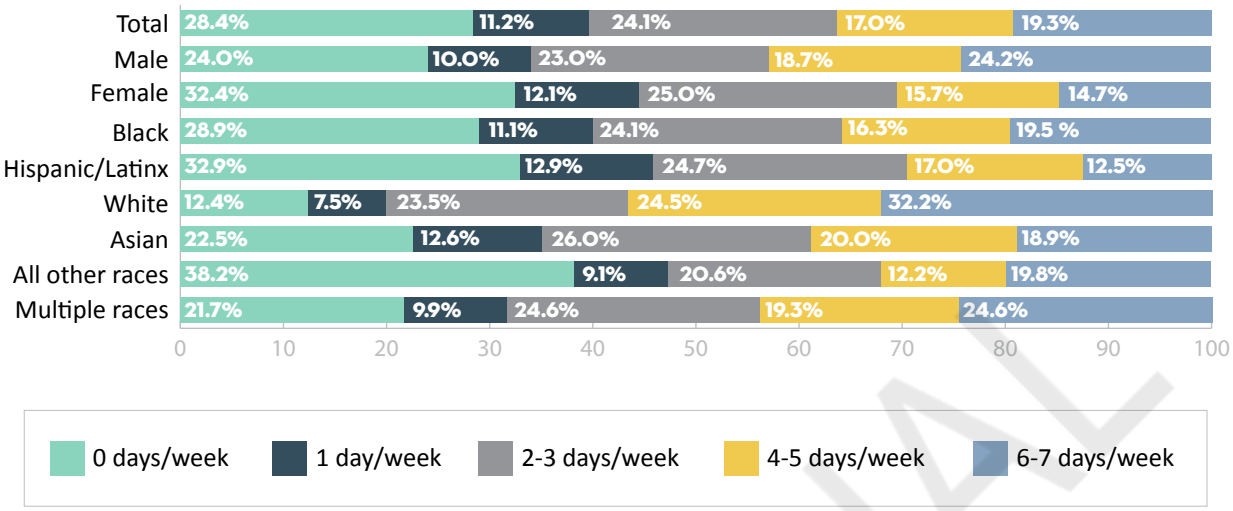
Fast food consumption among high school students, by race



* In the seven days prior to the survey

Four out of every five high school students reported having eaten at a fast food chain or carry out restaurant at least once in the week prior to the survey.

High school physical activity, by race and sex



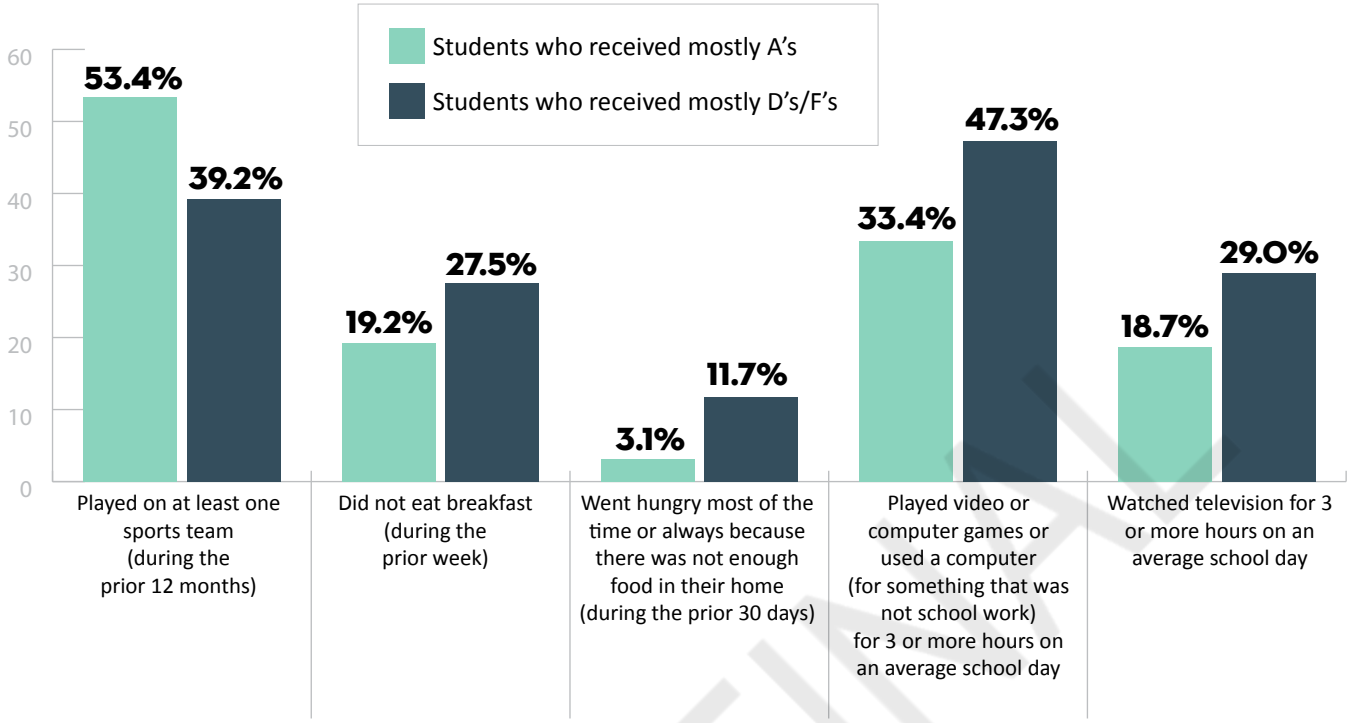
- Female high school students were about 40 percent less likely to be active on at least four days per week than their male peers, after accounting for other demographic factors.
- LGB high school students were about 15 percent less likely to be active on at least four days per week than their heterosexual peers, after accounting for other demographic factors.

Physical Activity: Sports Team Participation

Percentage of high school students who, during the prior 12 months…	2007	2012	2015	2017	2019	2017-2019 Trend	Long-Term Trend (2007-2019)
Played on at least one sports team (run by their school or community groups)	48.6	54.5	54.9	52.4	50.3	Down↓	No Change ↔

- High school students who participated on a sports team were 2.3 times as likely to be physically active on at least four or more days per week, after accounting for other demographic factors.
- More than 15 percent of high school students have had at least one concussion from playing a sport or being physically active; 7 percent of students have had more than one concussion.

High school physical activity, sedentary behavior, and eating habits, by academic performance



DISEASE PREVENTION/SEXUAL HEALTH

According to the CDC, youth ages 15-24 make up just over one quarter of the sexually active population, but account for half of the 20 million new sexually transmitted infections that occur in the United States each year.[6] In DC, we see several positive trends in sexual behaviors among youth, including lower rates of students' reporting ever having sexual intercourse and those reporting multiple sexual partners. However, we also see continued reason for concern. One in twelve middle school males reports having had sex by age 11. And while better than the national average, DC youth report declining rates of condom usage. Supporting students' sexual health will sustain these positive trends, help to turn the curve on negative trends, and assist youth with making choices that benefit their sexual and overall health and wellbeing.

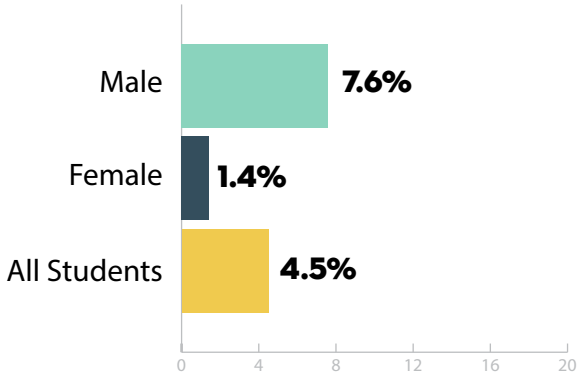
	MIDDLE SCHOOL							HIGH SCHOOL						
Percentage of youth who…	2007	2012	2015	2017	2019	2017-2019 Trend	Long-Term Trend (2007-2019)	2007	2012	2015	2017	2019	2017-2019 Trend	Long-Term Trend (2007-2019)
Had sexual intercourse during their life*	29.2%	18.5%	11.6%	13.7%	12.2%	Down ↓	Down ↓	56.5%	53.5%	40.9%	45.6%	44.0%	No Change ↔	Down ↓
Male youth	43.1%	28.5%	19.5%	22.9%	19.6%	Down ↓	Down ↓	64.1%	61.5%	50.9%	54.6%	51.6%	Down ↓	Down ↓
Female youth	16.5%	9.3%	4.1%	5.2%	5.4%	No Change ↔	Down ↓	51.0%	46.7%	32.7%	37.5%	37.6%	No Change ↔	Down ↓
Had sexual intercourse with one or more people during the past three months*	-	-	-	-	-	-	-	40.6%	36.6%	28.2%	31.1%	30.9%	No Change ↔	Down ↓
Had sexual intercourse with four or more people (high school) or three or more people (middle school) during their life*	12.0%	8.1%	4.7%	4.9%	4.0%	Down ↓	Down ↓	20.3%	21.7%	13.8%	14.0%	12.2%	Down ↓	Down ↓
Male youth	21.2%	13.8%	8.5%	8.7%	7.0%	Down ↓	Down ↓	29.9%	33.0%	23.4%	23.0%	19.6%	Down ↓	Down ↓
Female youth	3.4%	2.8%	1.0%	1.3%	1.0%	No Change ↔	Down ↓	14.3%	12.2%	5.9%	6.3%	5.8%	No Change ↔	Down ↓
Has ever had oral sex*	-	-	-	-		-	-	-	41.2%	33.5%	39.2%	38.1%	No Change ↔	Down ↓
Male youth	-	-	-	-		-	-	-	51.9%	42.7%	46.1%	42.8%	Down ↓	Down ↓
Female youth	-	-	-	-		-	-	-	31.4%	24.6%	32.0%	33.5%	No Change ↔	Up ↑

*Significant difference between male and female youth

Since 2007, the overall rates of DC youth reporting having sexual intercourse and oral sex have declined. However the rate of high school female youth who have had oral sex has risen approximately 2 percent since 2012.

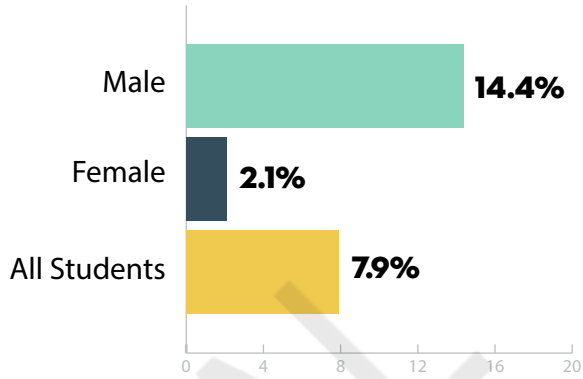
MIDDLE SCHOOL

Percent of middle school students who had sexual intercourse by age 11, by sex



HIGH SCHOOL

Percent of high school students who had sexual intercourse by age 13, by sex



*Significant difference between male and female youth

- Middle school students who are LGB are 2.5 times as likely to have had sex before the age of 11 as their heterosexual peers, after accounting for other demographic factors.
- High school students who are LGB are 1.4 times as likely to have had sex before the age of 13 as their heterosexual peers, after accounting for other demographic factors.

Trends in condom use during most recent sexual intercourse among middle school and high school youth*	2007	2012	2015	2017	2019	2017-2019 Trend	Long-Term Trend (2007-2019)
Middle School	78.1%	73.0%	68.8%	67.8%	63.0%	Down ↓	Down ↓
High School	69.9%	70.1%	66.6%	61.2%	57.1%	Down ↓	Down ↓

*This question was asked of high school youth who reported having sexual intercourse in the past three months and of middle school youth who reported ever having sexual intercourse.

DC high school students used a condom at a higher rate than the national average in 2017 (61 percent vs. 46 percent). National data are not yet available for 2019.

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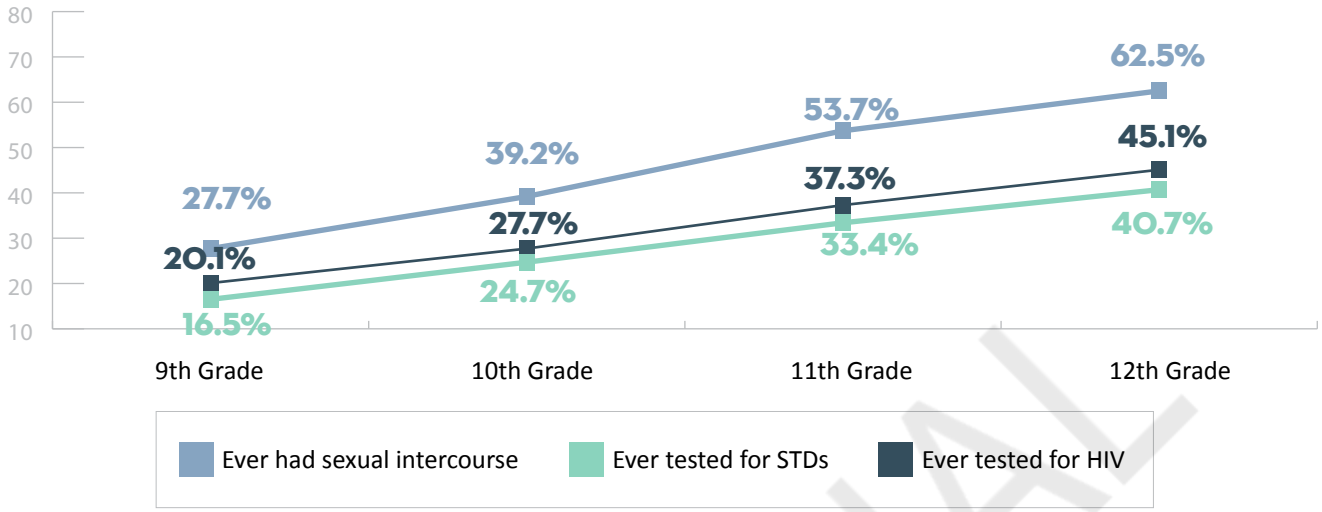
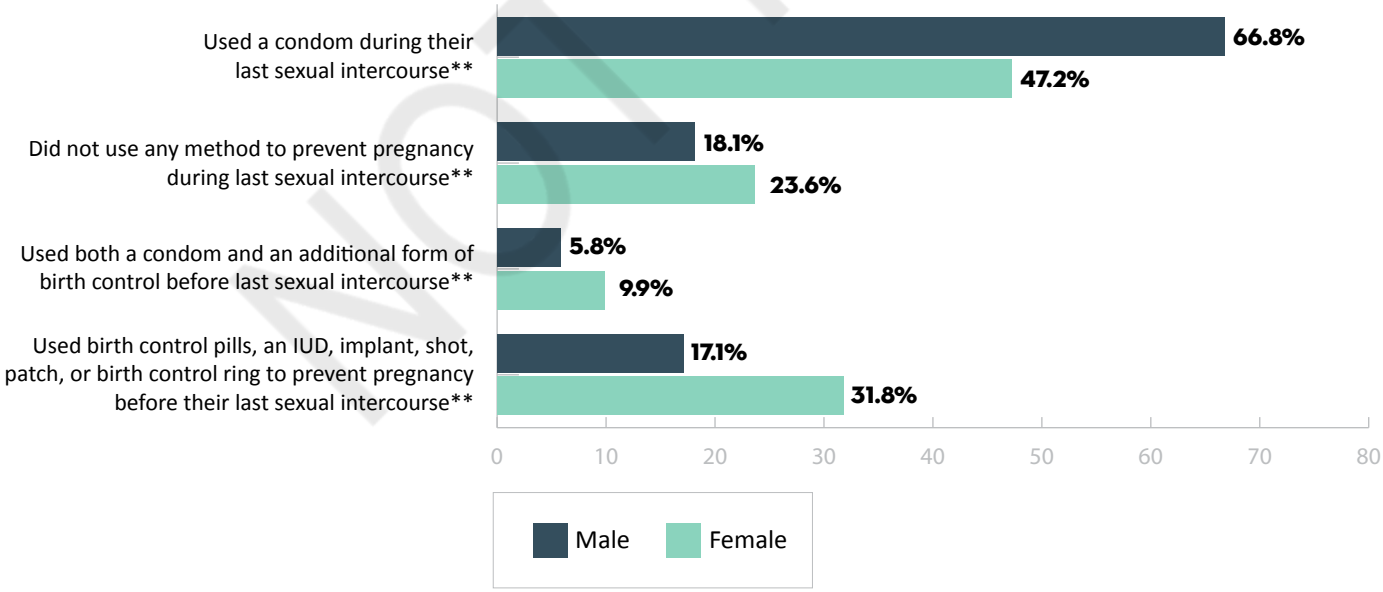
Sexual activity and STD and HIV testing among high school youth, by grade



Between grades 9 and 12, sexual activity and STD and HIV testing increased, but the rate of condom usage decreased from nearly 65 percent of sexually active students in grade 9 to only 52 percent in grade 12.

Birth control and condom use among high school youth, by sex*



*Among students who were sexually active within the last 3 months

** Significant difference between male and female youth

High school LGB students were 37 percent less likely to use a condom during their last sexual intercourse than heterosexual students, after accounting for other demographic factors.

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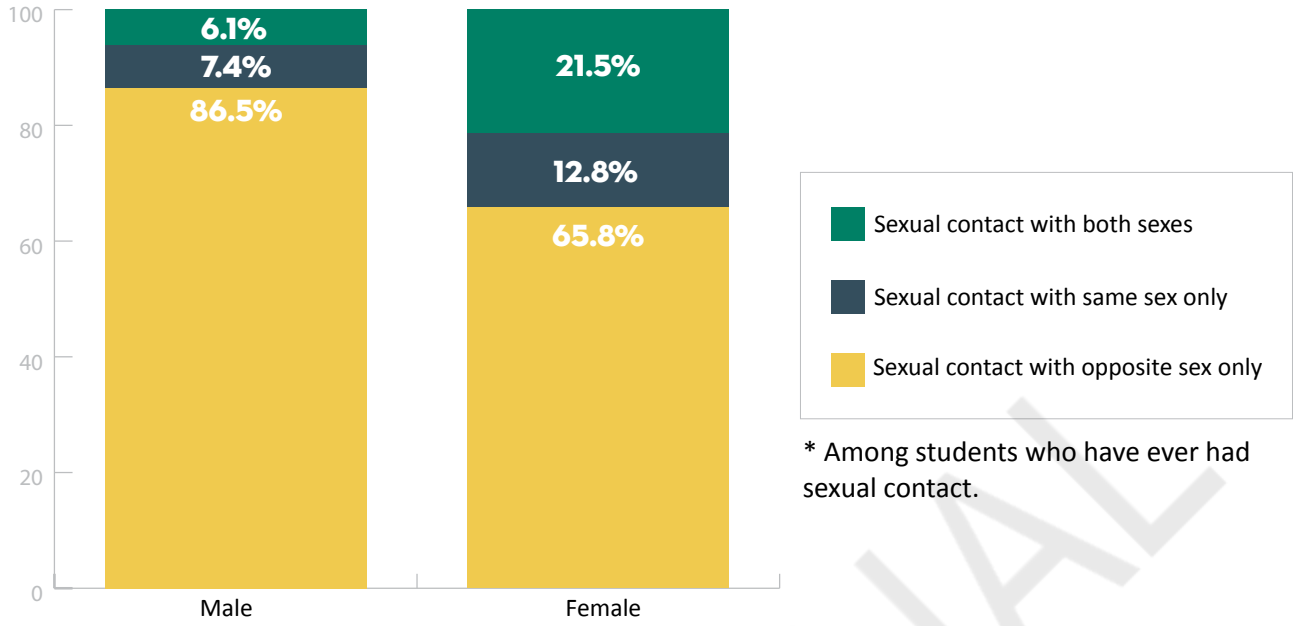
Sexual contact among high school youth, by sex*



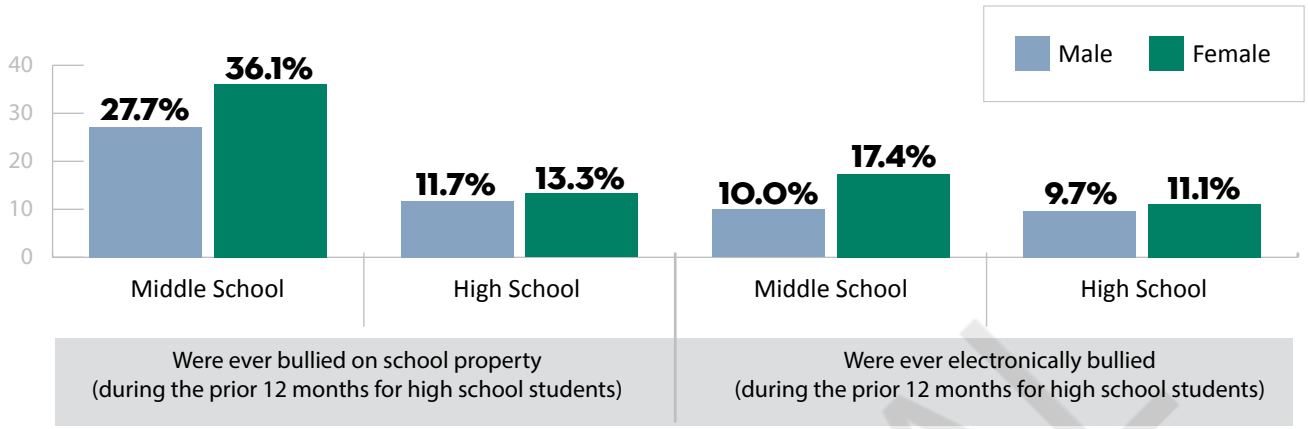
* Among students who have ever had sexual contact.

A higher proportion of female than male high school students reported having sexual contact with the same sex only or with both sexes.

SAFETY AND VIOLENCE

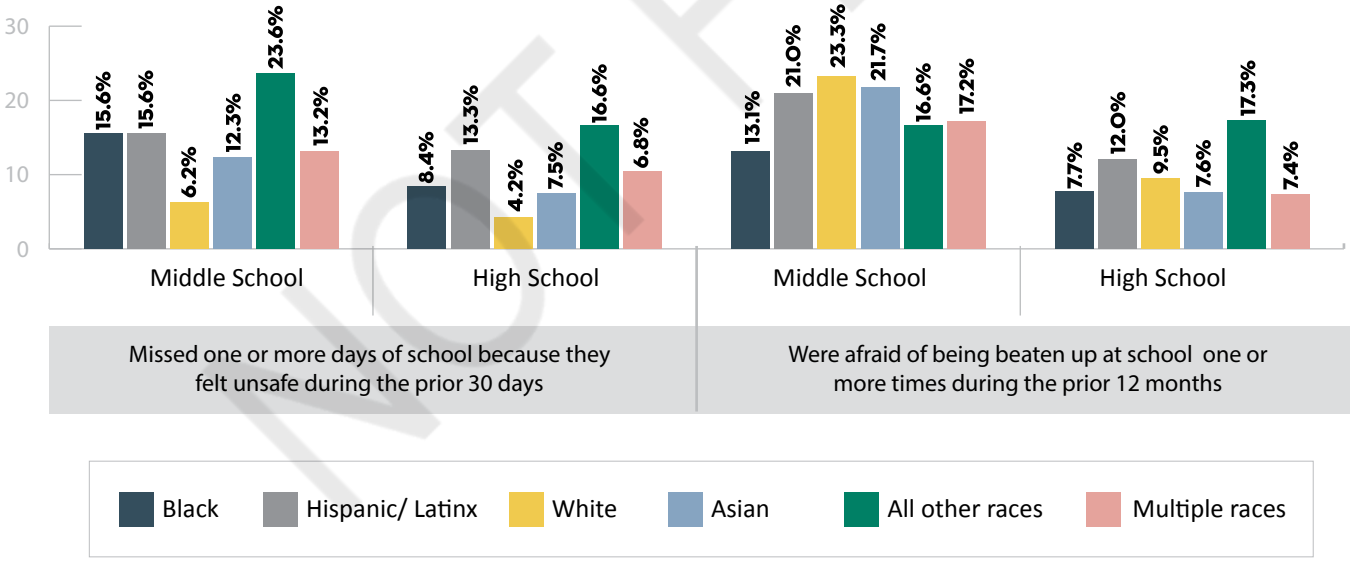
Violence is one of the leading causes of death and injuries among young people between the ages of 10 and 24 in the United States.[7] Since 2007, overall trends in violent behaviors have decreased in DC, but some groups are experiencing violence at much higher rates. At the high school level, black students reported missing school because they felt unsafe at double the rate of their white peers, and Hispanic/Latinx students at more than three times the rate of white students. Academic achievement was also associated with lower rates of violence. Students who received mostly A's reported being in a fight much less than their peers who received mostly F's. These data show the continued need for inclusive policies and programs that support safe schools and communities for all students.

Bullying among DC middle and high school students, by sex



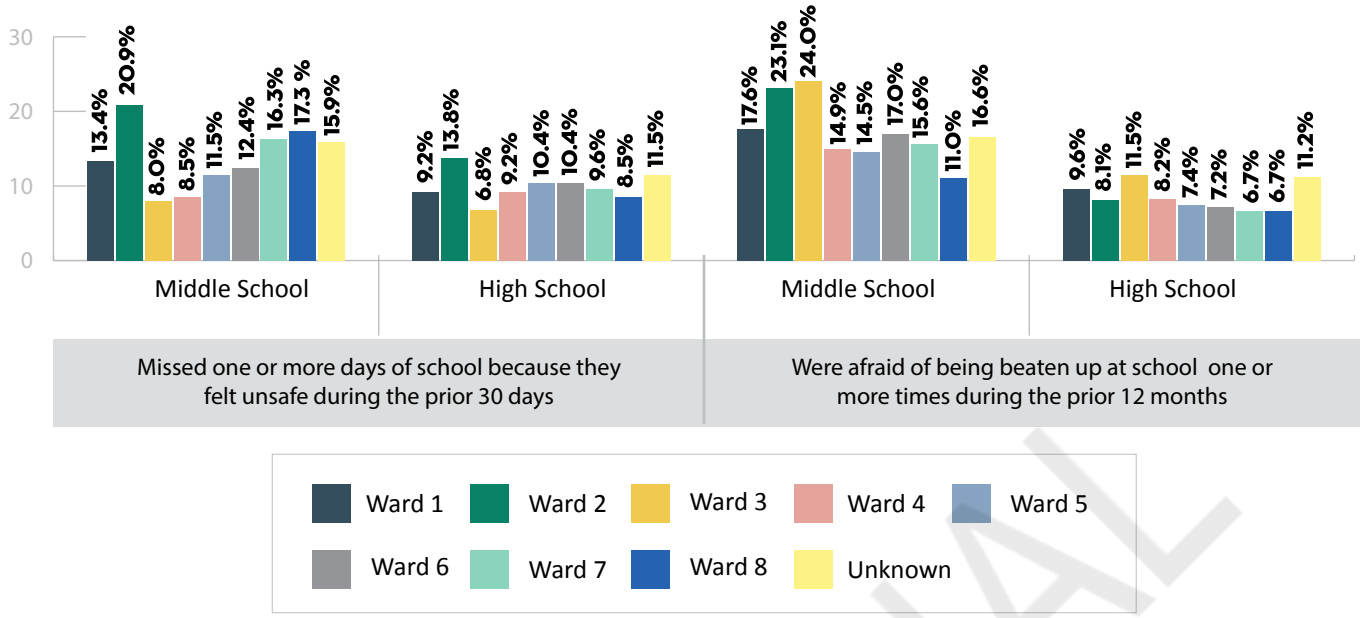
*Differences are statistically different between males and females in middle school, but not high school.

Feelings of unsafety, by race/ethnicity



High school students who report being removed from class for disciplinary reasons on four or more occasions are also more likely to report missing school due to feeling unsafe. They report missing school due to feeling unsafe at three times the rate of students who have never been removed from class.

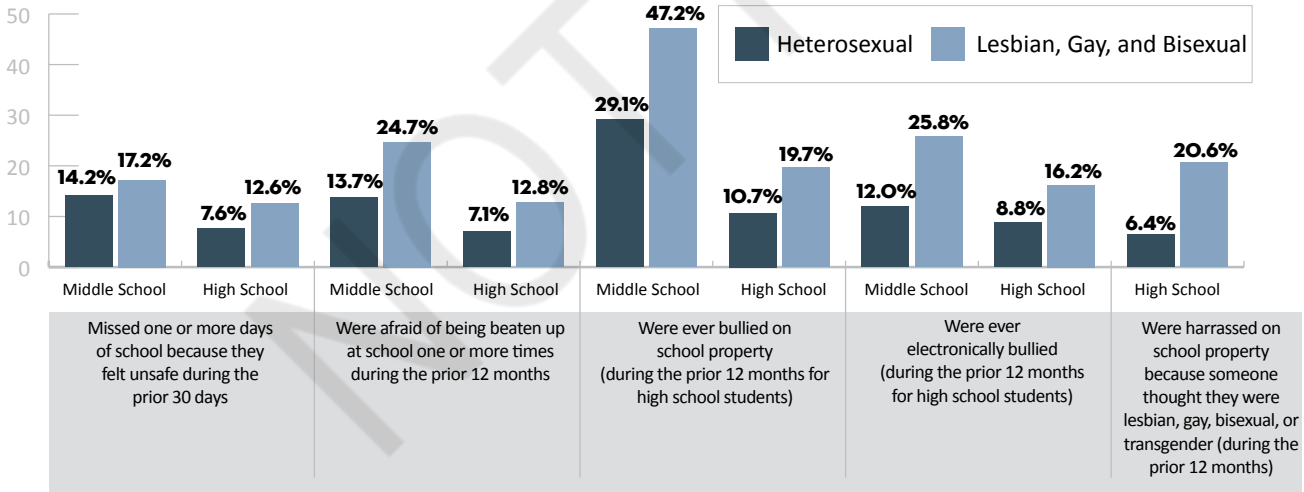
Feelings of unsafety, by ward of residence*



*Approximately 40 percent of middle school students report knowing in which DC ward they live.

*Approximately 60 percent of high school students report knowing in which DC ward they live.

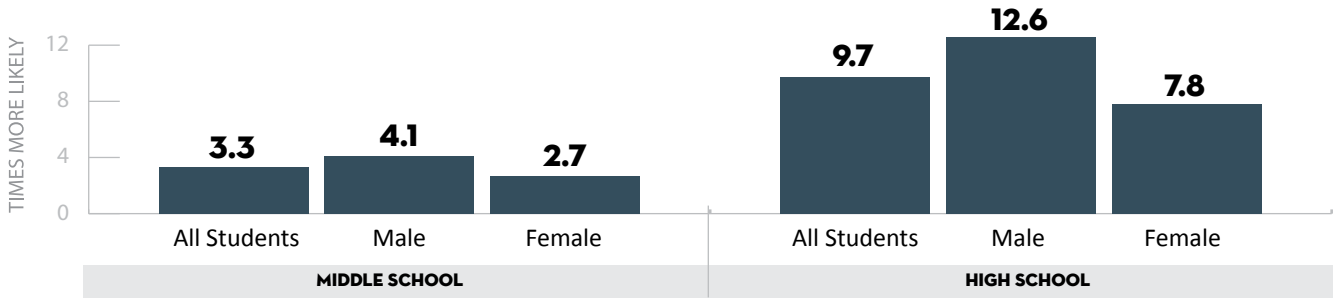
Percentage of students who...



*Differences are significant between heterosexual and LGB students for all questions in middle and high school.

High school students who identify as LGB report nearly double the rate of having been bullied on school property of their heterosexual peers. Notably, LGB high school students also report approximately 5 percent higher rates of being removed from class for at least one day for disciplinary reasons than their heterosexual peers.

Likelihood of bullying others among students who report having been bullied, by sex

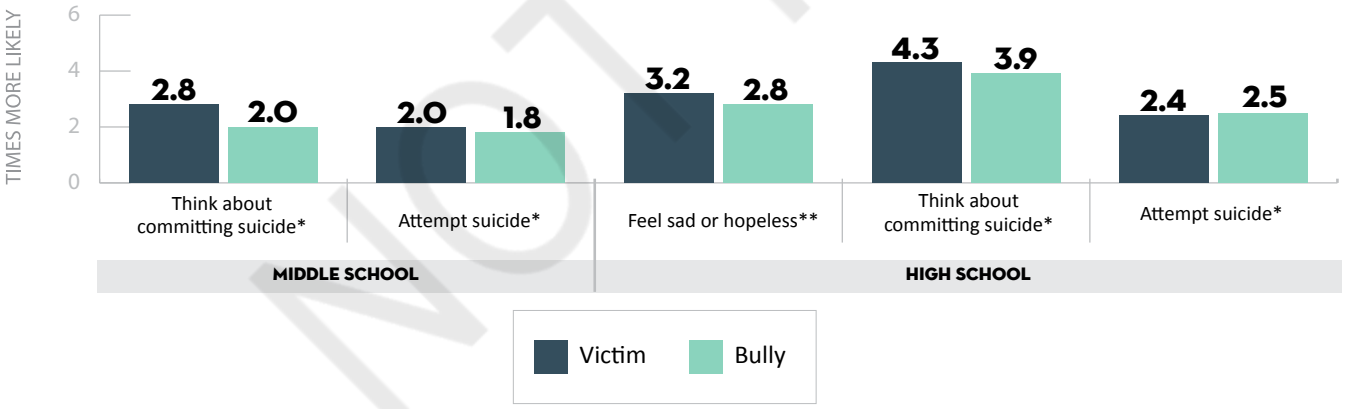


*After accounting for race, grade, and sexual orientation

High school males who report having been bullied during the prior 12 months were 12.6 times more likely than high school males who had not been bullied to report having ever bullied someone else on school property during the same 12 months, after accounting for other demographic factors.

Risk Factors Associated with Bullying Aggression and Victimization

Students who bully others and who are bullied were more likely to:



*Questions around suicidality for middle school students ask if students have in their lifetime "ever seriously thought about killing" or "ever tried to kill" themselves; questions for high school students ask if students have in the prior 12 months "ever seriously considered attempting suicide" or "actually attempted suicide."

**Questions around depression for high school students ask if students have in the prior 12 months "felt so sad or hopeless almost every day for two weeks or more in a row that you stopped doing some usual activities."

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Trends in violent behaviors among middle school students: 2007 to 2019

Violence perpetration among middle school students during the prior 12 months	2007	2012	2015	2017	2019	2017-2019 Trend	Long-Term Trend (2007-2019)
Were ever in a physical fight	76.3%	69.8%	63.7%	67.5%	65.1%	Down↓	Down↓
Ever carried a weapon	33.8%	22.8%	23.1%	26.7%	26.7%	No Change ↔	Down↓
Bullied someone else on school property during the prior 12 months	n/a	17.0%	13.9%	14.5%	12.1%	Down↓	Down↓

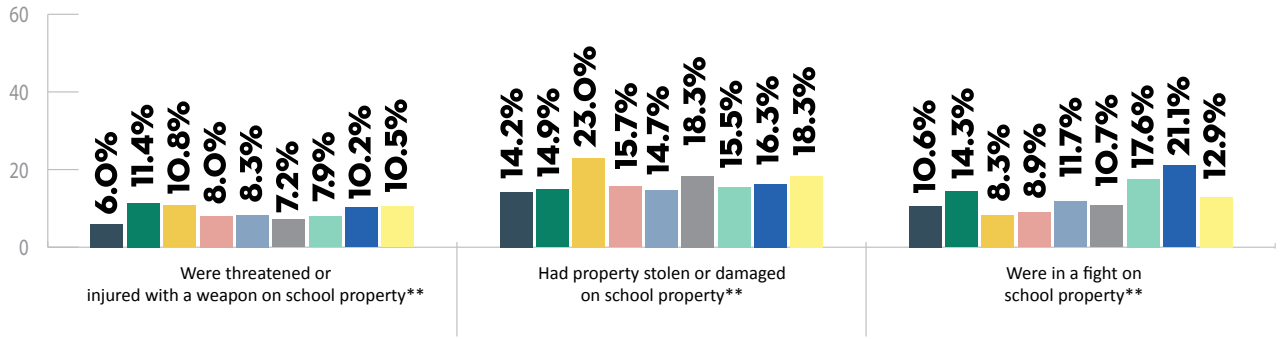
34 percent of middle school males reported carrying a weapon, compared to 19 percent of middle school females. Males also reported having been in a fight at higher rates than females, a comparison of 74 to 57 percent.

Trends in violence victimization and violent behaviors among high school students: 2007 to 2019

Violence victimization among high school students during the prior 12 months	2007	2012	2015	2017	2019	2017-2019 Trend	Long-Term Trend (2007-2019)
Were threatened or injured with a weapon on school property during the prior 12 months	11.2%	8.5%	7.6%	9.8%	9.4%	No Change ↔	Down↓
Had property stolen or deliberately damaged on school property one or more times during the prior 12 months	27.9%	21.3%	17.5%	18.9%	17.1%	Down↓	Down↓
Violence perpetration among high school students during the prior 12 months	**2007**	**2012**	**2015**	**2017**	**2019**	**2017-2019 Trend**	**Long-Term Trend (2007-2019)**
Were in a physical fight on school property one or more times during the prior 12 months	18.8%	15.3%	13.8%	15.5%	14.1%	Down↓	Down↓
Were in a physical fight one or more times during the prior 12 months	44.1%	37.6%	32.4%	31.0%	28.7%	Down↓	Down↓
Carried a weapon one or more times during the prior 30 days	21.5%	20.0%	18.1%	18.8%	15.6%	Down↓	Down↓

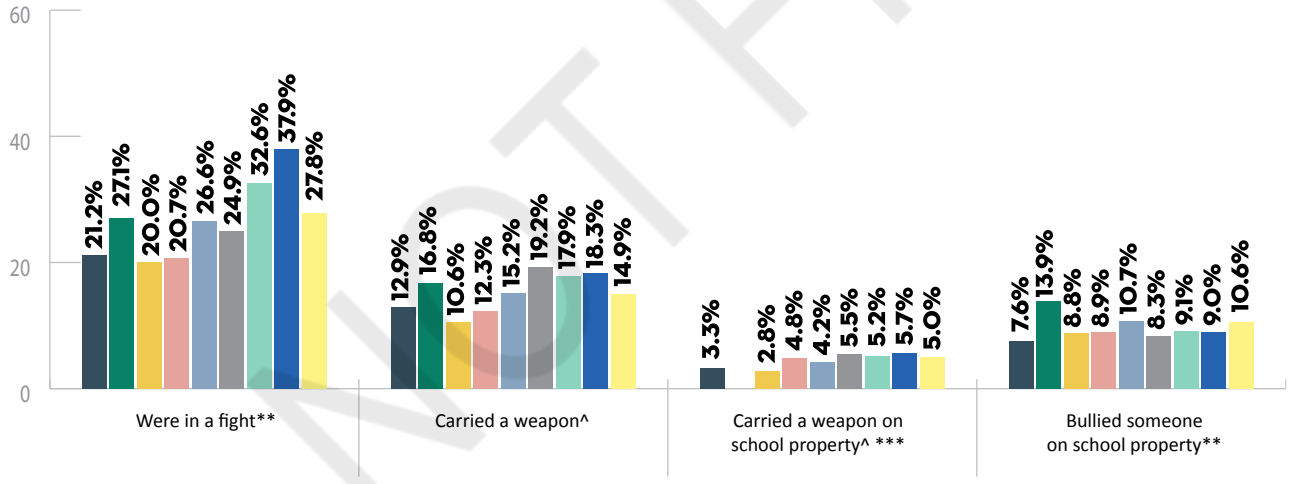
High school students who slept somewhere besides their parent's/guardian's home were 3.2 times as likely to have possessions stolen or deliberately damaged at school and 5.3 times as likely to be threatened with a weapon at school than students who slept in their parent's/guardian's home, after accounting for other demographic factors.

High school violence victimization, by ward of residence*



* Approximately 60 percent of high school students report knowing in which DC ward they live.
** In the 12 months prior to the survey.

High school violent behavior, by ward of residence*



* Approximately 60 percent of high school students report knowing in which DC ward they live.
** In the 12 months prior to the survey.
^ In the 30 days prior to the survey.
*** Data were suppressed for Ward 2 due to low sample size

The percentage of high school students who were in a physical fight (one or more times during the 12 months before the survey) is down from 44.1 percent in 2007 to 28.7 percent in 2019.

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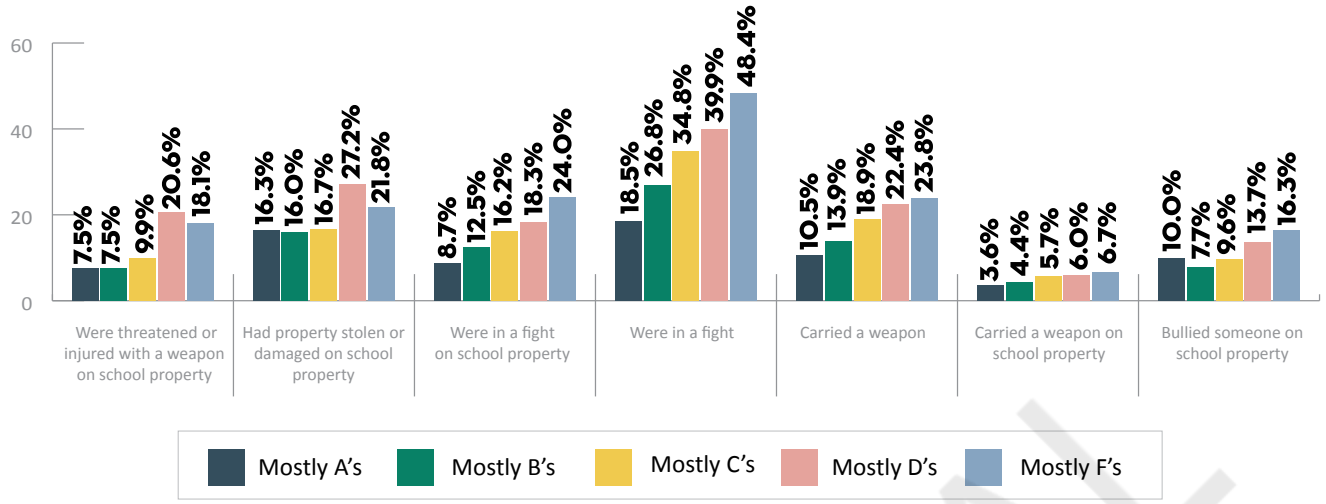
High school violence victimization and violent behavior, by academic performance

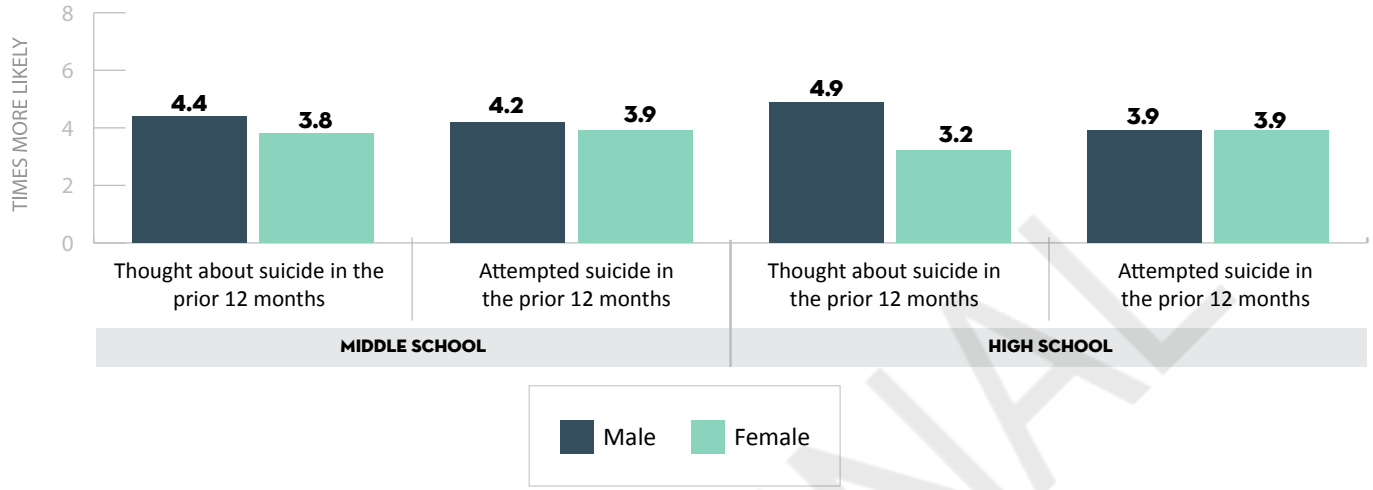


Percentage of students who...

Were a member of a gang or crew (during the prior 12 months)	2012	2015	2017	2019	2017-2019 Trend	Long-Term Trend (2007-2019)
High School	16.5%	17.3%	14.7%	13.4%	Down↓	Down↓
Male	21.6%	21.3%	18.6%	16.2%	Down↓	Down↓
Female	11.5%	13.3%	10.7%	10.4%	No Change ↔	Down↓

Membership in gangs and crews is down from 21.6 percent in 2012 to 16.2 percent in 2019 in high school males.

Students who were ever physically forced to have sexual intercourse (when they did not want to) were more likely to have:



Among female middle school students who reported ever being physically forced to have sexual intercourse (when they did not want to), 44 percent reported at least one suicide attempt during the prior 12 months.

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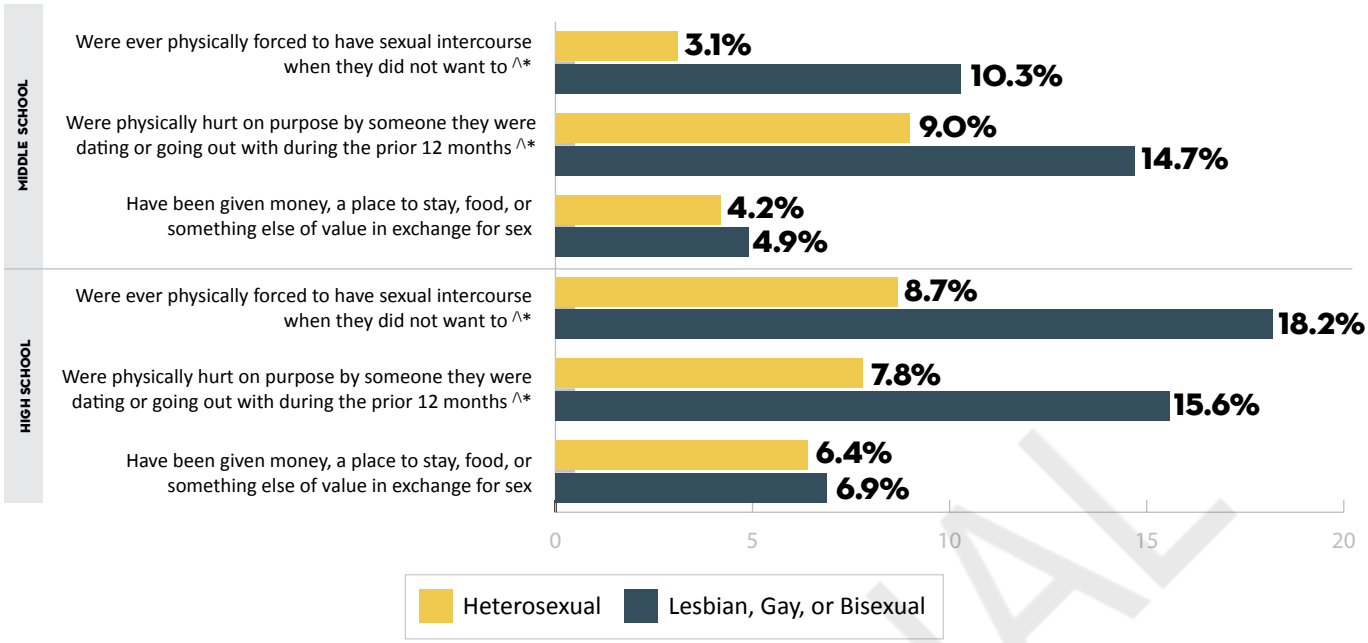
Violent experiences, by sexual orientation



^ Among students who dated or went out with someone during the past 12 months
* Statistical difference between heterosexual and LGB students

- LGB high school students were more than twice as likely to report being forced to have sexual intercourse (raped) and physically hurt by the person they were dating compared to heterosexual youth, after accounting for other demographic factors.
- Transgender youth were 3.8 times as likely to experience dating violence and twice as likely to have been physically forced to have sexual intercourse (raped) than non-transgender youth, after accounting for other demographic factors.

Youth Risk Behavior Survey Methodology

The District of Columbia Office of the State Superintendent of Education (OSSE) conducts the DC Youth Risk Behavior Survey (YRBS). The YRBS is part of the national Youth Risk Behavior Surveillance System (YRBSS) led by the Centers for Disease Control and Prevention (CDC). As such, the DC YRBS follows protocols developed by the CDC, and the DC middle and high school questionnaires are adapted from the CDC-developed core instruments. The following information describes the sampling, recruitment, and field data collection methods used for the 2019 DC YRBS.

Sampling Method

The first sampling stage included a census of all District of Columbia public schools (DCPS) and public charter middle and high schools, serving grades 6-8 and 9-12. In the second sampling stage, a census of students was taken using classes during second period. All students in these classes were eligible to participate in the survey.

Local YRBS surveys, such as the DC YRBS, that have (1) a scientifically selected sample, (2) appropriate documentation, and (3) an overall response rate of greater than 60 percent are able to be weighted by the CDC to adjust for student nonresponse and the distribution of students by grade, sex, and race/ethnicity. These three criteria ensure that data from the 2019 DC YRBS surveys can be considered representative of DC students in grades 6-8 and 9-12. Surveys that do not meet these criteria are not weighted by the CDC and are representative only of the students who participate in the survey.

School and Student Participation

Of the 39 high schools eligible to participate in the 2019 DC YRBS, 36 schools took part in the survey, for a 92 percent school response rate. The survey was completed by 11,409 students for a student response rate of 74 percent. The overall high school response rate was 69 percent.

Of the 76 middle schools eligible to participate in the 2019 DC YRBS, 71 schools took part in the survey, for a 93 percent school response rate. The survey was completed by 11,835 students for a student response rate of 83 percent. The overall middle school response rate was 77 percent.

Obtaining Agreements to Participate and

Managing Survey Logistics

Gaining approval to conduct the 2019 DC YRBS from local education agencies (LEAs) and each school required a well-coordinated effort between OSSE and the contractor, ICF International.

Beginning in the fall of 2018 OSSE provided LEA leaders with information about the survey through various communication methods (i.e., memoranda, newsletters, e-mails, and telephone calls). These communiqués included information on the purposes of the survey, content of the survey, uses of the DC YRBS data, the survey collection window, parental permission, and the requirements of the LEA and school for participating in the survey.

LEA Approval Process

Each LEA was provided with a form to be completed and returned to OSSE signifying their agreement to participate and designating a primary point of contact at the LEA. After the form was received, OSSE notified ICF, and each school was assigned an ICF school liaison. OSSE and ICF school liaisons worked with each LEA or each school directly to (1) identify a point of contact for the school to coordinate the survey logistics, (2) determine a date for the survey that was convenient and minimized disruptions to normal school day activities, and (3) obtain a list of second period classes for the data collection. ICF school liaisons worked closely with school points of contact to quickly finalize the survey arrangements in preparation for the field data collection.

DC YRBS Data Collection

The data collection included the training of survey administrators, classroom-level data collection, and processing of the data collected.

Training the Field Data Collection Staff

The survey administrators participated in a two-day training that was modeled after the highly successful national YRBS training. The training develops technical skills of the survey administrator, while engendering a strong commitment to the concept of the project and the project team. Over the course of the training, the survey administrators first observe demonstrations by the training team on the procedures for data collection. The survey administrators then acquire these skills through practice, demonstrating them to one another and refining each other's performance through constructive feedback.

By the end of the training, the survey administrators acquire the requisite skills; are capable of professionally representing OSSE and ICF; are bonded to the project, the training team, and each other; and are better equipped to perform effectively in the field.

Classroom-Level Data Collection

The 2019 DC YRBS was conducted by the trained survey administrators at eligible schools in Spring 2019. Prior to the scheduled survey administration date, field staff delivered a packet containing the following information to each school point of contact: finalized survey arrangement details, parent exemption letters, and instructions for teachers to read when distributing the letters. Approximately two to three days prior to the scheduled administration date, field staff communicated with the school point of contact to confirm that all teachers had sent the letters home with students and were tracking the return of any signed letters exempting a student from participating in the survey. On the day of the survey, field staff provided all the materials necessary to conduct the 2019 DC YRBS, and after the survey, staff reviewed survey materials to ensure all classes were accounted for and student response rates had been documented accurately. Students who were absent or unable to participate in the original survey administration were offered a make-up session. Field staff revisited schools to survey classes that may have missed the original survey session due to a field trip or other unforeseen circumstance.

Processing the Data Collected

On a weekly basis, the survey administrators returned all collected 2019 DC YRBS data to the ICF project office for processing. Processing of the data included ensuring that all school- and classroom-level data were received and reviewing individual surveys for excessive stray marks or damage.

At the conclusion of data processing, ICF packaged and transmitted all survey forms to CDC's YRBS technical assistance (TA) contractor for scanning. After scanning was completed, a data file was created and sent to the CDC to be edited. The CDC edited the data for logical consistency and overall data quality and returned the edited file to the YRBS TA contractor for weighting.

APPENDIX B

For additional information on student subgroup responses, please see the following:
osse.dc.gov/page/2019-dc-yrbs-data-files

Responses based on age, grade, race/ethnicity, and gender:
- 2019 DC Middle School Summary Tables
- 2019 DC High School Summary Tables

Responses based on academic achievement:
- 2019 DC Middle School Academic Achievement
- 2019 DC High School Academic Achievement

Responses based on sexual identity:
- 2019 DC Middle School Sexual Identity
- 2019 DC High School Sexual Identity

Responses based on sexual contacts (high school only):
- 2019 DC High School Sexual Contacts

Detailed Trend information:
- 2019 DC Middle School Trend Report
- 2019 DC High School Trend Report

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3. Centers for Disease Control and Prevention. (30 March 2020). *What are childhood mental health disorders?* cdc.gov/childrensmentalhealth/basics.html
4. Centers for Disease Control and Prevention. (30 March 2020). *Anxiety and depression in children.* cdc.gov/childrensmentalhealth/depression.html

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7. Centers for Disease Control and Prevention. (7 April 2020). *Preventing youth violence.* cdc.gov/violenceprevention/youthviolence/fastfact.html

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