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.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Prevention & Early Intervention

Priority Type: SUP, MHS

Population(s): SED, PP

Goal of the priority area:

Promote behavioral health wellness through prevention and early intervention services supports.

Strategies to attain the goal:

Development of new Community Prevention Networks and Community Action Plans
DBH and CBO Providers delivering School-Based Behavioral Health Services

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Development of new Community Prevention Networks and Community Action Plans

Baseline Measurement: In FY 23 there were 20 newly developed Community Prevention Networks and 16 newly developed and implemented Community Action Plans to promote substance use prevention.

First-year target/outcome measurement: At least a 10% increase (2) in newly developed Community Prevention Networks and newly developed and implemented Community Action Plans to promote substance use prevention.

Second-year target/outcome measurement: At least a 10% increase (2) in newly developed Community Prevention Networks and newly developed and implemented Community Action Plans to promote substance use prevention above the first-year target.

Data Source:

DC Prevention Center (DCPC) monthly progress reports, annual site visits, and grant monitoring.

Description of Data:

For the FY23 baseline, there were 20 newly developed Community Prevention Networks and 16 newly developed and implemented Community Action Plans to promote substance use prevention.

Data issues/caveats that affect outcome measures:

The development of Community Prevention Networks and Community Action Plans is contingent upon need, available stakeholders, and resources. Though the numbers actually achieved this year change, the objective remains to increase the targets annually.

Indicator #: 2

Indicator: DBH and CBO Providers delivering School-Based Behavioral Health Services

Baseline Measurement: Baseline measurement (Initial data collected prior to and during SFY 2024): In FY23 63% of public and public charter schools have a DBH or CBO provider.

First-year target/outcome measurement: At least 65% of public and public charter schools have a DBH or CBO provider.

Second-year target/outcome measurement: At least 70% of public and public charter schools have a DBH or CBO provider.

Data Source:

Weekly DBH and CBO Staffing reports which inform data on number of School Behavioral Health providers in schools and providing

school behavioral health services.

Description of Data:

The numerator is the (number of providers in buildings providing school behavioral health services) and the denominator is the (number of DC Public and Public Charter Schools in the landscape for the current school year). For FY23 baseline, the numerator is (159) and the denominator is (254 schools).

Data issues/caveats that affect outcome measures:

None

Priority #: 2

Priority Area: Access to Quality Services

Priority Type: SUT, SUR, MHS, ESMI, BHCS

Population(s): SMI, SED, ESMI, BHCS, PWWDC, PWID, EIS/HIV, TB

Goal of the priority area:

Ensure 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.

Strategies to attain the goal:

Establish SUD Youth Residential Treatment Facility
Maintain or Increase the Number of ESMI Providers
Connections to Service
ChAMPS Response Times

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: SUD Youth Residential Treatment Facility

Baseline Measurement: There are no DC SUD Youth Residential Treatment Facilities

First-year target/outcome measurement: Establish one SUD Youth Residential Treatment Facility in SFY 2024

Second-year target/outcome measurement: Maintain one or more SUD Youth Residential Treatment Facility(ies) in the District in SFY 2025

Data Source:

Claims Data; Contract Deliverables

Description of Data:

The numerator is the number of current SUD Youth Residential Treatment Facilities, and the denominator is number of new SUD Youth Residential Treatment Facilities. For FY23 baseline, the numerator is 0 and denominator is 0.

Data issues/caveats that affect outcome measures:

None

Indicator #: 2

Indicator: ESMI Providers

Baseline Measurement: The number of ESMI Providers in SFY 2023

First-year target/outcome measurement: Maintain one ESMI Provider in SFY 2024

Second-year target/outcome measurement: Maintain one or more EMSI Provider(s) in SFY 2025

Data Source:

DBH Certification Division Provider Listing

Description of Data:

The number of ESMI programs serving consumers. For the FY23 baseline, one provider is serving ESMI consumers.

Data issues/caveats that affect outcome measures:

None

Indicator #: 3

Indicator: Connections to Service (Integrated Care Coordination Team)

Baseline Measurement: In FY 23, 43% of the consumers were connected to care within 30 days of referral.

First-year target/outcome measurement: At least 45% of consumers will be connected to care within 30 days of the referral in SFY 2024

Second-year target/outcome measurement: At least 50% of consumers will be connected to care within 30 days of the referral in SFY 2025

Data Source:

ITE, monthly enrollment data

Description of Data:

The numerator is the number of consumers who have an enrollment event completed on their electronic medical record and the denominator is the number of consumers identified as engaged with the ICC team using the first ICC contact form present on the DBH electronic health record. For FY23 baseline, the numerator is 520 and the denominator is 1203.

Data issues/caveats that affect outcome measures:

None

Indicator #: 4

Indicator: ChAMPS Response Time

Baseline Measurement: Catholic Charities response time from determination to deploy to arrival on scene will be 60 minutes or less. In FY 22, 84% of deployments were within 60 minutes. To date in FY 23, the percentage has increased to 91%.

First-year target/outcome measurement: 93% of response time for deployments will be within 60 minutes from determination.

Second-year target/outcome measurement: 97% of response time for deployments will be within 60 minutes from determination.

Data Source:

Monthly and annual data reports on all deployments

Description of Data:

The number of deployments on scene within 60 minutes is the numerator and the total number of deployments is the denominator. To date for FY23 baseline the numerator was 237 and the denominator is 259.

Data issues/caveats that affect outcome measures:

None

Indicator #: 5

Indicator: Increasing PWWDC Outpatient Providers

Baseline Measurement: In FY 23, there are currently no outpatient providers that have programs specifically for PPWDC.

First-year target/outcome measurement: At least one SUD outpatient provider that has a program specifically for PPWDC.

Second-year target/outcome measurement: Maintain at least one or more outpatient programs specifically for PPWDC.

Data Source:

ITE

Description of Data:

The denominator total number of consumers in the level of care. The numerator is the number of
PPWDC in that level of care in the last 30 days. For FY23, the baseline data is 0 numerator and 0 as the denominator due to no specific outpatient programs focused on serving PWWDC.

Data issues/caveats that affect outcome measures:

None

Priority #: 3

Priority Area: Recovery & Resilience

Priority Type: SUT, SUR, MHS

Population(s): SMI, PWID, EIS/HIV, TB

Goal of the priority area:

Build and support a community that promotes recovery and resilience to help individuals and families thrive.

Strategies to attain the goal:

Increase and/or Maintain Supported Employment Providers
Increase Certified Peer Specialists

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase and/or Maintain Supported Employment Providers

Baseline Measurement: In FY23, there were four MH Supported Employment Providers and one SUD Supported Employment Provider.

First-year target/outcome measurement: Maintain at a minimum of four (4) MH Supported Employment Providers and a minimum of one (1) SUD Supported Employment Provider

Second-year target/outcome measurement: Maintain four (4) MH Supported Employment Providers and two-three (2-3) SUD Supported Employment Providers

Data Source:

DBH Accountability Administration, Certification Compliance/Approval

Description of Data:

For MH Providers, the numerator is the number of current providers, and the denominator is the number of new providers. For the SUD Providers, the numerator is the number of current providers, and the denominator is the number of new providers.
For FY23 baseline, MH Providers, the numerator 4 current Providers and the denominator, is 4 the goal of Providers to retain. For FY23 baseline, SUD Providers, the numerator 1 current Providers and the denominator, is 1 the goal of Providers to retain.

Data issues/caveats that affect outcome measures:

Currently, there is a moratorium on evidence based supported employment providers, which could prevent the number of SE providers increasing.

Indicator #: 2

Indicator: Increase Certified Peer Specialists

Baseline Measurement: As of August 2023, there were 30 certified Peers.

First-year target/outcome measurement: At least 30 peers will be trained and certified (including waivers).

Second-year target/outcome measurement: At least 35 peers will be trained and certified.

Data Source:

SharePoint Peer database

Description of Data:

The numerator is the number of current certified peers and the denominator is number of new peers. For FY 23 baseline the numerator is 30 and the denominator is 30.

Data issues/caveats that affect outcome measures:

None

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Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SUPTRS]

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2024/2025.
SUPTRS BG – ONLY include funds expended by the executive branch agency administering the SUPTRS BG.

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2025

Activity (See instructions for using Row 1.)	Source of Funds									
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SUPTRS BG)[a]	J. ARP Funds (SUPTRS BG)[b]
1. Substance Use Prevention[c] and Treatment	$5,271,207.00		$0.00	$21,844,496.00	$52,337,601.00	$0.00	$0.00		$3,353,904.00	$0.00
a. Pregnant Women and Women with Dependent Children[c]	$376,515.00				$2,316,434.00					
b. Recovery Support Services					$800,000.00					
c. All Other	$4,894,692.00			$21,844,496.00	$49,221,167.00				$3,353,904.00	
2. Primary Prevention[d]	$1,506,059.00		$0.00	$0.00	$905,030.00	$0.00	$0.00		$790,000.00	$0.00
a. Substance Use Primary Prevention	$1,506,059.00				$905,030.00				$790,000.00	
b. Mental Health Prevention										
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)										
4. Other Psychiatric Inpatient Care										
5. Tuberculosis Services					$300,000.00					
6. Early Intervention Services for HIV	$376,515.00				$80,000.00				$326,548.00	
7. State Hospital										
8. Other 24-Hour Care										
9. Ambulatory/Community Non-24 Hour Care										
10. Crisis Services (5 percent set-aside)										
11. Administration (excluding program/provider level) MHBG and SUPTRS BG must be reported separately	$376,515.00			$2,294,645.00	$1,035,620.00				$163,274.00	
12. Total	**$7,530,296.00**	**$0.00**	**$0.00**	**$24,139,141.00**	**$54,658,251.00**	**$0.00**	**$0.00**	**$0.00**	**$4,633,726.00**	**$3,000,000.00**

[a] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[b] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. Per the instructions, the planning period for standard MHBG/SUPTRS BG expenditures is July 1, 2023 – June 30, 2025. Please enter SUPTRS BG ARP planned expenditures for the period of July 1, 2023 through June 30, 2025

[c] Prevention other than primary prevention

[d] The 20 percent set-aside funds in the SUPTRS BG must be used for activities designed to prevent substance misuse.

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Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

Table 2 addresses funds to be expended during the 24-month period of July 1, 2023 through June 30, 2025. Table 2 now includes columns to capture state expenditures for COVID-19 Relief Supplemental and ARP funds. Please use these columns to capture how much the state plans to expend over a 24-month period (July 1, 2023 - June 30, 2025). Please document the use of COVID-19 Relief Supplemental and ARP funds in the footnotes.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2025

Activity (See instructions for using Row 1.)	Source of Funds										
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SUPTRS BG)[a]	J. ARP Funds (MHBG)[b]	K. BSCA Funds (MHBG)[c]
1. Substance Use Prevention and Treatment											
a. Pregnant Women and Women with Dependent Children											
b. Recovery Support Services											
c. All Other											
2. Primary Prevention											
a. Substance Use Primary Prevention											
b. Mental Health Prevention[d]					$84,135,034.00			$663,159.00		$986,820.00	
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)[e]		$237,982.00			$4,003,754.00			$82,895.00			
4. Other Psychiatric Inpatient Care				$2,485,655.00	$5,377,646.00						
5. Tuberculosis Services											
6. Early Intervention Services for HIV											
7. State Hospital				$4,521,520.10	$194,595,200.00		$348,000.00				
8. Other 24-Hour Care											
9. Ambulatory/Community Non-24 Hour Care		$1,903,855.00			$21,908,952.00	$36,515,096.00				$1,018,890.00	
10. Crisis Services (5 percent set-aside)[f]		$118,991.00		$511,427.00	$18,035,412.00			$41,447.00			
11. Administration (excluding program/provider level) MHBG and SUPTRS BG must be reported separately[g]		$118,991.00		$6,020,380.00	$59,508,806.00			$41,447.00		$717,328.00	
12. Total	**$0.00**	**$2,379,819.00**	**$0.00**	**$13,538,982.10**	**$387,564,804.00**	**$36,515,096.00**	**$348,000.00**	**$828,948.00**	**$0.00**	**$2,723,038.00**	**$64,815.50**

[a]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG. Columns H should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states. Note: If your state has an approved no cost extension, you have until March 14, 2024, to expend the COVID-19 Relief supplemental funds.

[b]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Columns H should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states.

[c]The expenditure period for the 1st allocation of Bipartisan Safer Communities Act (BSCA) supplemental funding is from **October 17, 2022 thru October 16, 2024** and the expenditure for the 2nd allocation of BSCA funding will be from September 30, 2023 thru September 29, 2025 which is different from the expenditure period for the "standard" MHBG. Column J should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states.

[d]While the state may use state or other funding for prevention services, the MHBG funds must be directed toward adults with SMI or children with SED.

[e]Column 3 should include Early Serious Mental Illness programs funded through MHBG set aside.

[f]Row 10 should include Behavioral Health Crisis Services (BHCS) programs funded through different funding sources, including the MHBG set aside. States may expend more than 5 percent of their MHBG allocation.

[g]Per statute, administrative expenditures cannot exceed 5% of the fiscal year award.

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Footnotes:

Planning Tables

Table 3 SUPTRS BG Persons in need/receipt of SUD treatment

To complete the Aggregate Number Estimated in Need column, please refer to the most recent edition of SAMHSA's National Survey on Drug Use and Health (NSDUH) or other federal/state data that describes the populations of focus in rows 1-5.

To complete the Aggregate Number in Treatment column, please refer to the most recent edition of the Treatment Episode Data Set (TEDS) data prepared and submitted to SAMHSA's Behavioral Health Services Information System (BHSIS).

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	32	10
2. Women with Dependent Children	618	283
3. Individuals with a co-occurring M/SUD	1,658	1,680
4. Persons who inject drugs	900	135
5. Persons experiencing homelessness	4,922	1,055

Please provide an explanation for any data cells for which the state does not have a data source.

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Table 4 SUPTRS BG Planned Expenditures

States must project how they will use SUPTRS BG funds to provide authorized services as required by the SUPTRS BG regulations, including the supplemental COVID-19 and ARP funds. Plan Table 4 must be completed for the FFY 2024 and FFY 2025 SUPTRS BG awards. The totals for each Fiscal Year should match the President's Budget Allotment for the state.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

	FFY 2024		
Expenditure Category	**FFY 2024 SUPTRS BG Award**	**COVID-19 Award[1]**	**ARP Award[2]**
1 . Substance Use Disorder Prevention and Treatment[3]	$5,271,207.00	$3,055,903.00	$2,100,000.00
2 . Substance Use Primary Prevention	$1,506,059.00	$924,725.00	$600,000.00
3 . Early Intervention Services for HIV[4]	$376,515.00	$326,549.00	$150,000.00
4 . Tuberculosis Services			
5 . Recovery Support Services[5]			
6 . Administration (SSA Level Only)	$376,515.00	$326,549.00	$150,000.00
7. Total	**$7,530,296.00**	**$4,633,726.00**	**$3,000,000.00**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19

Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the FY 2024 "standard" SUPTRS BG, which is October 1, 2023 - September 30, 2024. The SUPTRS BG ARP planned expenditures for the period of October 1, 2023 - September 30, 2024 should be entered here in the first ARP column, and the SUPTRS BG ARP planned expenditures for the period of October 1, 2024, through September 30, 2025, should be entered in the second ARP column.

[3]Prevention other than Primary Prevention

[4]For the purpose of determining which states and jurisdictions are considered "designated states" as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance use disorder Prevention and Treatment Block Grant (SUPTRS BG); Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the AtlasPlus HIV data report produced by the Centers for Disease Control and Prevention (CDC,), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention (NCHHSTP). The most recent AtlasPlus HIV data report published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SUPTRS BG allotments to establish one or more projects to provide early intervention services regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a “designated state” in any of the three years prior to the year for which a state is applying for SUPTRS BG funds with the flexibility to obligate and expend SUPTRS BG funds for EIS/HIV even though the state’s AIDS case rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SUPTRS BG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance will be allowed to obligate and expend SUPTRS BG funds for EIS/HIV if they chose to do so and may elect to do so by providing written notification to the CSAT SPO as a part of the SUPTRS BG Application.

[5]This expenditure category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023.

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Table 5a SUPTRS BG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

A		B		
Strategy	IOM Target	FFY 2024		
		SUPTRS BG Award	COVID-19 Award[1]	ARP Award[2]
1. Information Dissemination	Universal	$270,469	$117,134	$92,760
	Selected			
	Indicated			
	Unspecified			
	Total	**$270,469**	**$117,134**	**$92,760**
2. Education	Universal	$81,141	$65,140	$55,140
	Selected			
	Indicated			
	Unspecified			
	Total	**$81,141**	**$65,140**	**$55,140**
3. Alternatives	Universal	$54,094	$43,427	$38,700
	Selected			
	Indicated			
	Unspecified			
	Total	**$54,094**	**$43,427**	**$38,700**
4. Problem Identification and Referral	Universal	$27,047	$21,713	$23,400
	Selected			
	Indicated			
	Unspecified			
	Total	**$27,047**	**$21,713**	**$23,400**
	Universal	$972,738	$643,268	$390,000

5. Community-Based Processes	Selected			
	Indicated			
	Unspecified			
	Total	**$972,738**	**$643,268**	**$390,000**
6. Environmental	Universal	$40,570	$35,963	
	Selected			
	Indicated			
	Unspecified			
	Total	**$40,570**	**$35,963**	**$0**
7. Section 1926 (Synar)-Tobacco	Universal			
	Selected			
	Indicated			
	Unspecified	$60,000		
	Total	**$60,000**	**$0**	**$0**
8. Other	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
Total Prevention Expenditures		**$1,506,059**	**$926,645**	**$600,000**
Total SUPTRS BG Award[3]		**$7,530,296**	**$4,633,726**	**$3,000,000**
Planned Primary Prevention Percentage		**20.00 %**	**20.00 %**	**20.00 %**

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 1, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025.

[3]Total SUPTRS BG Award is populated from Table 4 - SUPTRS BG Planned Expenditures

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Table 5b SUPTRS BG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

Activity	FFY 2024 SUPTRS BG Award	FFY 2024 COVID-19 Award[1]	FFY 2024 ARP Award[2]
Universal Direct	$1,446,059	$926,745	$600,000
Universal Indirect	$60,000		
Selected			
Indicated			
Column Total	**$1,506,059**	**$926,745**	**$600,000**
Total SUPTRS BG Award[3]	**$7,530,296**	**$4,633,726**	**$3,000,000**
Planned Primary Prevention Percentage	**20.00 %**	**20.00 %**	**20.00 %**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 1, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025.

[3]Total SUPTRS BG Award is populated from Table 4 - SUPTRS BG Planned Expenditures

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Table 5c SUPTRS BG Planned Primary Prevention Priorities (Required)

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2024 and FFY 2025 SUPTRS BG awards.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

	SUPTRS BG Award	COVID-19 Award[1]	ARP Award[2]
Prioritized Substances			
Alcohol	☑	☑	☑
Tobacco	☑	☑	☑
Marijuana	☑	☑	☑
Prescription Drugs	☑	☑	☑
Cocaine	☐	☐	☐
Heroin	☑	☑	☑
Inhalants	☐	☐	☐
Methamphetamine	☐	☐	☐
Fentanyl	☐	☐	☐
Prioritized Populations			
Students in College	☑	☑	☑
Military Families	☐	☐	☐
LGBTQI+	☑	☑	☑
American Indians/Alaska Natives	☐	☐	☐
African American	☑	☑	☑
Hispanic	☑	☑	☑
Persons Experiencing Homelessness	☐	☐	☐
Native Hawaiian/Other Pacific Islanders	☐	☐	☐
Asian	☐	☐	☐
Rural	☐	☐	☐

Underserved Racial and Ethnic Minorities	☑	☑	☑

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 1, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025.

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Table 6 Non-Direct-Services/System Development [SUPTRS]

Please enter the total amount of the SUPTRS BG, COVID-19, or ARP funds expended for each activity.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

Expenditure Category	FFY 2024 A. SUPTRS BG Treatment	B. SUPTRS BG Prevention	C. SUPTRS BG Integrated[1]	D. COVID-19[2]	E. ARP[3]
1. Information Systems					
2. Infrastructure Support	$143,755.00		$583,097.00		$889,338.00
3. Partnerships, community outreach, and needs assessment			$800,000.00		
4. Planning Council Activities (MHBG required, SUPTRS BG optional)					
5. Quality Assurance and Improvement					
6. Research and Evaluation					
7. Training and Education					
8. Total	**$143,755.00**	**$0.00**	**$1,383,097.00**	**$0.00**	**$889,338.00**

[1]Integrated refers to non-direct service/system development expenditures that support both treatment and prevention systems of care.

[2]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[3]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the federal planned expenditure period of October 1, 2023 - September 30, 2025. Please list ARP planned expenditures for each standard FFY period.

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Planning Tables

Table 6 Non-Direct-Services/System Development [MH]

Please enter the total amount of the MHBG, COVID-19, ARP funds, and BSCA funds expended for each activity

MHBG Planning Period Start Date: MHBG Planning Period End Date:

Activity	FY Block Grant	FY [1] COVID Funds	FY [2] ARP Funds	FY [3] BSCA Funds
.	$	$	$	$
8. Total			**$**	**$**

Please wait while data loads...

[1] The 24-month expenditure period for the COVID-19 Rel **21 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG. Per the ins res captured in Columns A - G are for the state planned expenditure period of July 1, 2023 - June 30, 2025, for mo oved no cost extension, you have until March 14, 2024 to expend the COVID-19 Relief supplemental funds.

[2] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A - G are for the state planned expenditure period of July 1, 2023 - June 30, 2025, for most states.

[3] The expenditure period for the 1st allocation of Bipartisan Safer Communities Act (BSCA) supplemental funding is **October 17, 2022** thru **October 16, 2024** and for the 2nd allocation will be **September 30, 2023** thru **September 29, 2025** which is different from the expenditure period for the "standard" MHBG. Column D should reflect the spending for the state reporting period. The total may reflect the BSCA allotment portion used during the state reporting period.

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Environmental Factors and Plan

1. Access to Care, Integration, and Care Coordination – Required

Narrative Question

Across the United States, significant percentages of adults with serious mental illness, children and youth with serious emotional disturbances, and people with substance use disorders do not access needed behavioral health care. States should focus on improving the range and quality of available services and on improving the rate at which individuals who need care access it. States have a number of opportunities to improve access, including improving capacity to identify and address behavioral needs in primary care, increasing outreach and screening in a variety of community settings, building behavioral health workforce and service system capacity, and efforts to improve public awareness around the importance of behavioral health. When considering access to care, states should examine whether people are connected to services, and whether they are receiving the range of needed treatment and supports.

A venue for states to advance access to care is by ensuring that protections afforded by MHPAEA are being adhered to in private and public sector health plans, and that providers and people receiving services are aware of parity protections. SSAs and SMHAs can partner with their state departments of insurance and Medicaid agencies to support parity enforcement efforts and to boost awareness around parity protections within the behavioral health field. The following resources may be helpful: **https://store.samhsa.gov/product/essential-aspects-of-parity-training-tool-for-policymakers/pep21-05-00-001**; **https://store.samhsa.gov/product/Approaches-in-Implementing-the-Mental-Health-Parity-and-Addiction-Equity-Act-Best-Practices-from-the-States/SMA16-4983**. The integration of primary and behavioral health care remains a priority across the country to ensure that people receive care that addresses their mental health, substance use, and physical health problems. People with mental illness and/or substance use disorders are likely to die earlier than those who do not have these conditions.[1]Ensuring access to physical and behavioral health care is important to address the physical health disparities they experience and to ensure that they receive needed behavioral health care. States should support integrated care delivery in specialty behavioral health care settings as well as primary care settings. States have a number of options to finance the integration of primary and behavioral health care, including programs supported through Medicaid managed care, Medicaid health homes, specialized plans for individuals who are dually eligible for Medicaid and Medicare, and prioritized initiatives through the mental health and substance use block grants or general funds. States may also work to advance specific models shown to improve care in primary care settings, including Primary Care Medical Homes; the Coordinated Care Model; and Screening, Brief Intervention, and Referral to Treatment.

Navigating behavioral health, physical health, and other support systems is complicated and many individuals and families require care coordination to ensure that they receive necessary supports in and efficient and effective manner. States should develop systems that vary the intensity of care coordination support based on the severity seriousness and complexity of individual need. States also need to consider different models of care coordination for different groups, such as High-Fidelity Wraparound and Systems of Care when working with children, youth, and families; providing Assertive Community Treatment to people with serious mental illness who are at a high risk of institutional placement; and connecting people in recovery from substance use disorders with a range of recovery supports. States should also provide the care coordination necessary to connect people with mental and substance use disorders to needed supports in areas like education, employment, and housing.

[1]Druss, B. G., Zhao, L., Von Esenwein, S., Morrato, E. H., & Marcus, S. C. (2011). Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Medical care, 599-604.Avaiable at: **https://journals.lww.com/lww-medicalcare/Fulltext/2011/06000/Understanding_Excess_Mortality_in_Persons_With.11.aspx**

1. Describe your state's efforts to improve access to care for mental disorders, substance use disorders, and co-occurring disorders, including detail on efforts to increase access to services for:

a) Adults with serious mental illness

b) Pregnant women with substance use disorders

c) Women with substance use disorders who have dependent children

d) Persons who inject drugs

e) Persons with substance use disorders who have, or are at risk for, HIV or TB

f) Persons with substance use disorders in the justice system

g) Persons using substances who are at risk for overdose or suicide

h) Other adults with substance use disorders

i) Children and youth with serious emotional disturbances or substance use disorders

j) Individuals with co-occurring mental and substance use disorders

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 supports for enrolled consumers. Approximately 60% of enrolled consumers have a serious mental health diagnosis and a co-occurring substance use disorder. 100% of enrolled consumers have a serious mental illness and serious functional impairments. Consumers are identified for care using PATH homeless engagement teams, by providers of outpatient mental health and substance use disorder care, and by the individuals themselves and their informal support networks.

In FY23 the District developed and implemented The Intensive Care Coordination Team. This team, lead 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 invested to support a clinician in every public 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. As a part of the School-Based Behavioral Health expansion to increase access to behavioral health services while students are in school, the School Year 2022-2023 landscape of DC Public and DC Public Charter schools was expanded to 253 schools.

DBH continues to offer Community Based Intervention (CB) Services which are time-limited, intensive, mental health services delivered to children and youth with serious emotional disturbances. CBI services are intended to prevent the utilization of an out-of-home therapeutic resource or a detention of the consumer. In FY22, 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 in increase capacity and access to intensive community-based services.

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. In FY22 as an effort to increase capacity and access to services for toddlers and children with Early Serious Mental Illness, 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. The training was facilitated by the University of Delaware, the national training entity. 9 individuals from the Department of Behavioral Health (DBH), Core Service Agencies, and Medstar Georgetown were identified to complete certification to become ABC Coaches expanding access to services throughout the District and across diverse populations.

In an effort to increase access to services for youth with substance use disorders, in FY22, current youth SUD providers were trained in Motivational-Enhancement Therapy-Cognitive Behavioral Therapy (MET-CBT) which is a therapeutic modality for ages 12-18 that places the responsibility and decision to change on the client that target both the motivation to change the substance use behavior and the underlying thoughts and feelings that may be triggering the maladaptive substance use behaviors.

2. Describe your efforts, alone or in partnership with your state's department of insurance and/or Medicaid system, to advance parity enforcement and increase awareness of parity protections among the public and across the behavioral and general health care fields.

The Department of Behavioral Health and the Department of Health Care Finance, DC's state Medicaid agency, began partnering in 2020 to plan for the full integration of behavioral health services in the Managed Care Organizations (MCO) service delivery. The District will bring these services into the Medicaid managed care program in April 2024, to increase access to case coordination and whole person care, and improve outcomes. The MCOs will have greater flexibility in developing monitoring and reimbursement strategies to reduce hospital stays and increase access to community-based services. Over the last two years, DBH and DHCF have embarked on a rate study to determine the need for the increase in rates for behavioral health services in the district.

3. Describe how the state supports integrated behavioral health and primary health care, including services for individuals with mental disorders, substance use disorders, and co-occurring mental and substance use disorders. Include detail about:

a) Access to behavioral health care facilitated through primary care providers

b) Efforts to improve behavioral health care provided by primary care providers

c) Efforts to integrate primary care into behavioral health settings

The following examples demonstrate how the District integrates mental health and primary care, including services for individuals with co-occurring mental health and substance use disorders: 1) The D.C. Healthy Communities Collaborative (DCHCC) Community Health Needs Assessment: The DCHCC includes: 1) a coalition of four hospitals: Children's National Health System, Howard University Hospital, Providence Health System, and Sibley Memorial Hospital); 2) four Federally Qualified Health Centers: Bread for the City, Community of Hope, Mary's Center, and Unity Health Care; and 3) two associations: D.C. Hospital Association and D.C. Primary Care Association. The DCHCC authored the June 2019 Community Health Needs Assessment Report to serve as an evidence-based, community-driven foundation for community health improvement efforts. Four priority community needs emerged: 1) mental health (prevention and treatment of psychological, emotional, and relational issues that lead to higher quality of life); 2) place-based care/bringing care to the community (care options that are convenient and culturally sensitive); 3) care coordination (deliberate organization of patient care activities and information-sharing protocols among all of the participants concerned with

a patient's care to achieve safer and more effective care); and 4) health literacy (ability to obtain, process, and understand basic health information and services needed to make appropriate health decisions). The feedback from this integrated, collaborative assessment is used to inform DBH initiatives and outcome evaluations. 2) Federally Qualified Health Centers (FQHCs), more commonly known as Community Health Centers (CHCs) are community-based and patient-directed primary care centers. They serve those who have limited access to 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. The following providers are FQHCs: Community of Hope - creates opportunities for low-income families in the District, including those experiencing homelessness to achieve good health, a stable home, family-sustaining income, and hope. There are three locations in the District. Family and Medical Counseling Services – employs community-based, culturally competent approaches to provide comprehensive services that promote the emotional and physical health of families and individuals, regardless of income or socioeconomic status, to maximize the quality of life. La Clinica Del Pueblo - Serves the Latino and immigrant populations of the Washington DC metropolitan area. The goal is to provide culturally appropriate health services, focusing on those most in need. Mary's Center for Maternal and Child Care, Inc. - Provides health care, family literacy, and social services to individuals whose needs often go unmet by the public and private systems. It uses a holistic, multipronged approach to help each participant access individualized services that set them on the path toward good health, stable families, and economic independence. Mary's Center is a DBH-certified Mental Health Rehabilitation Services (MHRS) core services agency and has three District health locations. Unity Health Care Inc.- Promotes healthier communities through compassion and comprehensive health and human services, regardless of ability to pay. Unity Health Care has ten clinic sites, eleven homeless sites, three school-based health centers, and two specialty sites. Whitman Walker Clinic- The mission is to provide high quality, culturally competent community health center services to the District's diverse urban community, including individuals who face barriers to accessing care, and with special expertise in Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ) and HIV care. There are two centers in the District. Bread for the City- This FQHC look-a-like provides District residents with comprehensive services, including food, clothing, medical care, and legal and social services. There are two centers in the District. 3) The Integration of Behavioral Health and Primary Care Health Homes/MY DC Health Home: - The District of Columbia Health Homes (HH) initiative named My DC Health Homes/(Health Homes 1) was launched in January 2016 as a joint effort by DBH and the Department of Health Care Finance (DHCF) as a state plan benefit. The primary goals include: 1) improve care coordination; 2) prevent avoidable hospital and emergency room visits; 3) improve the overall health status of persons with serious mental illnesses, and 4) reduce health care costs. The Health Homes 1 program is for adults with Medicaid who have a serious and persistent mental illness. Services may be delivered in a Core Service Agency or a Free Standing Mental Health Clinic. Health home services include: 1) comprehensive care management; 2) care coordination; 3) health promotion; 4) comprehensive transitional care/follow-up; 5) patient and family support; and 6) referral to community and social support services. The District of Columbia Health Homes (HH) initiative named MyHealth GPS/Health Homes 2 program was launched in July 2017 and is overseen by the Department of Health Care Finance. It operates primarily in Federally Qualified Health Centers and other primary care settings. It provides the same six services described under the Health Homes 1 program. The goals include: 1) improve the integration of physical and behavioral health care; 2) reduce healthcare costs (lower rates of avoidable Emergency Department use and reduce preventable hospital admissions and re-admissions); 3) improve the experience of care and quality of services delivered, and 4) improve health outcomes. To be eligible for the MyHealth GPS program the beneficiary must have three or more listed chronic health conditions and a SMI or SUD diagnosis is included among the seventeen listed conditions). 4) The DC Mental Health Access in Pediatrics (DC MAP) To promote the integration of behavioral health and primary care, DBH developed the Quality Improvement Mental Health Learning Collaborative and the DC Mental Health Access in Pediatrics (DC-MAP) program. There are two primary initiatives: 1) annual, universal mental health screening through the pediatric primary care provider and 2) DC Mental Health Access in Pediatrics (DC MAP), a children's mental health consultation program for pediatricians and primary care physician practices. Through the 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. 5) 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, Hepatitis C testing services, HIV pre and post counseling, linkage, and referral 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 Assessment and Referral Center (MARC) van that provides for same-day substance use disorder assessments and referrals in the community. The MARC visits multiple locations around the District, targeting areas of high need. The MARC staff consists of a registered nurse and a social worker who provide same day assessments and referrals to substance use treatment. Testing for TB, HIV/HEP-C and pregnancy are offered as part of the overall assessment process. In an effort to provide greater access to care, the MARC van has also begun assessing for and prescribing buprenorphine. In 2019, DBH utilized its regulatory authority to expand intake and assessment services by requiring all certified behavioral health providers to provide these services.

4. Describe how the state provides care coordination, including detail about how care coordination is funded and how care coordination models provided by the state vary based on the seriousness and complexity of individual behavioral health needs. Describe care coordination available to:

a) Adults with serious mental illness

b) Adults with substance use disorders

c) Children and youth with serious emotional disturbances or substance use disorders

In FY23 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 Teams 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 supports. These partnerships promote a No Wrong Door approach to accessing behavioral health services in the District.

The District continues to offer High Fidelity Wraparound which is a strength-based, evidence- informed process, led by a Care Coordinator who is responsible for collaborating a team-based planning process where representatives of multiple systems come together with a child, youth, and their family to create a highly individualized plan to address the complex emotional needs of a child or youth. The individualized plan of care is designed to prevent out-of-home placement and juvenile involvement with the courts. The plan of care is monitored by the Wraparound Coordinator several times per week to ensure that the family is receiving the required services including the incorporation of informal and natural support for the family. The average length of stay of youth and families enrolled in wraparound in FY22 was 9.5 months. One hundred percent of youth involved in Wraparound in FY22 were diverted from treatment in a PRTF. In FY23, DBH has contracted with two vendors to provide High Fidelity Wraparound in the twelve identified schools and have secured training and coaching through the National Wraparound Implementation Center to support the initiative and fidelity of model. The school wraparound program will begin school year 2023-2024.

5. Describe how the state supports the provision of integrated services and supports for individuals with co-occurring mental and substance use disorders, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders. Please describe how this system differs for youth and adults.

DBH requires that all certified mental health providers screen individuals for potential co-occurring behavioral health concerns utilizing the GAIN-SS. The outcome of this screening will inform the provider of other behavioral health needs and a referral will be made. If the mental health provider is also a certified SUD provider, they may refer internally for further assessment for treatment.

As part of the screening and assessment process with DBH, whether through DBH's primary assessment site (the DBH Assessment and Referral Center (ARC)), the contracted court system assessment center, the withdrawal management service providers, the Department of Corrections' (DOC) assessment office, or the HIV-EIS contracted provider, under the auspices of a local Federally Qualified Healthcare Center (FQHC), there is a thorough biopsychosocial assessment conducted on everyone entering our system. This process consists of the use of the ASAM standardized assessment tool, Co-Triage, which provides, a level of care determination based on the individual's reported and collateral information if available. Additionally, providers can utilize their own biopsychosocial assessment to support the level of care as well as identify additional behavioral health and social service needs. After referral to the most appropriate level of care, the identified SUD provider will conduct a more comprehensive assessment using the ASAM Continuum assessment tool. Continuum incorporates questions related that cover multiple social, emotional and health related needs that inform and support the identified level of care and other behavioral health needs.

DBH has two certified youth SUD providers that are also mental health providers for youth with co-occurring disorders. Both agencies utilize the GAIN-I assessment to determine SUD treatment needs and the GAIN-SS and their own internal diagnostic assessment tools to assess for youth mental health disorders.

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

No noted technical assistance needed at this time.

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

Footnotes:

Environmental Factors and Plan

2. Health Disparities - Required

Narrative Question

In accordance with Advancing Racial Equity and Support for Underserved Communities Through the Federal Government (Executive Order 13985), Advancing Equality for Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex Individuals (Executive Order 14075), the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[1], **Healthy People, 2030**[2], **National Stakeholder Strategy for Achieving Health Equity**[3], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual orientations, gender identities, races, and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (e.g., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the **Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care** (CLAS)[4].

Collecting appropriate data are a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[5]. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations[6]. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBTQI+ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. In addition, LGBTQI+ individuals are at higher risk for suicidality due to discrimination, mistreatment, and stigmatization in society. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

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

[1] **https://www.minorityhealth.hhs.gov/assets/pdf/hhs/HHS_Plan_complete.pdf**

[2] **https://health.gov/healthypeople**

[3] **https://www.mih.ohio.gov/Portals/0/Documents/CompleteNSS.pdf**

[4] **https://thinkculturalhealth.hhs.gov/**

[5] **https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status**

[6] **https://www.whitehouse.gov/wp-content/uploads/2017/11/Revisions-to-the-Standards-for-the-Classification-of-Federal-Data-on-Race-and-Ethnicity-October30-1997.pdf**

Please respond to the following items:

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

a) Race ● Yes ○ No

b) Ethnicity ● Yes ○ No

c) Gender ● Yes ○ No

d) Sexual orientation ● Yes ○ No

e) Gender identity ● Yes ○ No

f) Age ● Yes ○ No

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

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

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

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

6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care? ○ Yes ● No

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

Please indicate areas of technical assistance needed related to this section

There are no areas of technical assistance needed related to this section at this time.

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Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

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

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

SAMHSA anticipates that the movement toward value-based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services. The **National Center of Excellence for Integrated Health Solutions**[1] offers technical assistance and resources on value-based purchasing models including capitation, shared-savings, bundled payments, pay for performance, and incentivizing outcomes.

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

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. SAMHSA's Evidence Based Practices Resource Center (EBPRC) assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. SAMHSA's EBPRC provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions used with individuals with mental illness and substance use disorders, including youth and adults with substance use disorders, adults with SMI, and children and youth with SED. The recommendations build on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General[2], The New Freedom Commission on Mental Health[3], the IOM, NQF, and the **Interdepartmental Serious Mental Illness Coordinating Committee** (ISMICC)[4].

One activity of the EBPRC[5] was a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[6] SAMHSA and other HHS federal partners, including the Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many innovative and promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, evidence is collected to determine their efficacy and develop a more detailed understanding of for who and in what circumstances they are most effective.

SAMHSA's Treatment Improvement Protocol Series **(TIPS)**[7] are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation **(KIT)**[8] was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. Each KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice

demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, for educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is interested with what additional information is needed by SMHAs and SSAs to support their and other purchasers' decisions regarding value-based purchase of M/SUD services.

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[1] **https://www.thenationalcouncil.org/program/center-of-excellence/**

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

[3] The President's New Freedom Commission on Mental Health (July 2003). *Achieving the Promise: Transforming Mental Health Care in America*. Rockville, MD: Department of Health and Human Services, Substance use disorder and Mental Health Services Administration.

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

[5] **https://www.samhsa.gov/ebp-resource-center/about**

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

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

[8] **https://store.samhsa.gov/?f%5B0%5D=series%3A5558**

Please respond to the following items:

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

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

- **a)** ☐ Leadership support, including investment of human and financial resources.
- **b)** ☐ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
- **c)** ☐ Use of financial and non-financial incentives for providers or consumers.
- **d)** ☐ Provider involvement in planning value-based purchasing.
- **e)** ☐ Use of accurate and reliable measures of quality in payment arrangements.
- **f)** ☐ Quality measures focused on consumer outcomes rather than care processes.
- **g)** ☐ Involvement in CMS or commercial insurance value-based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
- **h)** ☐ The state has an evaluation plan to assess the impact of its purchasing decisions.

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

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

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Footnotes:

Environmental Factors and Plan

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

Narrative Question

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

SAMHSA's working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5 (APA, 2013). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

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

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

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

Please respond to the following items:

1. Please name the model(s) that the state implemented including the number of programs for each model for those with ESMI using MHBG funds.

Model(s)/EBP(s) for ESMI/FEP	Number of programs
Navigate Treatment Model - a comprehensive program designed to provide early and effective treatment to individuals who have experienced a first episode of psychosis.?	1

2. Please provide the total budget/planned expenditure for ESMI/FEP for FY 24 and FY 25 (only include MHBG funds).

FY2024	FY2025
352427	352427

3. Please describe the status of billing Medicaid or other insurances for ESMI/FEP services? How are components of the model currently being billed? Please explain.

The Navigate Treatment Model has not been billed via Medicaid to date. DBH is, however, working to create a structure that will allow us to use existing billing paths?for this service.?

4. Please provide a description of the programs that the state funds to implement evidence-based practices for those with ESMI/FEP.

DBH implements a Navigate Team approach to address 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 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 the following staff:??

Case Manager – provides individual and team case management, community education, and recruitment of individuals who have begun to experience psychosis and a;??

Medication Manager - monitors the medication of FEP clients and encourages the use of low doses of medications as well as addresses the special issues of clients with first-episode psychosis.??

Individual Resiliency Trainer (IRT) – promotes individual resiliency by enhancing illness management and building strengths.??

Family Education (FE) Clinician – encourages how to work together as a family to support the individual's recovery.??

Supported Employment and Education (SEE) Specialist – pursues employment and educational goals.??

Peer Specialist - provides peer support to the family and the individual.?

Specific to FEP, the District implements:

1) NAVIGATE-like 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. The NAVIGATE program includes four different treatments: NAVIGATE Psychopharmacological Treatment Manual, Supported Employment and Education, Individual Resiliency Training (IRT), and Family Education.

2) Individual Placement and Support (IPS)/Supported Employment/Education (SEE): This evidence-based program is designed to help people with a psychiatric disorder achieve their vocational and educational goals including people who have had a recent psychosis episode.

3) 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.

4) 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.

5) 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:

6) 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. A-CRA is a necessary intervention for the targeted population as TAY with mental illness have higher rates of substance abuse than other age groups with mental illness and this behavioral approach has proven to be effective in reducing substance and alcohol use. No modifications will be necessary.

7) 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.

8) 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. TAY TREM consists of three major parts. The first section, on empowerment, helps group members learn strategies for self-comfort and accurate self-monitoring as well as ways to establish safe physical and emotional boundaries. The second component of TAY TREM focuses more directly on trauma experience and its consequences. In the third section, focus shifts explicitly to skills building. These sessions include emphasis on communication style, decision-making, regulating overwhelming feelings, and establishing safer, more reciprocal relationships.

9) 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. It is an extremely safe model as it directly addresses both trauma and addiction, but without requiring clients to delve into the trauma narrative (the detailed account of disturbing trauma memories), thus making it relevant to a very broad range of clients and easy to implement from the very start of treatment (no prior treatment is needed).

10) Child-Parent Psychotherapy for Family Violence- A relationship-based treatment intervention for young children 0-6 with a history of trauma exposure or maltreatment, and their parents or caregivers.

11) 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.

12) Parent-Child Interaction Therapy- A supported treatment for young children ages 2-6 who are experiencing extreme behavioral difficulties.

13) 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.

14) 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.

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

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

5. Does the state monitor fidelity of the chosen EBP(s)?

(●) Yes ( ) No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI/FEP?

(●) Yes ( ) No

7. Explain how programs increase access to essential services and improve client outcomes for those with an ESMI/FEP?

The purpose of the FEP Treatment Program for Transition Age Youth makes available essential services designed 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 District's FEP treatment program improves the outcomes for those with an ESMI/FEP.?

8. Please describe the planned activities for FY 2024 and FY 2025 for your state's ESMI/FEP programs.

In FY 24 and FY25, the Department of Behavioral Health (DBH) will expand services to ensure that there is a stepped-care approach, where treatments of differing intensity will be offered to young adults who have experienced or are at risk for experiencing psychosis. Our identified young adults will receive an array of community and evidenced-based interventions to help them manage stress, anxiety, and uncertainty associated with psychosis. DBH will create a referral process that allows young adults to be easily connected with the best-fit services to address their needs.?

9. Please list the diagnostic categories identified for your state's ESMI/FEP programs.

1. Major Depressive Disorder
2. Schizoaffective Disorder Bipolar Type
3. Schizoaffective Disorder
4. Bipolar Disorder with Psychotic Features
5. Schizophrenia with Co-Occurring Substance Use Disorder
6. Schizophrenia
7. Substance Induced Psychotic Disorder
8. Post-Traumatic Stress Disorder
9. Acute Stress Disorder

10. What is the estimated incidence of individuals with a first episode psychosis in the state?

It is estimated that no less than 70 young adults will be identified as individuals with an incidence of the first episode of psychosis.?

11. What is the state's plan to outreach and engage those with a first episode psychosis who need support from the public mental health system?

Partnering with 988 and DBH social media outlets (Instagram, Twitter, and Facebook), DBH will outreach to the target population. DBH will involve young adults in the identification of social media methods that are most attractive to the population of focus. DBH will use available social media channels, and conduct community and school presentations to raise awareness about FEP and the services available. Existing formal and natural support networks will be used to develop and carry out outreach strategies. DBH will collaborate with the DBH's Consumer and Family Affairs Administration to provide support through consumer engagement/ outreach activities, identifying community partners, and leading caregivers' meetings.?

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

There are no areas of technical assistance needed related to this section at this time.

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Footnotes:

Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required for MHBG

Narrative Question

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

In addition to adopting PCP at the service level, for PCP to be fully implemented it is important for states to develop systems which incorporate the concepts throughout all levels of the mental health network. Resources for assessing and developing PCP systems can be found at the National Center on Advancing Person-Centered Practices and Systems **https://ncapps.acl.gov/home.html** with a systems assessment at **https://ncapps.acl.gov/docs/NCAPPS_SelfAssessment_201030.pdf**

1. Does your state have policies related to person centered planning? (●) Yes ( ) No

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

N/A

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

The DBH, CCNY, CCSI partnership treatment planning process begins by orienting the individual and his/her natural supporters to the process. This process increases the likelihood that the consumer actively participates in all stages of plan development and implementation. Before the process of developing a treatment plan begins, the treatment team lead will encourage pre-planning activities and goal prioritization with the consumer. This step allows the consumer to not only prepare for their planning meeting but to empower them to communicate their choice of how they would like their recovery to be understood by the treatment team. After completion of a comprehensive diagnostic assessment, assessment results are reviewed with the consumer to ensure that there is a shared and agreed- upon understanding of the issues to address in treatment. Since the beginning of the pandemic, the District has increased telehealth options for providers and consumers, including allowing audio-only telehealth. This has allowed consumers the flexibility of options to stay connected to mental health services while social distancing. In FY 22, 36,031 behavioral health consumers received at least one telehealth service. Also, in FY23 YTD, 34,238 behavioral health consumers received at least one telehealth service. DC is actively working to enhance tools and capabilities in the Health Information Exchange (HIE), improve HIE access across all provider types, and implement an e-consent platform for consumers to authorize the secure exchange of data protected by 42CFR through the HIE.??

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

The person-centered planning process consists of the following:?

1. Conducting a comprehensive, strengths-based assessment.?

2. Developing an interpretive assessment-based summary.?

3. Reviewing and considered cultural concerns and preferences in planning and goal development.?

4. Orienting individuals and their natural supporters regarding the purpose and process of person-centered planning.

5. Empowering the individual to identify their hopes and dreams (goals), strengths and barriers to goal accomplishment and then partnering in the development of short-term objectives and interventions that overcome barriers and support individual recovery and resilience.?

DBH has continued to offer training to the provider network to support high quality assessments. In FY23, DBH will review the current person-centered courses offered and update as needed to comply with national standards.?

?TAY services have continued the TAY focused person-centered Appreciative Inquiry (AI) initiative. This included training on Appreciative Inquiry (AI) that incorporates working with TAY from a person-centered approach. This initiative uses a collaborative and strengths-based approach to support young adult treatment and services. In conjunction with the AI, TAY providers have been trained to utilize empathetic understanding and non-judgmental positive regard for the client identified goals which allows young adults to plan and execute their own recovery. ?

5. What methods does the SMHA use to encourage people who use the public mental health system to develop Psychiatric Advance Directives (for example, through resources such as SAMHSA's **A Practical Guide to Psychiatric Advance Directives**)?"

DBH strongly supports a consumer's right to create advance directives. DBH has a policy in place that highlights the procedures governing the use of advance directives regarding health care treatment decisions, including behavioral health treatment.??

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

Technical Assistance is needed to provide additional training to our provider network to support Person-Centered Planning and Assessments.??

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Footnotes:

Environmental Factors and Plan

6. Program Integrity - Required

Narrative Question

SAMHSA has a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x–5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SUPTRS BG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SUPTRS BG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: **http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf**. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SUPTRS BG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SUPTRS BG funds are allocated to support evidence-based, culturally competent programs, substance use primary prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for M/SUD services funded by the MHBG and SUPTRS BG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of M/SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? (●) Yes ( ) No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? (●) Yes ( ) No

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

MH/SUD Block Grant funding issued via a grant (via the Grants Management Office) or contract (via Office of Contracts and Procurement) includes the statutory requirements in the notice of grant award or contract agreement. Leading up to the award, the request for application provides guidance on the funding opportunity and any restrictions and the pre-application conference will review the funding opportunity and any restrictions, along with program, performance and fiscal expectations.

The DBH also includes terms and conditions for any grant award, which the applicant has to sign an assurance and include in the application submission. Within the final executed agreement, the SAMHSA issued notice of award is included. Program and fiscal staff provide orientations after the award is issued to reinforce expectations and requirements.

Additionally, our 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 Division of Program Integrity conducts claims audits, investigations of potential false claiming, monitors provider compliance with DBH regulations and policies, and issues and monitors Corrective Action Plans for providers needing to remediate issues

related to service provision or compliance concerns.

The Investigations Division conducts major investigations of complaints. Develops the final investigative report submitted to the Agency Director, General Counsel, and other appropriate parties that includes recommendations for remedial action.

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

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

Our Provider Relations Division under our Adult Services Administration, provides education and technical support to providers to support their compliance with Chapter 34 regulations and quality indicators identified by the Department. This includes, but is not limited, to training on Person Centered Planning, Locus/ Child and Adolescent Functional Assessment Scale(CAFAS) / Child and Adolescent Functional Assessment Scale (CAFAS)/Preschool and Early Childhood Functional Assessment Scale (PECFAS), and basic administrative operations.

Also, the Division regularly monitors provider treatment plans & encounter note documentation, audit results, and complaints. Technical assistance and training are provided based on assessment of identified needs. This may require coordination of support from DC government sister agencies (i.e., Department of Health Care Finance, MCOs, Courts and other clinical divisions within DBH).

Please indicate areas of technical assistance needed related to this section

There are no areas of technical assistance needed related to this section at this time.

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Footnotes:

Environmental Factors and Plan

7. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the **2009 Memorandum on Tribal Consultation**[56] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

[56] **https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf**

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

The District of Columbia does not have any federally recognized tribes.

2. What specific concerns were raised during the consultation session(s) noted above?

N/A

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

N/A

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

There is no technical assistance needed at this time.

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Footnotes:

Environmental Factors and Plan

8. Primary Prevention - Required SUPTRS BG

Narrative Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification and Referral*** that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)? ○ Yes ◉ No

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply) ○ Yes ○ No

- **a)** ☑ Data on consequences of substance-using behaviors
- **b)** ☑ Substance-using behaviors
- **c)** ☑ Intervening variables (including risk and protective factors)
- **d)** ☑ Other (please list)

The DC Department of Behavioral Health (DBH) has established an email account (suds.prevention@dc.gov) that is a repository for training and technical assistance requests. Once the request is received, a member of the Prevention team begins the process of preparing a response based on the expressed need(s). Also, sub-grantees can submit formal requests for training and technical assistance through progress reports submitted on an annual basis. Lastly, during site visits, sub-grantees can request training and technical assistance for staff and/or key community leaders.?

The Provider Relations Division at DBH also serves as a liaison to each contracted behavioral health provider, and Provider Relations Specialists provide a variety of technical assistance and training to the provider network. Any provider can contact its Specialist with questions or a request for assistance. The Provider Relations Division provides education and technical support to providers to support their compliance with Chapter 34 regulations and quality indicators identified by the Department. This includes training on Person Centered Planning, Locus/ CAFAS/PECFAS, and basic administrative operations. In addition, the Division regularly monitors provider treatment plans and encounter note documentation, audit results, and complaints. Technical assistance and or training is provided based on assessment of identified needs. This may require coordination from DC government sister agencies (i.e., Department of Health Care Finance, MCOs, Courts and other clinical divisions within DBH).?

3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups?

(check all that apply)

- **a)** ☑ Children (under age 12)
- **b)** ☑ Youth (ages 12-17)
- **c)** ☑ Young adults/college age (ages 18-26)
- **d)** ☑ Adults (ages 27-54)
- **e)** ☑ Older adults (age 55 and above)
- **f)** ☑ Cultural/ethnic minorities
- **g)** ☑ Sexual/gender minorities
- **h)** ☐ Rural communities
- **i)** ☑ Others (please list)

The DC Department of Behavioral Health (DBH) developed an assessment tool that is used by sub-grantees to assess community readiness to implement prevention strategies formally. The assessment tool used is the Strategic Prevention Framework (SPF) which a five-step planning process. The five steps are assessment, capacity, planning, implementation, and evaluation. Following these steps allows for the assessment of community needs and strategically developing a plan in place to address these needs.?

4. Does your state use data from the following sources in its Primary prevention needs assesment? (check all that apply)

- **a)** ☐ Archival indicators (Please list)
- **b)** ☑ National survey on Drug Use and Health (NSDUH)
- **c)** ☑ Behavioral Risk Factor Surveillance System (BRFSS)
- **d)** ☑ Youth Risk Behavioral Surveillance System (YRBS)
- **e)** ☐ Monitoring the Future
- **f)** ☐ Communities that Care
- **g)** ☐ State - developed survey instrument
- **h)** ☐ Others (please list)

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds? ◉ Yes ○ No

- **a)** If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based?

  The Community Conversation is a qualitative data collection tool used by the DC Prevention Centers (DCPC) to examine emerging trends and also assess needs within their respective wards.?
- **b)** If no, (please explain) how SUPTRS BG funds are allocated:

6. Does your state integrate the National CLAS standards into the assessment step? ◉ Yes ○ No

- **a)** If yes, please explain in the box below.

  The DC Department of Behavioral Health's (DBH) Substance Use Disorders (SUD) Prevention team strives to integrate National CLAS Standards into the assessment step. In working with stakeholders and District residents, the team ensures that those leading the Strategic Prevention Framework (SPF) process have received training in cultural sensitivity. Additionally, resources are readily available to support individuals walking through the process in order to understand implications of the unique populations that are being targeted through the various strategies.??
- **b)** If no, please explain in the box below.

7. Does your state integrate sustainability into the assessment step? ◉ Yes ○ No

- **a)** If yes, please explain in the box below.

  In working with stakeholders and communities to develop strategies aimed at promoting substance use prevention, the Substance Use Disorders (SUD) Prevention team has goal of ensuring that those involved are equipped with the skills and tools through preparing them during the assessment phase to anticipate what will be needed during and after implementation of the plan to sustain efforts.??
- **b)** If no, please explain in the box below.

Narratve Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
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6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Capacity Planning

1. Does your state have a statewide licensing or certification program for the substance use primary prevention workforce? (●) Yes ( ) No

a) If yes, please describe.

The DC Department of Behavioral Health (DBH) is currently in the process of having 50 prevention practitioners trained to become Certified Prevention Specialists.?

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use primary prevention workforce? (●) Yes ( ) No

a) If yes, please describe mechanism used.

The DC Department of Behavioral Health (DBH) has established an email account (suds.prevention@dc.gov) that serves as a repository for training and technical assistance requests. Once the request is received, a member of the Prevention team begins the process of preparing a response based on the expressed need(s). Also, sub-grantees can submit formal requests for training and technical assistance through progress reports submitted on an annual basis. Lastly, during site visits, sub-grantees have the opportunity to request training and technical assistance for their staff and/or key community leaders. The Provider Relations Division at DBH also serves as a liaison to each contracted behavioral health provider, and Provider Relations Specialists provide a variety of technical assistance and training to the provider network. Any provider can reach out to its Specialist with questions or a request for assistance.?

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies? (●) Yes ( ) No

a) If yes, please describe mechanism used.

The DC Department of Behavioral Health (DBH) has developed an assessment tool that is used by sub-grantees to assess community readiness to implement prevention strategies formally. The assessment tool used is the Strategic Prevention Framework (SPF) which is a five (5) step planning process. The five (5) steps are assessment, capacity, planning, implementation, and evaluation. Following these steps allows for the assessing of community needs and strategically developing and setting a plan in place to address the needs.?

4. Does your state integrate the National CLAS Standards into the capacity building step? (●) Yes ( ) No

a) If yes, please explain in the box below.

The DC Department of Behavioral Health's (DBH) Substance Use Disorders (SUD) Prevention team strives to integrate National CLAS Standards into the capacity building step. When addressing capacity building, it is imperative that cultural

competence and sensitivity goes into understanding how communities and stakeholders can play a vital role in being able to support their communities and interests following the implementation of the plan. Does your state integrate sustainability into the capacity building step??

5. Does your state integrate sustainability into the capacity building step? (●) Yes ( ) No

a) If yes, please explain in the box below.

The focus on the inclusion of CLAS Standards into the capacity building step is how the SUD Prevention Team works to integrate sustainability into the step as well. This integration enables stakeholders and communities include the necessary partners who will help to sustain efforts beyond implementation.??

b) If no, please explain in the box below.

Narratve Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Planning

1. Does your state have a strategic plan that addresses substance use primary prevention that was developed within the last five years? ○ Yes ◉ No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan.

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SUPTRS BG? ○ Yes ○ No ◉ N/A

3. Does your state's prevention strategic plan include the following components? (check all that apply):

- **a)** ☐ Based on needs assessment datasets the priorities that guide the allocation of SUPTRS BG primary prevention funds
- **b)** ☐ Timelines
- **c)** ☐ Roles and responsibilities
- **d)** ☐ Process indicators
- **e)** ☐ Outcome indicators
- **f)** ☐ Cultural competence component (i.e., National CLAS Standards)
- **g)** ☐ Sustainability component
- **h)** ☐ Other (please list):
- **i)** ☑ Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SUPTRS BG primary prevention funds? ◉ Yes ○ No

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds? ○ Yes ◉ No

- **a)** If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based

  N/A

6. Does your state have an Advisory Council that provides input into decisions about the use of SUPTRS BG ◉ Yes ○ No

primary prevention funds?

7. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds? ○ Yes ◉ No

a) If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based?

N/A

8. Does your state integrate the National CLAS Standards into the planning step? ◉ Yes ○ No

a) If yes, please explain in the box below.

The DC Department of Behavioral Health's (DBH) Substance Use Disorders (SUD) Prevention team strives to integrate National CLAS Standards into the planning step of the strategic prevention framework. Cultural competency is followed to ensure the appropriateness of the plans which are developed in an effort to have plans which are realistic and achievable.?

b) If no, please explain in the box below.

N/A

9. Does your state integrate sustainability into the planning step? ◉ Yes ○ No

a) If yes, please explain in the box below.

As plans are developed, sustainability remains a focal point for ensuring that plans have the foundation and supports needed to have a lasting impact once implemented? and goals are met.??

b) If no, please explain in the box below.

N/A

Narratve Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Implementation

1. States distribute SUPTRS BG primary prevention funds in a variety of different ways. Please check all that apply to your state:

- **a)** ☑ SSA staff directly implements primary prevention programs and strategies.
- **b)** ☐ The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
- **c)** ☐ The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
- **d)** ☐ The SSA funds regional entities that provide training and technical assistance.
- **e)** ☑ The SSA funds regional entities to provide prevention services.
- **f)** ☐ The SSA funds county, city, or tribal governments to provide prevention services.
- **g)** ☑ The SSA funds community coalitions to provide prevention services.
- **h)** ☑ The SSA funds individual programs that are not part of a larger community effort.
- **i)** ☐ The SSA directly funds other state agency prevention programs.
- **j)** ☐ Other (please describe)

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SUPTRS BG primary prevention dollars in at least one of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

a) Information Dissemination:

The DC Department of Behavioral Health's (DBH) Substance Use Disorders (SUD) Prevention Branch continues 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. 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 FY2023, the SUD Prevention Team used discretionary funding to support the redevelopment of the aforementioned social marketing strategies. These newly revised strategies will be housed on the Drug Free Youth DC websites and will be available during for 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 SABG.

The goal is to disseminate targeted prevention messages and resources to DC youth and adults via the four DC Prevention Centers (DCPCs), website, digital engagement, social media events, and other communication channels. Digital measures are to 1) increase the reach of synthetic drug, underage marijuana use, and underage drinking prevention messages by 20%, segment by local and acquisition channel; 2) increase the level of primary and target audiences by 1-2% each month; 3) maintain steady engagement with youth influencers (parents/caregivers, other adults); and 4) maintain steady engagement with youth. The utilization of digital engagement and reliance on digital measures has been extremely critical during and post the COVID-19 Global Pandemic where the ability to hold larger in person events was hindered due to safety reasons. Social media platforms such at Facebook, Twitter, and Instagram have continued allowing the team to reach broader audiences in need of SUD prevention information. For more focused efforts, in addition to continue to use technology, during FY2024 and FY2025, the team anticipates being able to increase participation in local in-person events such as health fairs, community meetings, and outreach and engagement activities now that opportunities for doing so have resumed.

In addition, DBH prevention staff will collaborate with DC Prevention Centers (DCPC) to:

• Update drug facts each month using the best evidence from SAMHSA, NIDA, NIAAA, and ONDCP;

• Update new information and calendar/event notices from District, Ward, and community leaders;

• Include resource request sections and continue to make available digital versions of DC substance use prevention campaign materials;

• Add contact forms for questions and suggestions from the public who do not frequently use social media or are needing immediate assistance;

• Check social media pages (Facebook, Twitter, and Instagram) regularly and respond to immediate requests;

• Issue proactive posts describing events and activities, new resources, and digital campaign information;

• Use and create hashtags to identify new users and expand prevention messaging; and

• Repost follower and non-follower related prevention messages as appropriate. DBH will continue to brand prevention as an integral component in achieving the agency mission. To ensure that the messaging is clear, similar colors and graphics will be used across the various social marketing campaigns and literature that is disseminated. In addition, the DCPCs will continue to use the uniform templates that were created that were created such as signage, banners, table-top exhibits, and templates for business cards, newsletters, and flyers are so that all messaging is aligned. Information dissemination data is collected, analyzed, and reported through the online Program Grant monitoring and event closeout forms. DBH will continue to build upon enhancements previously made for the better collection and reporting of data; specifically for annual SABG reporting.

b) Education:

During FY2024 and FY2025, SABG funded DBH prevention staff and DC Prevention Center staff will continue to support education strategies that are based on DC EOW data findings, emerging community trends, and approaches that have a plausible connection to target outcomes. In the past, DBH has invested SABG, Strategic Prevention Framework (SPF) State Incentive Grant (SIG), SPF Partnership for Success (PFS), and local funds for ongoing education delivered to and by DBH prevention staff, DC Prevention Centers, and other sub-recipients. Most recently, the SUD Prevention team has used COVID and ARPA supplemental funds to further support these efforts. Educational strategies included:

• Implementation of the Too Good for Drugs curriculum across three (3) different school grades in an effort to provide prevention education as a tool to further prevention and/or delay the onset of substance use.

• Sponsoring training and technical assistance on the DBH prevention conceptual and operational framework (cultural humility, risk, and protective factors Institute of

• Medicine Classification System, and the Strategic Prevention Framework five-step planning process).

• Developing data-driven logic models with culturally appropriate evidence-based preventive interventions for use in SPF planning.

• Using District and ward data and community conversation findings to make policy, program, and resource decisions.

• Supporting the development of the prevention workforce through another wave of IC&RC Prevention Specialist training and testing for certification.

• Training and technical assistance tailored to effective prevention approaches in working with selective and indicated populations.

• Training and technical assistance in using the online DIRS system for submitting and monitoring monthly prevention program grant reports.

• Increasing awareness and educating District and ward stakeholders on priority drug issues (underage drinking, underage marijuana use, synthetic drug use, and Initiative 71 laws).

Additionally, over the next two (2) years, SABG funds will support the development of a more comprehensive and sustainable education strategy that builds needed workforce skills through structured learning processes. The priority audiences are:

DBH prevention staff;

DC Prevention Centers that reach and educate approximately 20,000 community stakeholders annually;

Key community leaders who work with the DC Prevention Centers;

Other DBH substance use prevention subrecipients; and

Targeted District agency partners that are addressing risk and protective factors for anxiety and depression, violence, delinquency, and poor school performance. DBH prevention staff and the DCPCs will continue to support educational events based on identified substance use prevention need; in high need communities with low capacity; and with populations that have documented disparities. Also, the District's Substance Use Prevention team will continue working with DBH school-based clinicians to identify the best method for school engagement whether with universal populations such as within the classroom or among selective and indicated populations that have been referred to the program.

c) Alternatives:

Alternative strategies will continue to be supported at the District level through DBH prevention staff and DCPCs at the Ward level. These activities coincide with the Marion S. Barry Summer Youth Employment Program (SYEP) which has transitioned to virtual platforms, a locally funded initiative sponsored by the Department of Employment Services that provides District youth ages 14 to 21 with enriching and constructive summer work experiences through subsidized placements in the private and government sectors. In addition, the four (4) DC Prevention Centers (DCPCs) that are supported through the SABG will continue working with the Youth Prevention Leadership Corps (YPLCs) and summer interns to provide creative and safe alternatives to engaging in substance use.??

In an effort to be more intentional in planning and supporting alternative activities, the DBH prevention team will continue implementing its "pop-up" events. The purpose of these events have been to create fun engagement events to foster a fun atmosphere for communities within the District that are at the highest risk for substance use and other anti-social activities. As DBH has been committed to supporting whole person care, the scope of these pop-up events has been enhanced to better target transitional aged youth and older adults in need of substance use prevention services. During FY2023, the SUD Prevention team began working with the DC Department of Parks and Recreation to host wellness events through the form of yoga and other activities to promote movement and health alternatives to engaging in substance use.??

?Additionally, the team will continue building upon the lessons learned through activities implemented virtually in an effort boost ongoing engagement. To support these efforts, the DBH prevention team will continue work with District agency partners and DCPCs year around. DBH will be pro-active in planning structured alternative strategies across the 8 Wards with the following partners:

• DBH DOES SYEP program planners

• DC Parks and Recreation and Roving Leaders Program

• After school activities

• DCPC Community Prevention Networks Alternative activities will focus on increasing awareness of prevention and substance use disorder resources, risks of underage alcohol and marijuana use, ward-level data that lead to structured alternates at high-risk times (e.g., summer months, holidays, school breaks, after school). The COVID-19 pandemic and beyond heightened the need to ensure that the team promotes constructive ways of dealing with anxiety, boredom, and stress. Approaches to implementing alternatives will continue to be data-driven, pro-active opposed to reactive requests, provide consistency across Wards, and have the potential for evaluation.?

d) Problem Identification and Referral:

The District remains committed to ensuring that individuals in need of substance use disorder services are engaged as early as possible and provided information on an array of services that are available. The District's SUD Prevention team consistently utilizes local and national quantitative and qualitative data as a guide. Based on this data, initiatives and strategies have been developed to best engage target populations.

The SUD Prevention team will continue working with the four (4) DC Prevention Centers (DCPCs), community partners, and DBH's School Based Clinicians to share about the District's SUD prevention supports and services. Based upon the sharing of this information and further engagement of targeted populations, the aforementioned partners are able to identify both youth and adults in need of prevention education.

Prevention education is made available to District residents through trainings, workshops, small groups, and the adoption of curricula. The Mendez Foundation's "Too Good for Drugs" curricula has and will continue to be implemented in both community and school environments to educate participants on the dangers associated with engaging in substance use. Additionally, the SUD prevention team remains committed to its objective of reducing priority risk factors that place District children, youth and families, and communities at risk for substance use and interrelated problems. There will continue to be a focus on using the remaining five (5) Core Strategies in order to identify those who are in need and to refer them to the appropriate resources.

e) Community-Based Processes:

DBH will continue to allocate SABG prevention set-aside funds for four DC Prevention Centers, dynamic hubs that engage, support, and help connect the many community elements needed for promoting healthy drug-free youth. Each Center serves two Wards each (Wards 1 and 2; Wards 3 and 4; Wards 5 and 6; Wards 7 and 8). Through their grants, DCPC focus on three core functions:

1) community education;

2) community leadership;

3) community changes. These functions provide a consistent strategy but have the flexibility to address the unique characteristics and priorities of the geographic area and populations in their designated Wards. Flexibility in this community prevention system allows partnerships across Ward boundaries to address shared and emergent substance use problems.

The Substance Use Disorder Prevention team will begin revisiting the activities included under community-based processes to ensure that the activities and requirements remain in alignment with the needs of the District and mission and vision of the DC Department of Behavioral Health (DBH). DBH released a new Request for Proposals (RFP) for DCPCs that would begin in FY2024. The FY2024 scope of work for awardees will include the following requirements: Administrative Leadership:

• Ensure staffing patterns that include one full-time Project Director/Coordinator and one Community Mobilizer FTE's that share responsibilities for the three core functions.

• Attend DBH required roundtables, technical assistance, and training.

• Submit and revise as needed monthly program reports through the online Data Infrastructure Reporting System.

• Submit quarterly financial reports and revise as needed.

• Participate in at least one DCPC grant site visit in cooperation with DBH.

• Attend the National Association of State Alcohol and Drug Directors Prevention Research Conference and the SAMHSA Prevention Day. DCPC funds to attend other conferences require written permission from DBH.

• Allocate a maximum of 10% of the grant funds for indirect or overhead costs.

• Community Education: This function is designed to provide current, comprehensive, and relevant information for a wide range of audiences within the Prevention Center's respective geographic areas.

• Market as a DCPC using DBH provided templates (logo, business cards, letterheads, etc.)

• Provide an "early warning system," track and recommend actions to address new drug trends within the two Wards.

• Disseminate science-based substance abuse prevention education materials within two Wards.

• Coordinate and support District and National campaigns (e.g., SAMHSA Week, "Talk. They Hear You.", Synthetic Drug

Campaign, and the Underage Marijuana Campaign).

• Use the Community Conversation Guidance document for implementing Community Conversations and submit findings and recommendations in the monthly program progress report.

f) Environmental:

Moving forward, SABG funded DBH prevention staff, and DCPCs will disseminate underage drinking prevention, underage marijuana prevention, synthetic narcotics prevention, and tobacco prevention social marketing materials to increase understanding of District laws about youth and adults. The preventing underage marijuana use social marketing campaign will focus on the laws about the passage of Initiative 71 and the behavioral health risks associated with underage use as this remains to be a need. Also, with the increase in the legal age to purchase tobacco products going from 18 to 21, the prevention staff will continue to engage retailers and District residents about the change in the law. Lastly, SABG funded DBH prevention staff will continue to serve on District task forces such as the Criminal Justice Coordinating Council New Psychoactive Substances Workgroup to identify policy and program environmental changes.?

3. Does your state have a process in place to ensure that SUPTRS BG dollars are used only to fund primary prevention services not funded through other means? (●) Yes ( ) No

a) If yes, please describe.

The DC Department of Behavioral Health (DBH) allocates the budget per the terms and conditions of the SABG award (e.g., the set-aside requirement for Primary Prevention). In addition, the Primary Prevention set-aside requirement of SABG funds support a four (4) DC Prevention Centers at approximately $250,000 each ($1,000,000 total) who serve as prevention hubs within the community and provides coverage for the District's eight (8) wards. Lastly, the Primary Prevention set-aside goes towards supporting five (5) DBH Prevention Services staff.?

4. Does your state integrate National CLAS Standards into the implementation step? (●) Yes ( ) No

a) If yes, please describe in the box below.

The DC Department of Behavioral Health's (DBH) Substance Use Disorders (SUD) Prevention team strives to integrate National CLAS Standards into the implementation step of the strategic prevention framework. Cultural competency is followed to ensure when implementing plans, that those targeted for the engagement have the opportunity to contribute to and help guide the direction of the implementation.??

b) If no, please explain in the box below.

N/A

5. Does your state integrate sustainability into the implementation step? (●) Yes ( ) No

a) If yes, please describe in the box below.

Within the implementation step, sustainability is integrated to ensure that the resources that are being allocated to the effort are reasonable and that the success of the plan being implemented is not contingent upon the ongoing availability of funding.??

b) If no, please explain in the box below

N/A

Narratve Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification and Referral*** that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Evaluation

1. Does your state have an evaluation plan for substance use primary prevention that was developed within the last five years? ○ Yes ◉ No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan.

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

- **a)** ☐ Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
- **b)** ☐ Includes evaluation information from sub-recipients
- **c)** ☐ Includes SAMHSA National Outcome Measurement (NOMs) requirements
- **d)** ☐ Establishes a process for providing timely evaluation information to stakeholders
- **e)** ☐ Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
- **f)** ☐ Other (please list:)
- **g)** ☑ Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SUPTRS BG funded prevention services:

- **a)** ☑ Numbers served
- **b)** ☑ Implementation fidelity
- **c)** ☐ Participant satisfaction
- **d)** ☑ Number of evidence based programs/practices/policies implemented
- **e)** ☑ Attendance
- **f)** ☑ Demographic information
- **g)** ☐ Other (please describe):

4. Please check those outcome measures listed below that your state collects on its SUPTRS BG funded prevention services:

- **a)** ☑ 30-day use of alcohol, tobacco, prescription drugs, etc
- **b)** ☐ Heavy use

- **c)** ☐ Binge use
- **d)** ☑ Perception of harm
- **e)** ☑ Disapproval of use
- **f)** ☐ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)
- **g)** ☐ Other (please describe):

5. Does your state integrate the National CLAS Standards into the evaluation step? ○ Yes ◉ No

a) If yes, please explain in the box below.

N/A

b) If no, please explain in the box below.

Currently, the District does not have an updated Substance Use Disorder (SUD) Prevention plan for evaluation.?

6. Does your state integrate sustainability into the evaluation step? ◉ Yes ○ No

a) If yes, please describe in the box below.

With the goal of ensuring lasting impacts following plan implementation, DBH integrates sustainability into its evaluation step as well. Through evaluating whether or not the plan to promote Substance Use Disorder (SUD) Prevention resulted in the goals being met, adjustments are made in an effort revise the plan as needed and for the intended change to be sustainable.

b) If no, please explain in the box below.

N/A

Footnotes:

Environmental Factors and Plan

9. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occuring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

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 supports for children, youth, and adults with mental and/or substance use disorders including emergency psychiatric care, community-based outpatient, and residential services. DBH is 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 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:?

?? -Enhance engagement of community employers to support consumers/clients in securing and maintaining meaningful employment?

-Integrate Free Standing Mental Health Clinics (FSMHC) into DBH and the District broader service system?

-Support treatment interventions that reduce rates of incarceration, when appropriate?

-Conduct regular level of care assessments for consumers in community residential facilities (CRF) to support independence and integration into the community?

-Require regular level of care assessments for Assertive Community Treatment (ACT) consumers to ensure access to the appropriate level of placement?

-Conduct 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. 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. This administration is made up of the following teams: Peer Support, Consumer Engagement, Consumer Rights, Quality Improvement, and Saint Elizabeth's Hospital. It also contracts with a Peer Operated Drop-in Center and launched the D.C. Certified Peer Academy.??

Evidence-Based Practices: 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.??

District Agency and Other Partners: DBH partners include : 1) DC Public Schools, 2) DC Public Charter Schools, 3) Office of the State

Superintendent of Education, 4) Child and Family Services Agency, 5) Department of Youth Rehabilitation Services, 6) Department of Disability Services, 7) Department of Human Services, 8) DC Office of Aging, 9) Department of Health, 10) Department of Health Care Finance, 11) Office of Disability Rights, 12) Rehabilitation Services Administration, 13) DC Housing Authority, 14) Department of Housing and Community Development, 15) Department of General Services, 16) DC Metropolitan Police Department, 17) Department of Corrections, 18) Superior Court of the District of Columbia, and 19) DC Superior Court Juvenile Division 20) CSOSA Court Services and Offender Supervision Agency?

2. Does your state coordinate the following services under comprehensive community-based mental health service systems?

a)	Physical Health	(•) Yes ( ) No
b)	Mental Health	(•) Yes ( ) No
c)	Rehabilitation services	(•) Yes ( ) No
d)	Employment services	(•) Yes ( ) No
e)	Housing services	(•) Yes ( ) No
f)	Educational Services	(•) Yes ( ) No
g)	Substance misuse prevention and SUD treatment services	(•) Yes ( ) No
h)	Medical and dental services	(•) Yes ( ) No
i)	Support services	(•) Yes ( ) No
j)	Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)	(•) Yes ( ) No
k)	Services for persons with co-occuring M/SUDs	(•) Yes ( ) No

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

3. Describe your state's case management services

Currently, Chapter 34 of the DC Code prescribes mental health rehabilitation services (MHRS) standards. Case management is not one of the nine (9) listed services, but the District offers Community Support in lieu of case management as well as Recovery Support Services, which has a case management component. Community Support Services are rehabilitation and environmental supports, which are essential to assist the consumer in achieving rehabilitation and recovery goals that focus on building and maintaining a therapeutic relationship with the consumer. These services may include: 1) a variety of interventions provided by a team of staff that is responsible for an assigned group of consumers, or by staff who are individually responsible for assigned consumers. 2) services provided at the MHRS provider site, natural settings or a residential facility with 16 beds or less. Providers are required to have service-specific policies and procedures. Qualified practitioners include psychiatrists, psychologists, licensed social workers, advanced practice nurses, registered nurses, licensed practical nurses, licensed professional counselors, social workers with supervision designation, and addiction counselors.?

Recovery Support Services (RSS) are non-clinical services provided to a client by a certified RSS provider to assist the client in achieving or sustaining recovery from an SUD. RSS include Recovery Support Evaluation, and Environmental Stability. The recovery coach must have participated in an educational training for at least thirty hours from a program approved by DBH. The client and recovery coach work together to develop a recovery support plan, a document developed during a Recovery Support Evaluation that outlines the client's needs, goals, and recovery support services to be utilized to achieve those goals. The Recovery Support plan assists a client in recovery to develop goals and objectives to maintain their sobriety in the community with supports from family, community, and recovery support programs. ?

However, as a part of the District's system transformation efforts, the District is moving to unbundling community support services into its component parts to make service provision more targeted and to provide rehabilitation supports through other existing and new-to-Medicaid services. This will remove duplication, help the District better track utilization and demand for services, and more appropriately reimburse for the component parts of the community support services. By clarifying this pathway for the provision of community support services, the District is expanding the scope of the services and creating nuance. All the expanded services will be billed separately, using their own unique procedure code and modifier combinations and span the spectrum of eligible populations to include adults, families, children, youth, and transitional aged youth. Additionally, each of the expanded services now reflects the cost of providing services and results in a higher reimbursement compared to community support services as they are currently billed.???

The service(s) which replace each of the community support service components are Therapy, Clinical Care Coordination, Recovery Support Services, Peer Support Services, Transition to Independence, and Mental Health and Substance Use Disorder Supported Employment.?

4. Describe activities intended to reduce hospitalizations and hospital stays.

Saint Elizabeths Hospital (SEH), the District of Columbia's inpatient psychiatric facility, is operated by the Department of Behavioral

Health. SEH provides inpatient psychiatric, medical, and psycho-social person-centered treatment to adults to support their recovery and return to the community. The Hospital's goal is to maintain an active treatment program that supports individuals, and focus on increasing post discharge linkages with community-based treatment and support services. Saint Elizabeths monitors its discharge process for ?effectiveness of its planning for the next level of care post discharge.? Additionally, the Hospital's Therapeutic Learning Center (TLC) offers a comprehensive array of programming designed to prepare patients for life in the community after discharge.? One such cluster of programming is offered through the Community Living Skills Programs, and includes skills training in community travel such as use of public transportation and walking through the community, grocery shopping training, budgeting, food handling, and how to engage in community leisure activities.? These programs are designed to prepare the patient for life in the community after discharge and to reduce the likelihood of readmission.?

Integrated Care?

In June 2012, the District initiated a pilot program to shift 911 calls to emergency mental health services from an automatic police dispatch to a dispatch inclusive of a mental health crisis response. When operators from the 911 call center assess that a mental health crisis exists but police or EMS response is not indicated, they transfer calls to our Access Helpline for support, counseling, linkage to services, or will dispatch our Community Response Team for a face-to-face intervention. This program is overseen by our Division of Care Access and Innovation. Integrated care provides clinical and technical assistance to the District's contracted acute care inpatient psychiatric hospitals. The Integrated care team helps coordinate clinical services, while the patient is involuntarily hospitalized, and links the patients to the appropriate outpatient behavioral health services. When complex cases arise, the Integrated Care team will coordinate Community Integration Team (CIT) meetings with outpatient providers, hospitals. Residential providers, medical hospitals, and Nursing Facilities to consult on complex behavioral health cases where there is a significant risk of hospitalization, or there has been a recent history of hospitalization and guidance is sought to revise treatment plans to better address the needs of the individual at a lower level of care.?

The My DC Health Home program for consumers with SPMI uses population management techniques to address chronic health conditions to reduce or prevent unnecessary hospitalizations and emergency department (ED) visits. When Health Home consumers have an ED visit or hospitalization, the Health Home Program receives a notification from the District's Health Information Exchange. When appropriate, the Health Home primary care liaison coordinates care with hospital soon after admission. The Health Home nurse care managers reconcile medications with inpatient providers as necessary, coordinate discharge planning with the hospitals follow up with consumers within forty-eight hours of discharge, coordinate care with the consumer's assigned managed care organization, update care plans to better address the antecedents that precipitated the hospital visit including necessary health education, and assist with scheduling necessary appointments and/or referrals to community based healthcare providers to reduce emergency department visits or hospitalizations.??

The District's community-based intensive mental health and substance use disorder services are available to Medicaid beneficiaries today but are provided outside of the managed care program. The District will bring these services into the Medicaid managed care program in April 2024, to increase case coordination and whole person care, and improve outcomes. The MCOs will have greater flexibility in developing monitoring and reimbursement strategies to reduce hospital stays.?

For most of the past two decades, DBH has funded fifteen crisis beds with two providers out of local funds. This service is intended to provide a supportive intervention to avert hospitalizations and is also used as a step-down from hospitalization which individuals no longer require a hospital level of care but benefit from additional support while they reintegrate into the community. In June 2022, these services were made Medicaid reimbursable through an 1115 waiver which may allow expansion of the service.??

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

There are no areas of technical assistance needed at this time.

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	38,410	36,700
2.Children with SED	4,903	4,860

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

The Department of Behavioral Health (DBH) does not generate data on prevalence and incidence. DBH reports information provided by SAMHSA from the Center for Behavioral Health Statistics and Quality (CBHSQ). SAMSHA fills-in the prevalence data on the relevant Uniform Reporting System (URS) tables.?

The most recent data that the Department of Behavioral Health (DBH) has is 2021data provided by Hendall for adults with SMI and children/youth with SED.??

Number of Adults with Serious Mental Illness (SMI), age 18 and older, by State, 2021?

Civilian Population Adults Age 18+ 540,982?

Civilian Population Age 18+ with SMI (5.4%) 29,213?

Lower Limit of Estimate (3.7%) 20,016?

Upper Limit of Estimate (7.1%) 38,410?

?? (2021) District of Columbia Children/Youth with Serious Emotional Disturbances (SED) Civilian Population Youth Age 18+ 54,482?

LOF Score < 50 Lower Limit 3,814?

Upper Limit 4,903?

LOF Score > 60 Lower Limit 5,993?

Upper Limit 7,083?

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

Technical assistance is not needed at this time.

Criterion 3

Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care*?

a)	Social Services	(•) Yes ( ) No
b)	Educational services, including services provided under IDEA	(•) Yes ( ) No
c)	Juvenile justice services	(•) Yes ( ) No
d)	Substance misuse preventiion and SUD treatment services	(•) Yes ( ) No
e)	Health and mental health services	(•) Yes ( ) No
f)	Establishes defined geographic area for the provision of services of such systems	(•) Yes ( ) No

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

Technical assistance is needed to strengthen the system of care for youth SUD services (Youth Residential and SUD Withdrawal Management for adolescents)?

In addition, Technical Assistance is needed around the implementation partial hospitalization, day treatment, therapeutic respite, crisis beds, and a District of Columbia- specific Psychiatric Residential Treatment Facility (PRTF) within the District's children's behavioral health system.??

**A system of care is: A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.*
https://gucchd.georgetown.edu/products/Toolkit_SOC_Resource1.pdf

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

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4

a. Describe your state's targeted services to rural population. **See SAMHSA's Rural Behavioral Health page for program resources**

The District of Columbia is an urban setting. The 2019 U.S. Census Bureau American Community Survey (ACS) 5-year population estimate for the District of Columbia is 692,683. In the District of Columbia 364,039 females represent 52.6% of the population, while 328,644 males represent 47.4% of the population. The majority of the residents are 25 to 64 years of age (410,446) followed by those 65 years and older (83,670). The majority of the residents are African American (46.3% or 320,811) followed by White alone (41.3% or 285,857). The majority of residents 25 and over attained professional degrees beyond the bachelor's level followed by those with bachelor's degrees and high school graduates (includes equivalency).?

b. Describe your state's targeted services to people experiencing homelessness. **See SAMHSA's Homeless Programs and Resources for program resources**

Targeted Services to Rural and Homeless Populations of The District of Columbia is an urban setting with a population of 692,683 residents living within 68.34 square miles between the states of Virginia and Maryland. The District does not have any rural populations.?? • Targeted Services to Homeless Populations? • District of Columbia Interagency Council on Homelessness? Interagency Council on Homelessness: The District of Columbia Interagency Council on Homelessness (ICH) is a group of cabinet- level leaders, providers of homeless services, advocates, homeless and formerly homeless leaders that come together to inform and guide the District's strategies and policies for meeting the needs of individuals and families who are homeless or at imminent risk of becoming homeless.? Strategic Plan: The ICH Homeward DC 2.0 Strategic Plan (2021-2025) envisions ending long-term homelessness, and to create a system that quickly stabilizes households that do experience housing loss and connects them back to permanent housing and quickly as possible.? The ICH Vision states, "Homelessness in the District of Columbia will be rare, brief, and nonrecurring. We will eliminate racial inequities in the homeless services system and create systemic fair treatment for all people."? This plan builds on the work of Homeward DC and focuses on twelve (12) strategies. Those strategies are: Goal 1: Identify and Address Barriers That Impede Development of New Permanent Supportive Housing, Goal 2: Increase Speed and Efficiency of Housing Lease-Up Process; Goal 3: Continue Capital and Program Improvements to Shelter Stock; Goal 4: Reform Front Door of System for Individuals; Goal 5: Continue Family System Reforms: Goal 6: Support Provider Capacity Expansion; Goal 7: Improve Service Quality and Consistency; Goal 8: Improve Employment and Income Growth Opportunities for Clients; Goal 9: Improve Access to Care for Individuals with Complex Health needs; Goal 10: Coordinate with Upstream Systems to track and Stem Inflow; Goal 11: Continue Efforts to Improve Data Quality; and Goal 12: Provider Leadership on Creating a Right to Housing in the United States.?? FY 2023 Winter Plan: The Homeless Services Reform Act (HSRA) of 2005 mandates that by September 1 of each year, a plan be in place describing how those who are homeless will be protected from cold weather injury. The Winter Plan describes how District government agencies and providers within the Continuum of Care (CoC) will coordinate to provide hypothermia shelter and other services for those who are homeless consistent with the right of consumers to shelter in severe weather conditions.? This plan builds on past efforts, incorporates new strategies and responds to lessons learned from previous winters. The Plan addresses: 1) how the District will manage communications among stakeholders; 2) process for calling a hypothermia alert and the considerations involved; 3) process used to develop estimates for shelter capacity needs during the FY 2017 winter as well as the plan for delivering the number of beds/units needed; 4) transportation services that will be provided to ensure that clients have access to shelter and services; 5) services provided to help clients access shelter and while in shelter; 6) protocol and available resources for serving unaccompanied minors and transition aged youth (TAY); and 7) resources in place to monitor shelter operations as well as protocol for raising concerns and/or filing complaints.? ? District of Columbia 2020 Point-in-Time Count of People Experiencing Homelessness The Community Partnership for the Prevention of Homelessness (TCP) has conducted the Point-in-Time (PIT) count, a requirement for all jurisdictions receiving federal homeless assistance funding, on behalf of the District since 2001. On January 25, 2023 TCP conducted the annual PIT count. It provides a snapshot of the number and demographic characteristics of adults and children who were experiencing homelessness in the District on that day. This single day enumeration of the homeless services CoC gives TCP and District government partners an opportunity to identify gaps in the current portfolio of services and informs future program planning with special consideration to Homeward DC, the local strategic plan to end homelessness. In 2023 PIT there were 8,944 individuals experiencing homelessness in the District. This is an increase of 11.6% when compared to 2022, but it is also the fifth consecutive year of counts below 10,000 people for the District.? Homelessness in Metropolitan Washington Results and Analysis from the Annual Point-in-Time Count of Persons Experiencing Homelessness 2023 also conducted a regional enumeration of the area's homeless and formerly homeless population.? Overview of District Services: 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. Families facing housing crises in the District can visit the Department of Human Services (DHS) Virginia Williams Family Resource Center and receive homelessness prevention services, emergency rental or utility assistance, housing services, or other community resources such as Temporary Assistance for Needy Families (TANF), childcare assistance, access to the food stamp program, or Medicaid. Unaccompanied individuals in need of homeless services may access the District's low barrier, severe weather, or temporary emergency shelters for overnight accommodation and meals. To access the CoC supportive housing resources, unaccompanied persons may visit one of numerous sites throughout the District associated with the Coordinated Assessment and Housing Placement (CAHP) system (including the District's low barrier, severe weather, and temporary shelters). Through CAHP, individuals experiencing homelessness are matched to the appropriate assistance that meets their immediate and long-term housing and service needs. Unaccompanied veterans or youth experiencing homelessness can receive population specific resources through CAHP as well. D.C. 2023 Shelter and Housing Inventory: The data for the shelter and housing inventory from the Homeward DC 2.0 report includes the following:? 2,307 emergency shelter beds, 284 transitional housing beds, 1,095 rapid rehousing vouchers, 8,817 permanent supportive housing vouchers.??? Families: According to the PIT final report, thirty-three (33)

percent of all people experiencing homelessness in the Metroplitan Washington region are families. This includes 388 families that were counted in Washington DC specifically. As the number of families in shelter decreased as the result of Homeward DC interventions, the number of families connected to Rapid Rehousing assistance increased shifting the resource demand and need.??? Efforts were made to assist families at risk of homelessness with continued investments into the Homeless Prevention Program (HPP). HPP aims to help families resolve a housing crisis before a shelter stay is necessary and to connect them to shelter when there are no other safe options. Since its launch, HPP has prevented over 7,000 families from experiencing homelessness.? Planning is underway to replace the Harriet Tubman Women's Shelter and to conduct extensive renovations of the New York Avenue Men's Shelter, Blair Shelter, and Emery Shelter which serve men experiencing homelessness.? The launch of this work to reform the shelter system for unaccompanied adults coincides with other major changes to the "front door," including the addition of a Downtown Day Services Center created in partnership with the Downtown DC Business Improvement District and Pathways to Housing DC. The Center is an important access point to the homeless services system and is a critical resource for laundry, showers, meals, and an array of health services and agency services including those from the District Department of Employment Services, the Department of Health's Office of Vital Records, the Department of Motor Vehicles, DHS's Economic Security Administration, Unity Health Care, and the Washington Legal Clinic for the Homeless. Since opening, the facility has enrolled over 1,000 men and women in case management and has completed close to 800 Vulnerability Index - Service Prioritization Decision Assistance Tool (VI-SPDAT) assessments to connect clients to housing resources. This complements a growing network of daytime services in the District, including the Adams Place Day Center, which serves an average of 160 people per day in Northeast DC. 2019 also marked the development of a locally funded Comprehensive Street Outreach Network, designed to increase resources, enhance coordination, and provide more real-time support to unsheltered residents. As these important pieces of system reform continue to take shape, they will improve the District's ability to connect those experiencing homelessness to available housing resources and services while aiding in efforts to prevent homelessness whenever possible. Transition Age Youth (TAY): Since youth experiencing homelessness often remain more hidden to the public eye (i.e., "couch surfing" versus sleeping on the street), PIT is not always the best tool for measuring the prevalence of homelessness among youth given the parameters of the count. The District continues progress towards the goals outlined in Solid Foundations DC, the CoC's strategic plan to prevent and end youth homelessness and has made significant investments over the past year to serve the unique needs of youth experiencing homelessness. Now, in the middle of its third year of implementation and with new resources provided by the District, efforts include further refining the CAHP system for young people and expanding shelter, transitional housing, and permanent housing options available to youth experiencing, or at risk of experiencing, homelessness. The District's Youth Action Board, which was created in 2018 to ensure youth who have experienced homelessness have a role in planning services for this population, has served in a leadership role on several efforts over the past year. The counts of Transition Age Youth (TAYs, young people aged 18 to 24 years) remained relatively flat between the 2019 and 2020 PIT counts, with 485 TAYs counted in 2020, an increase of two (2) from the previous year. However, there was a difference in the share of TAYs in families versus unaccompanied households between years. TAYs in families increased by 5.9 percent, whereas unaccompanied TAYs decreased by 5.8 percent. TAY-headed households have also increased 7.4 percent between 2019 and 2020. An increase in youth-headed households was also seen in the 2019 Homeless Youth Census, which TCP conducts each summer, a change from trends in past years. In 2019, the District added new transitional housing beds and extended transitional housing (ETH) beds for youth with the highest needs. ETH allows for up to six years of housing placement with intensive supportive services, progressive engagement, and a housing first approach. Through the collaborative effort of the ICH, DHS, TCP, the Youth Action Board, and other youth-serving partners, the District was awarded a $4.28 million grant under the Youth Homelessness Demonstration Program (YHDP) from HUD. Being a demonstration site has given the District an opportunity to conduct a thorough mid-plan review to examine where efforts under Solid Foundations are working and where there are gaps to fill. New resources from this award will be online in 2020. Lastly, at the beginning of 2020, the District launched Zoe's Doors – a 24-hour drop-in center for youth ages 24 and under. Zoe's Doors provides a safe, welcoming space for young people in the District, offering meals, laundry facilities, shower facilities, healthcare services, on-site linkages to behavioral health services, life skills workshops, connection to education and employment resources, and social supports. Veterans: The District's count of veterans experiencing homelessness remains relatively flat with 12 more veterans counted year-to- year. Despite this year's slight increase, the number of veterans is still down from 2016 by 11.7 percent. Through the efforts of the Veteran Leadership Team and CAHP workgroups, the CoC has had success in connecting known veterans to housing resources, housing an average of 29 veterans per month between the 2019 and 2020 PIT counts, totaling to more than the number of veterans counted at 2019 PIT.? Moreover, the Distict continues to improve coordination among CAHP systems within the region. Since the summer of 2019, the CoC has helped more than 70 veterans reconnect with CAHP systems in surrounding jurisdictions based on history of housing and homelessness as well as client preferences. Additionally, a new veteran specific permanent supportive housing program on the Walter Reed campus opened in 2019. Sixty-one (61) veterans experiencing homelessness obtained housing at the site with another 14 more placements to be made in 2020.? Permanent Housing Solutions: As a part of the PIT count, TCP also counts formerly homeless persons – unaccompanied individuals and persons in families whose experience of homelessness ended upon entry into a dedicated housing resource. Most of these households would still be in emergency shelters, transitional housing, or living in unsheltered situations if not for these resources. At PIT 2020, 4,727 formerly homeless unaccompanied individuals and 4,074 formerly homeless families were in permanent supportive housing, rapid rehousing, or other permanent housing programs (such as targeted affordable housing). The data for singles and persons in families housed through each permanent housing solution is in the table that follows.?? Point in Time Needs Assessment Results: The unaccompanied individuals and adults in families counted during PIT were surveyed to inform the CoC on the demographic make-up, service needs, barriers to housing, economic indicators, and primary reasons for homelessness. This helps the District identify gaps in the system and to plan the development of interventions that will strategically address these gaps. Reported Disabling Conditions Among Persons Experiencing Homelessness: Reported Subpopulation Affiliation Among Persons Experiencing Homelessness:? Income and Employment: The tables below provide income information for unaccompanied individuals and adults in families, including whether they receive income of any kind, whether they are employed, and the primary income source for those with some type of income. While information collected at PIT continues to show that most persons experiencing homelessness have some type of income, only 16.7 percent of individuals and 25.5 percent of adults in families report having employment as an income source.? The differential between wages relative to rental costs has not changed significantly for low-income households over the last several years, remaining a primary driver of homelessness in the community as it leads to both system inflow and makes system exits difficult for those who do not qualify for permanent financial supports. Any shock to the household (job loss, a health crisis, death, divorce, etc.) can lead to housing instability or housing loss. This instability is seen most keenly in the system serving unaccompanied individuals, where there is relatively less assistance available in terms of housing resources and income and food assistance.???

c. Describe your state's targeted services to the older adult population. **See SAMHSA's Resources for Older Adults webpage for resources.**

Targeted Services to Older Adults Older Adults with SMI enrolled in the public mental health system includes 4043 adults aged 55-64 and 9470 adults aged 65 and above. Of the 13,513 enrolled older adults, 152 had a PASSR level II determination completed in FY21 for placement in a skilled nursing facility. The majority of older adults receiving services in the Districts public mental health system live in the community. Significant resources and supports are identified to support the care needs for this population as many consumers have complex medical needs as well as a SMI diagnosis.? The Department of Behavioral Health has an authority level registered nurse who manages the PASRR requests, and who provides technical support and care coordination guidance to providers, DBH partners including the Department of Health Care Finance (DHCF), the Office on Aging, Freeman's Health, and the Long-Term Care Ombudsman. These cross-agency teams coordinate Home and Community Based Services, Mental Health Rehabilitation Services/Adult Substance Abuse Rehabilitation services needs, and supports treatment teams to determine and then secure the appropriate levels of care to include identifying and securing housing supports. Additionally, the District has targeted housing services available to address the needs of TAY (aged 18-25) with SMI who are enrolled in the public mental health system. Through the Wayne Place independent Transition Living Program, young adults receive educational, job support, money management and other life skills.? TAY share common space, allowing the young people to build social skills, healthy relationships, and a sense of community.? Residents work to save a percentage of their income for future self-sufficiency and through the on-site teachings, coaching and mentoring, the TAY get a needed boost necessary for solid footing in the adult world.????

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

There are no areas of technical assistance needed at this time.

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Telehealth is a mode of service delivery that has been used in clinical settings for over 60 years and empirically studied for just over 20 years. Telehealth is not an intervention itself, but rather a mode of delivering services. This mode of service delivery increases access to screening, assessment, treatment, recovery supports, crisis support, and medication management across diverse behavioral health and primary care settings. Practitioners can offer telehealth through synchronous and asynchronous methods. 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. Practitioners can use telehealth with a hybrid approach for increased flexibility. For instance, a client can receive both in-person and telehealth visits throughout their treatment process depending on their needs and preferences. Telehealth methods can be implemented during public health emergencies (e.g., pandemics, infectious disease outbreaks, wildfires, flooding, tornadoes, hurricanes) to extend networks of providers (e.g., tapping into out-of-state providers to increase capacity). They can also expand capacity to provide direct client care when in-person, face-to-face interactions are not possible due to geographic barriers or a lack of providers or treatments in a given area. However, implementation of telehealth methods should not be reserved for emergencies or to serve as a bridge between providers and rural or underserved areas. Telehealth can be integrated into an organization's standard practices, providing low-barrier pathways for clients and providers to connect to and assess treatment needs, create treatment plans, initiate treatment, and provide long-term continuity of care. States are encouraged to access, the SAMHSA Evidence Based Resource Guide, **Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders**.

Criterion 5

a. Describe your state's management systems.

Telehealth is a mode of service delivery that has been used in clinical settings for over 60 years and empirically studied for just over 20 years. Telehealth is not an intervention itself, but rather a mode of delivering services. This mode of service delivery increases access to screening, assessment, treatment, recovery supports, crisis support, and medication management across diverse behavioral health and primary care settings. Practitioners can offer telehealth through synchronous and asynchronous methods. 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. Practitioners can use telehealth with a hybrid approach for increased flexibility. For instance, a client can receive both in-person and telehealth visits throughout their treatment process depending on their needs and preferences. Telehealth methods can be implemented during public health emergencies (e.g., pandemics, infectious disease outbreaks, wildfires, flooding, tornadoes, hurricanes) to extend networks of providers (e.g., tapping into out of-state providers to increase capacity). They can also expand capacity to provide direct client care when in-person, face-to-face interactions are not possible due to geographic barriers or a lack of providers or treatments in a given area. However, implementation of telehealth methods should not be reserved for emergencies or to serve as a bridge between providers and rural or underserved areas. Telehealth can be integrated into an organization's standard practices, providing low-barrier pathways for clients and providers to connect to and assess treatment needs, create treatment plans, initiate treatment, and provide long-term continuity of care. States are encouraged to access, the SAMHSA Evidence Based Resource Guide, Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders.

b. Describe your state's current telehealth capabilities, how your state uses telehealth modalities to treat individuals with SMI/SED, and any plans/initiatives to expand its use.

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 launch last year, was delayed as we explored and resolved legal concerns to ensure compliance with Federal anti-kick back 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.

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

No technical assistance requested at this time

Footnotes:

Environmental Factors and Plan

10. Substance Use Disorder Treatment - Required SUPTRS BG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

i)	Screening	(•) Yes ( ) No
ii)	Education	(•) Yes ( ) No
iii)	Brief Intervention	(•) Yes ( ) No
iv)	Assessment	(•) Yes ( ) No
v)	Detox (inpatient/residential)	(•) Yes ( ) No
vi)	Outpatient	(•) Yes ( ) No
vii)	Intensive Outpatient	(•) Yes ( ) No
viii)	Inpatient/Residential	(•) Yes ( ) No
ix)	Aftercare; Recovery support	(•) Yes ( ) No

b) Services for special populations:

i)	Prioritized services for veterans?	(•) Yes ( ) No
ii)	Adolescents?	(•) Yes ( ) No
iii)	Older Adults?	(•) Yes ( ) No

Criterion 2

Criterion 3

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability? (●) Yes ( ) No

2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities? (●) Yes ( ) No

3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? (●) Yes ( ) No

4. Does your state have an arrangement for ensuring the provision of required supportive services? (●) Yes ( ) No

5 Has your state identified a need for any of the following:

a) Open assessment and intake scheduling (●) Yes ( ) No

b) Establishment of an electronic system to identify available treatment slots (●) Yes ( ) No

c) Expanded community network for supportive services and healthcare (●) Yes ( ) No

d) Inclusion of recovery support services (●) Yes ( ) No

e) Health navigators to assist clients with community linkages (●) Yes ( ) No

f) Expanded capability for family services, relationship restoration, and custody issues? (●) Yes ( ) No

g) Providing employment assistance (●) Yes ( ) No

h) Providing transportation to and from services (●) Yes ( ) No

i) Educational assistance (●) Yes ( ) No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

The DBH Accountability Administration oversees provider certification, incident management, major investigations, claims audits, and compliance monitoring and corrective actions. DBH Provider Relations staff also work with providers to provide technical assistance, discuss enrollment data, training, and performance feedback to the system of care. The District's Continuous Quality Improvement (CQI) process monitors data for key performance indicators that measure clinical quality or client outcomes and provide analysis on system performance and individual provider performance. The CQI staff facilitate planning programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families, and project/manage the implementation of those plans and their impact on performance. Policies and procedures include a description of the process for responding to emergencies, waitlist management, critical incidents, complaints, and grievances.

Criterion 4,5&6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

a)	90 percent capacity reporting requirement	(•) Yes ( ) No
b)	14-120 day performance requirement with provision of interim services	( ) Yes (•) No
c)	Outreach activities	(•) Yes ( ) No
d)	Syringe services programs, if applicable	( ) Yes (•) No
e)	Monitoring requirements as outlined in the authorizing statute and implementing regulation	( ) Yes (•) No

2. Has your state identified a need for any of the following:

a)	Electronic system with alert when 90 percent capacity is reached	(•) Yes ( ) No
b)	Automatic reminder system associated with 14-120 day performance requirement	(•) Yes ( ) No
c)	Use of peer recovery supports to maintain contact and support	(•) Yes ( ) No
d)	Service expansion to specific populations (e.g., military families, veterans, adolescents, LGBTQI+, older adults)?	(•) Yes ( ) No

3. States are required to monitor program compliance related to activites and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

The DBH Accountability Administration oversees provider certification, incident management, major investigations, claims audits, and compliance monitoring and corrective actions. DBH Provider Relations staff also work with providers to provide technical assistance, training, and performance feedback to the system of care. The District's CQI process monitors data for key performance indicators that measure clinical quality or client outcomes and provide analysis on system performance and individual provider performance. The CQI staff facilitate planning programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families, and then project manage the implementation of those plans and their impact on performance. Policies and procedures include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.?

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery? (•) Yes ( ) No

2. Has your state identified a need for any of the following:

a)	Business agreement/MOU with primary healthcare providers	( ) Yes (•) No
b)	Cooperative agreement/MOU with public health entity for testing and treatment	(•) Yes ( ) No
c)	Established co-located SUD professionals within FQHCs	( ) Yes (•) No

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

BH and the DC Dept. of Healthcare Finance, the District of Columbia's State Medicaid agency, engaged in the following activities to build TB testing capabilities within SUD programs.?

• DC Health provided SUD providers with guidance on step-by-step process of what to do when clients test positive for TB (programmatic expectations).

• Ordered TB testing for Assessment & Referral sites and hand delivered to the sites.

• DHCF supported CPT code for billing Medicaid for medical services such as TB testing.

• DBH and DCHF had numerous trainings with the providers to assist with their billing concerns.

• TA was provided to the Assessment & Referral sites to assist them in identifying FQHCs and other neighboring sites for TB services when A&R providers are unable to administer. The Certification Division within DBH's Office of Accountability is responsible for evaluating certified providers, and those pursuing certification, at prescribed intervals to ensure provider internal policies and practices align with DBH regulations, policies, and practices. The Certification Division issues corrective action plans and notices of infractions (where applicable), when certified providers are found to be non-compliant with expectations. DBH also maintains a 24-hour compliance line where clients, staff, etc. can report instance of potential regulatory or policy violations.?

?DBH continues to work with DC Health to support SUD providers with screening and testing for tuberculosis and linking individuals to care if testing is positive. DBH and DC Department of Healthcare Finance also provide technical assistance to new and existing SUD around the use of CPT codes for billing Medicaid for screening and testing. The Certification Division within DBH's Office of Accountability is responsible for evaluating certified providers, and those pursuing certification, at prescribed intervals to ensure provider internal policies and practices align with DBH regulations, policies, and practices. The Certification Division issues corrective action plans and notices of infractions (where applicable), when certified providers are found to be non-compliant with expectations. DBH also maintains a 24-hour compliance line where clients, staff, etc. can report instance of potential regulatory or policy violations.?

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring such service delivery? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Establishment of EIS-HIV service hubs in rural areas ( ) Yes (●) No

b) Establishment or expansion of tele-health and social media support services ( ) Yes (●) No

c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS (●) Yes ( ) No

Syringe Service Programs

1. Does your state have in place an agreement to ensure that SUPTRS BG funds are NOT expended to provide individuals with hypodermic needles or syringes(42 U.S.CÂ§ 300x-31(a)(1)(F)? ( ) Yes (●) No

2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program? ( ) Yes (●) No

3. Do any of the programs use SUPTRS BG funds to support elements of a Syringe Services Program? ( ) Yes (●) No

If yes, plese provide a brief description of the elements and the arrangement

Criterion 8,9&10

Service System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Workforce development efforts to expand service access — (●) Yes ( ) No
- **b)** Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services — (●) Yes ( ) No
- **c)** Establish a peer recovery support network to assist in filling the gaps — (●) Yes ( ) No
- **d)** Incorporate input from special populations (military families, service memebers, veterans, tribal entities, older adults, sexual and gender minorities) — (●) Yes ( ) No
- **e)** Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations — (●) Yes ( ) No
- **f)** Explore expansion of services for:
  - **i)** MOUD — (●) Yes ( ) No
  - **ii)** Tele-Health — (●) Yes ( ) No
  - **iii)** Social Media Outreach — (●) Yes ( ) No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person -centered and person-directed care? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services — (●) Yes ( ) No
- **b)** Establish a program to provide trauma-informed care — (●) Yes ( ) No
- **c)** Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education — (●) Yes ( ) No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C.§ 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)? — (●) Yes ( ) No

2. Does your state provide any of the following:

- **a)** Notice to Program Beneficiaries — (●) Yes ( ) No
- **b)** An organized referral system to identify alternative providers? — (●) Yes ( ) No
- **c)** A system to maintain a list of referrals made by religious organizations? — (●) Yes ( ) No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Review and update of screening and assessment instruments — (●) Yes ( ) No
- **b)** Review of current levels of care to determine changes or additions — (●) Yes ( ) No

c) Identify workforce needs to expand service capabilities — (●) Yes ( ) No

d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background — (●) Yes ( ) No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Training staff and community partners on confidentiality requirements — (●) Yes ( ) No

b) Training on responding to requests asking for acknowledgement of the presence of clients — (●) Yes ( ) No

c) Updating written procedures which regulate and control access to records — (●) Yes ( ) No

d) Review and update of the procedure by which clients are notified of the confidentiality of their records including the exceptions for disclosure: — (●) Yes ( ) No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? — (●) Yes ( ) No

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

a) Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

Samaritan Inns.

3. Has your state identified a need for any of the following:

a) Development of a quality improvement plan — (●) Yes ( ) No

b) Establishment of policies and procedures related to independent peer review — (●) Yes ( ) No

c) Development of long-term planning for service revision and expansion to meet the needs of specific populations — (●) Yes ( ) No

4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds? — (●) Yes ( ) No

If Yes, please identify the accreditation organization(s)

i) [x] Commission on the Accreditation of Rehabilitation Facilities

ii) [x] The Joint Commission

iii) [x] Other (please specify)

Council on Accreditation

Criterion 7&11

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? ○ Yes ◉ No

2. Has your state identified a need for any of the following:

a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service ○ Yes ◉ No

b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing ○ Yes ◉ No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:

a) Recent trends in substance use disorders in the state ◉ Yes ○ No

b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services ◉ Yes ○ No

c) Performance-based accountability: ◉ Yes ○ No

d) Data collection and reporting requirements ◉ Yes ○ No

2. Has your state identified a need for any of the following:

a) A comprehensive review of the current training schedule and identification of additional training needs ◉ Yes ○ No

b) Addition of training sessions designed to increase employee understanding of recovery support services ◉ Yes ○ No

c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services ◉ Yes ○ No

d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort ◉ Yes ○ No

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?

a) Prevention TTC? ◉ Yes ○ No

b) Mental Health TTC? ◉ Yes ○ No

c) Addiction TTC? ◉ Yes ○ No

d) State Targeted Response TTC? ◉ Yes ○ No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924. and 1928 (42 U.S.C.§ 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:

a) Allocations regarding women ○ Yes ◉ No

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:

a) Tuberculosis ○ Yes ◉ No

b) Early Intervention Services Regarding HIV ○ Yes ◉ No

3. Additional Agreements

a) Improvement of Process for Appropriate Referrals for Treatment ○ Yes ◉ No

b) Professional Development ○ Yes ◉ No

c) Coordination of Various Activities and Services ○ Yes ◉ No

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

Chapter 34:

https://www.dcregs.dc.gov/Common/DCMR/RuleList.aspx?ChapterNum=22-A34&ChapterId=2120

Chapter 63:

https://www.dcregs.dc.gov/Common/DCMR/RuleList.aspx?ChapterNum=22-A63&ChapterId=3496

If the answer is No to any of the above, please explain the reason.

There are no areas of technical assistance needed related to this section at this time.

Footnotes:

Environmental Factors and Plan

11. Quality Improvement Plan- Requested

Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2022-FFY 2023? ○ Yes ◉ No

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

Technical assistance is not needed at this time.

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Footnotes:

Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma[1] is a common experience for adults and children in communities, and it is especially common in the lives of people with mental and substance use disorders. For this reason, the need to address trauma is increasingly seen as an important part of effective behavioral health care and an integral part of the healing and recovery process. It occurs because of violence, abuse, neglect, loss, disaster, war, and other emotionally harmful and/or life-threatening experiences. Trauma has no boundaries regarding age, gender, socioeconomic status, race, ethnicity, geography, ability, or sexual orientation. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system and children and families in the child welfare system have high rates of mental illness, substance use disorders and personal histories of trauma. Similarly, many individuals in primary, specialty, emergency, and rehabilitative health care also have significant trauma histories, which impacts their health and responsiveness to health interventions. Also, schools are now recognizing that the impact of traumatic exposure among their students makes it difficult for students to learn and meet academic goals. As communities experience trauma, for some, these are rare events and for others, these are daily events. Children and families living in resource scarce communities remain especially vulnerable to experiences of trauma and thus face obstacles in accessing and receiving M/SUD care. States should work with these communities to identify interventions that best meet the needs of their residents. In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink how practices are conducted. These public institutions and service settings are increasingly adopting a trauma-informed approach distinct from trauma-specific assessments and treatments. Trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues with a focus on equity and inclusion. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[2] paper.

[1] Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*

[2] *Ibid*

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

1.	Does the state have a plan or policy for M/SUD providers that guides how they will address individuals with trauma-related issues?	(•) Yes ( ) No
2.	Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers?	(•) Yes ( ) No
3.	Does the state provide training on trauma-specific treatment and interventions for M/SUD providers?	(•) Yes ( ) No
4.	Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care?	(•) Yes ( ) No
5.	Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?	(•) Yes ( ) No
6.	Does the state use an evidence-based intervention to treat trauma?	(•) Yes ( ) No

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

As part of the screening and assessment process with DBH, whether through DBH'ss primary assessment site (the DBH Assessment and Referral Center (ARC)), the contracted court system assessment center, the withdrawal management?service providers, the Department of Corrections' (DOC) assessment office, or the HIV-EIS contracted provider, under the auspices of a local Federally Qualified Healthcare Center (FQHC), there is a thorough biopsychosocial assessment conducted on everyone entering our system. This process consists of the use of the ASAM standardized assessment tool, Co-Triage, which provides, a level of care

determination based on the individual's reported and collateral information if available.? Additionally, providers can utilize their own biopsychosocial assessment to support the level of care as well as identify additional behavioral health and social service needs. After referral to the most appropriate level of care, the identified provider will conduct a more comprehensive assessment using the ASAM Continuum assessment tool.? Continuum incorporates questions related to trauma at help to inform the identified level of care and other behavioral health needs. As part of the District's integration of behavioral health services into the Medicaid system, all certified substance use disorder providers will be required to utilize Co-Triage and Continuum.?

At present, District Providers implement the use of the Trauma Recovery and Empowerment Model (TREM), Cognitive Behavioral Therapy (CBT), and Cognitive Behavioral Interventions (CBI). ?

All District funded substance providers are governed by the agency's Title 22A, Chapter 63 Certification Standard, which speaks to the need for providers to coordinate individualized care for the population seeking services, and for providers to ensure that consumers connect to services based on individualized needs identified in their treatment plans. Also, specific policies incorporate the requirement that individuals are referred to?the appropriate level of care (modality) and the treatment interventions and techniques which address trauma are included in the individualized treatment plans. ?

DBH provides the provider network with training, which includes Integrated Dual Diagnosis Treatment, Patient-Center Training, and other treatment-related trainings to support trauma-informed care. The Trauma Recovery and Empowerment Model (TREM) is a fully manualized group-based intervention designed to facilitate trauma recovery among people with histories of exposure to sexual, physical and emotional abuse. Drawing on cognitive restructuring, psychoeducational, and skills-training techniques, the gender-specific 24-29 session group emphasizes the development of coping skills, survivor empowerment, peer/social support and teaches survivors techniques for self-soothing, boundary maintenance and current problem solving.? It addresses both short- and long-term consequences of violent victimization, including mental health symptoms, especially posttraumatic stress disorder (PTSD) and depression, and substance abuse.?

The Department continues to partner with Child and Family Services Agency (CFSA), the District's child welfare agency to offer trauma-informed Evidence-Based practices to include Child-Parent Psychotherapy, which is a relationship-based treatment intervention for young children 0-6 with a history of trauma exposure or maltreatment, and their parents or caregivers; Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), which is a psychotherapeutic intervention designed to help children ages 3-18, working with their parent or caregivers, overcome the negative effects of traumatic life events; Trauma Systems Therapy (TST), which is a comprehensive, phase-based model for treating traumatic stress in children and adolescents ages 6-18; and Functional Family Therapy (FFT), which is a family focused intervention for at-risk and juvenile justice involved youth ages 11-18.??

CFSA extended support for the expansion of Functional Family Therapy (FFT) utilizing the Community Based Child Abuse Prevention (CBCAP) funding to provide intensive therapeutic interventions to families as a key service to prevent or reduce child abuse and neglect.? During FY 23, the funding was utilized to sustain the certification of both FFT providers. Both providers hired additional staff increasing the capacity to serve families.??

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, ensuring that services are readily available to all families regardless of their socio-economic circumstances. Simultaneously, DBH will work towards improving 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.?

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

There are no areas of technical assistance needed at this time.

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Footnotes:

Environmental Factors and Plan

13. Criminal and Juvenile Justice - Requested

Narrative Question

More than a third of people in prisons and nearly half of people in jail have a history of mental health problems.[1] Almost two thirds of people in prison and jail meet criteria for a substance use disorder.[2] As many as 70 percent of youth in the juvenile justice system have a diagnosable mental health problem.[3] States have numerous ways that they can work to improve care for these individuals and the other people with mental and substance use disorders involved in the criminal justice system. This is particularly important given the overrepresentation of populations that face mental health and substance use disorder disparities in the criminal justice system.

Addressing the mental health and substance use disorder treatment and service needs of people involved in the criminal justice system requires a variety of approaches. These include:

- Better coordination across mental health, substance use, criminal justice and other systems (including coordination across entities at the state and local levels);
- Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups;
- Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system;
- Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community;
- Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems);
- Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, at booking, jails, the courts, at reentry, and through community corrections);
- Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system;
- Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met;
- Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges;
- Partnering with the judicial system to engage in cross-system planning and development at the state and local levels;
- Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system; and
- Supporting court-based programs, including specialty courts and diversion programs that serve people with M/ SUD.
- Addressing the increasing number of individuals who are detained in jails or state hospitals/facilities awaiting competence to stand trial assessments and restoration.

These types of approaches can improve outcomes and experiences for people with M/SUD involved in the criminal justice system and support more efficient use of criminal justice resources. The MHBG and SUPTRS BG may be especially valuable in supporting a stronger array of community-based services in these and other areas. SSAs and SMHAs can also play a key role in partnering with state and local agencies to improve coordination of systems and services. This includes state and local law enforcement, correctional systems, and courts. SAMHSA strongly encourages state behavioral health authorities to work closely with these partners, including their state courts, to ensure the best coordination of services and outcomes, especially in light of health disparities and inequities, and to develop closer interdisciplinary programming for justice system involved individuals. Promoting and supporting these efforts with a health equity lens is a SAMHSA priority.

[1]Bronson, J., & Berzofsky, M. (2017). Indicators of mental health problems reported by prisoners and jail inmates, 2011–12. Bureau of Justice Statistics, 1-16.

[2]Bronson, J., Stroop, J., Zimmer, S., & Berzofsky, M. (2017). Drug use, dependence, and abuse among state prisoners and jail inmates, 2007–2009. Washington, DC: United States Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

[3]Vincent, G. M., Thomas Grisso, Anna Terry, and Steven M. Banks. 2008. "Sex and Race Differences in Mental Health Symptoms in Juvenile Justice: The MAYSI-2 National Meta-Analysis." Journal of the American Academy of Child and Adolescent Psychiatry 47(3):282–90.

Please respond to the following items

1. Does the state (SMHA and SSA) engage in any activities of the following activities:

- [x] Coordination across mental health, substance use disorder, criminal justice and other systems
- [x] Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups
- [x] Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system, including those related to medications for opioid use disorder
- [x] Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- [x] Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- [x] Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community
- [x] Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems)
- [x] Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, booking, jails, the courts, at reentry, and through community corrections)
- [x] Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system
- [x] Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met
- [x] Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges
- [x] Partnering with the judicial system to engage in cross-system planning and development at the state and local levels
- [x] Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system
- [x] Supporting court-based programs, including specialty courts and diversion programs that serve people with M/SUD
- [x] Addressing Competence to Stand Trial; assessments and restoration activities.

2. Does the state have any specific activities related to reducing disparities in service receipt and outcomes across racial and ethnic groups for individuals with M/SUD who are involved in the criminal justice system? If so, please describe.

○ Yes ◉ No

3. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances?

◉ Yes ○ No

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

Juvenile Justice Programs

Assessment Center for Child Welfare, Juvenile Justice, and Family Court: 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 who have involvement in child welfare, juvenile justice, and family court.

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

option of participating in mental health services rather than being prosecuted.

JBDP Enrollment Data:

Fiscal Year

JBDP Enrollment

2017

84

2018

50

2019

72

2020

60

2021

53

2022

46

2023 – end Q2

28

HOPE Court: Here Opportunities Prepare you for Excellence (HOPE) Court operates within D.C. Superior Court in partnership with Court Social Services, Office of the Attorney General, and community-based providers. HOPE Court is a voluntary, specialized court for youth who have either a Person In Need of Supervision (PINS), delinquency and/or neglect cases, and who have specific factors that make them eligible for referral, review, and if appropriate, participation. This Court specializes in the treatment and support of youth that have engaged in or are at risk of commercial sexual exploitation. Youths eligible for HOPE Court are invited to partner with community supports in their treatment planning.

HOPE Court Youth Served:

Fiscal Year

Youths

Served

2019

56

2020

46

2021

49

2022

33

2023 – end Q2

29

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

Forensic Services Division

Provides and oversees a continuum of behavioral health evaluation, treatment, consultation, and referral services for justice-involved individuals from pre-arrest to post-incarceration to ensure their successful return to the community.

Forensic Services Programs

Court Clinic – Competency Evaluations:? DBH is statutorily required to perform court-ordered competency evaluations for defendants appearing before the D.C. Superior Court. The forensic psychologists perform screening and full evaluations of defendants who are detained at D.C. Jail and defendants in the community on bond or personnel recognizance status. The results of these evaluations then determine whether defendants require competency restoration on an outpatient or inpatient basis.

Year

Competency

Evaluations

(Detained)

Competency Evaluations (Outpatient)

2019

552

517

2022

702

255

2023 (5 mos.)

220

176

Pre-Trial and Re-Entry Forensic Services: Links pre-trial individuals and returning citizens to mental health services. A Mental Health Liaison is co-located at the Court to provide screenings and mental health assessments for the Pretrial Services Agency to identify potential diversion opportunities for defendant to get out of the criminal justice system, recommend appropriate behavioral health supervision levels, and make referrals for mental health services. Individuals who are released to the community directly from the courthouse also utilize this assessment and referral service.

Year

MH Assessments Conducted

Release

Referrals

2023 (6 mos.)

162

184

Court Urgent Care Clinic (D.C. Superior Court): The mission of the Court Urgent Care Clinic is to identify and provide 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 CInical

Services

2022

205

1288

2023 (6 mos.)

101

612

Department of Corrections: Forensic Services employees are co-located at the Department of Corrections. As individuals are admitted to the jail, they ensure there is continuity of care by sharing pertinent behavioral health information with jail-based treatment providers. These staff also link returning citizens to community-based providers and schedule intake and other appointments 30 days prior to the individual's release. Additionally, we are beginning a program whereby individuals with serious and persistent mental illness who are released from jail are connected to a Certified Forensic Peer Specialist. This peer will build rapport with the individual prior to their release and continue their engagement with them in the community for several months. These individuals with a severe and persistent mental illness are being incentivized (with nominal gift cards to local grocery stores) to attend their mental health appointments.

Year

Offered Linkage to Services

2023 (5 mos.)

323

Court Services and Offenders Supervision Agency (CSOSA): DBH partners with CSOSA, a federal law enforcement entity responsible for supervising individuals returning to the District from the Federal Bureau of Prisons. Forensic Mental Health Liaisons are co-located in the agency to provide linkage support, to promote behavioral health services, and to ensure continuity of care for justice-involved persons.

Saint Elizabeths Hospital: Within the hospital, the Forensic Services Division provides pre-trial and post-trial forensic evaluations for inpatients who are involved in the criminal justice system. These evaluations are typically 30-day evaluations following treatment and competency restoration. The Program also conducts court-ordered criminal responsibility, aid-in-sentencing, and

violence risk assessment evaluations. The Forensic Services Division oversees the management of Not Guilty by Reason of Insanity (NGRI) individuals to ensure that court-ordered updates and directives are executed in a timely manner.

Fiscal Year

Competency Evaluations

2019

578

2022

429

2023 (5 mos.)

232

Outpatient Competency Restoration Program (OCRP): Following a determination the defendant is incompetent to stand trial, the D.C. Superior Court may order the defendant to receive competency restoration at OCRP, in lieu of sending them to Saint Elizabeths Hospital. This psychoeducational program provides interventions individually and/or in a group milieu based on the defendant's identified needs. Following a 30 to 45-day period of restoration, the defendant's competency to stand trial will be re-evaluated.

Year

Initial Restoration

Orders

Percent Re-ordered for Additional Restoration

2019

83

61%

2022

86

86%

Forensic Peer Navigators: Forensic Services Division utilizes Certified Forensic Peer Specialist to (a) help divert justice-involved consumers out of jails and inpatient treatment settings and remain in community-based treatment settings, and (b) help ensure behavioral health services are being delivered to justice-involved consumers in an appropriate, sustained, and effective manner. The Division currently has three Forensic Peer Navigators supporting:? the D.C. Superior Court Mental Health Community Court, the Outpatient Competency Restoration Program, and citizens returning to the community from the Department of Corrections.

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

Technical assistance is not needed at this time.

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Footnotes:

Environmental Factors and Plan

14. Medications in the Treatment of Substance Use Disorders, Including Medication for Opioid Use Disorder (MOUD) – Requested (SUPTRS BG only)

Narrative Question

In line with the goals of the Overdose Prevention Strategy and SAMHSA's priority on Preventing Overdose, SAMHSA strongly request that information related to medications in the treatment of substance use disorders be included in the application.

There is a voluminous literature on the efficacy of the combination of medications for addiction treatment and other interventions and therapies to treat substance use disorders, particularly opioid, alcohol, and tobacco use disorders. This is particularly the case for medications used in the treatment of opioid use disorder, also increasingly known as Medications for Opioid Use Disorder (MOUD). The combination of medications such as MOUD; counseling; other behavioral therapies including contingency management; and social support services, provided in individualized, tailored ways, has helped countless number of individuals achieve and sustain remission and recovery from their substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based, or non-medication inclusive, treatment for these conditions. The evidence base for medications as standards of care for SUDs is described in SAMHSA TIP 49 Incorporating Alcohol Pharmacotherapies Into Medical Practice and TIP 63 Medications for Opioid Use Disorders.

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to offer MOUD and medications for alcohol use disorder or have collaborative relationships with other providers that can provide all FDA-approved medications for opioid and alcohol use disorder and other clinically needed services.

Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs. States should use Block Grant funds for the spectrum of evidence-based interventions for opioids and stimulants including medications for opioids use disorders and contingency management.

In addition, SAMHSA also encourages states to require equitable access to and implementation of medications for opioid use disorder (MOUD), alcohol use disorder (MAUD) and tobacco use disorders within their systems of care.

SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding the use of medications for substance use disorders? (●) Yes ( ) No

2. Has the state implemented a plan to educate and raise awareness of the use of medications for substance disorder, including MOUD, within special target audiences, particularly pregnant women? (●) Yes ( ) No

3. Does the state purchase any of the following medication with block grant funds?

- **a)** [x] Methadone
- **b)** [ ] Buprenophine, Buprenorphine/naloxone
- **c)** [ ] Disulfiram
- **d)** [ ] Acamprosate
- **e)** [ ] Naltrexone (oral, IM)
- **f)** [x] Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based treatment with the use of FDA-approved medications for treatment of substance use disorders is combined with other therapies and services based on individualized assessments and needs? (●) Yes ( ) No

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

The State Opioid Treatment Authority conducts monthly calls with Opioid Treatment Programs (OTPs) to discuss best practices and challenges faced in the OTPs. With support of the State Opioid response grant, the OTPs and other organizations that prescribe MOUD, are receiving technical assistance around establishing integrated care programs.?

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

Footnotes:

Environmental Factors and Plan

15. Crisis Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Substance Abuse and Mental Health Services Administration (SAMHSA) is directed by Congress to set aside 5 percent of the Mental Health Block Grant (MHBG) allocation for each state to support evidence-based crisis systems. The statutory language outlines the following for the 5 percent set-aside:

> *....to support evidenced-based programs that address the crisis care needs of individuals with serious mental illnesses and children with serious emotional disturbances, which may include individuals (including children and adolescents) experiencing mental health crises demonstrating serious mental illness or serious emotional disturbance, as applicable.*
>
> *CORE ELEMENTS: At the discretion of the single State agency responsible for the administration of the program, the funds may be used to expend some or all of the core crisis care service components, as applicable and appropriate, including the following:*
>
> - *Crisis call centers*
> - *24/7 mobile crisis services*
> - *Crisis stabilization programs offering acute care or subacute care in a hospital or appropriately licensed facility, as determined by such State, with referrals to inpatient or outpatient care.*
>
> *STATE FLEXIBILITY: In lieu of expanding 5 percent of the amount the State receives pursuant to this section for a fiscal year to support evidence based programs as required a State may elect to expend not less than 10 percent of such amount to support such programs by the end of two consecutive fiscal years.*

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-intervention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination, stabilization service to support reducing distress, promoting skill development and outcomes, manage costs, and better invest resources.

SAMHSA developed **Crisis Services: Meeting Needs, Saving Lives**, which includes "**National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit**" as well as an **Advisory: Peer Support Services in Crisis Care** and other related National Association of State Mental Health Programs Directors (NASMHPD) papers on crisis services. SAMHSA also developed "**National Guidelines for Child and Youth Behavioral Health Crisis Care**" which offers best practicies, implementation strategies, and practical guidance for the design and development of services that meet the needs of children, youth and their families experiencing a behavioral health crisis. Please note that this set aside funding is dedicated for the core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with serious mental illness or children with serious emotional disturbances. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by this new 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

1. Briefly narrate your state's crisis system. For all regions/areas of your state, include a description of access to the crisis call centers, availability of mobile crisis and behavioral health first responder services, utilization of crsis receiving and stabilization centers.

The District of Columbia's Department of Behavioral Health (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 operated directly by employees of the Department of Behavioral Health.

2. In accordance with the guidelines below, identify the stages where the existing/proposed system will fit in.

*a) The **Exploration** stage: is the stage when states identify their communities' needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.*
*b) The **Installation** stage: occurs once the state comes up with a plan and the state begins making the changes necessary to implement the crisis services based on the SAMHSA guidance. This includes coordination, training and community outreach and education activities.*
*c) **Initial Implementation** stage: occurs when the state has the three-core crisis services implemented and agencies begin to put into practice the SAMHSA*

guidelines.

*d) **Full Implementation** stage: occurs once staffing is complete, services are provided, and funding streams are in place.*

*e) **Program Sustainability** stage: occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.*

Other program implementation data that characterizes crisis services system development.

1. Someone to talk to: Crisis Call Capacity

- *a. Number of locally based crisis call Centers in state*
  - *i. In the 988 Suicide and Crisis lifeline network*
  - *ii. Not in the suicide lifeline network*
- *b. Number of Crisis Call Centers with follow up protocols in place*
- *c. Percent of 911 calls that are coded as BH related*

2. Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the toal number of communities)

- *a. Independent of first responder structures (police, paramedic, fire)*
- *b. Integrated with first responder structures (police, paramedic, fire)*
- *c. Number that employs peers*

3. Safe place to go or to be:

- *a. Number of Emergency Departments*
- *b. Number of Emergency Departments that operate a specialized behavioral health component*
- *c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis)*

a. Check one box for each row indicating state's stage of implementation

	Exploration Planning	Installation	Early Implementation Less than 25% of counties	Partial Implementation About 50% of counties	Majority Implementation At least 75% of counties	Program Sustainment
Someone to talk to	☐	☐	☐	☐	☑	☐
Someone to respond	☐	☐	☐	☐	☑	☐
Safe place to go or to be	☐	☐	☐	☐	☑	☐

b. Briefly explain your stages of implementation selections here.

As described in detail above, DBH directly operates the District's behavioral health crisis call center (AHL), mobile crisis (CRT), and the District's only psychiatric crisis receiving center (CPEP). The District also provides child and adolescent mobile crisis via a contract. We are seeking to expand and optimize but these are not new programs. First with ARPA funding and with local appropriations going forward, the District's budget has invested funding to greatly expand mobile crisis (from 38 to 65 positions) and the call center (from 16 to 30 positions). The District has committed capital funding for two sobering and stabilization centers and awarded a contract for the first to begin operating before the end of FY23.

3. Based on SAMHSA's National Guidelines for Behavioral Health Crisis Care, explain how the state will develop the crisis system.

In addition to the planned expansions identified above, DBH is actively working to strengthen activities in the 4th (information technology) and 5th (training/consultation) "lanes." We are evaluating options for procuring and implementing technologies and software to enable us to more fully achieve the vision of the "air traffic control" model with the capacity to geo-track mobile teams, schedule clinic appointments, and connect people in crisis to resources in real time to avoid unnecessary emergency department encounters and inpatient stays. We are also exploring enhanced pre-service and in-service training for all crisis services staff including possible certifications where available.

4. Briefly describe the proposed/planned activities utilizing the 5 percent set aside.

DBH plans to utilize the 5% crisis set aside to enhance the technology tools needed to enable us to fully achieve the vision of the "air traffic control" model with the capacity to geo-track mobile teams, schedule clinic appointments, and connect people in crisis to resources in real time to avoid unnecessary emergency department encounters and inpatient stays. Through recent consultation with SAMHSA and the Vibrant team, we have decided to engage a consulting group to optimize the telephony and to add functionality and data analytic capability. We recently experienced a drop in our in-state answer rate for 988 calls and need in-house expertise under our direct control to assist in more quickly diagnosing and remediating technical problems. While DBH has a Chief Information

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

As noted above, we are seeking to procure ongoing assistance with the technology and data sophistication required to stay on the cutting edge of behavioral health crisis response. We also anticipate needing technical assistance as we build out the 988 chat and text functions and work to better reach specific populations such as the LGBTQ population which may be reluctant to use mainstreams crisis services because of historically being poorly served.

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

As noted above, we are seeking to procure ongoing assistance with the technology and data sophistication required to stay on the cutting edge of behavioral health crisis response. We also anticipate needing technical assistance as we build out the 988 chat and text functions and work to better reach specific populations such as the LGBTQ population which may be reluctant to use mainstreams crisis services because of historically being poorly served.

Footnotes:

Environmental Factors and Plan

16. Recovery - Required

Narrative Question

Recovery supports and services are essential for providing and maintaining comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders.

Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery- guided the approach to person-centered care that is inclusive of shared decision-making, culturally welcoming and sensitive to social determinants of health. The continuum of care for these conditions involves psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder, and services to reduce risk related to them. Because mental and substance use disorders can become chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management recovery and personal success over the lifespan.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see **SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.**

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

a)	Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care?	(●) Yes	( ) No
b)	Required peer accreditation or certification?	(●) Yes	( ) No
c)	Use Block grant funding of recovery support services?	( ) Yes	(●) No
d)	Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?	(●) Yes	( ) No

2. Does the state measure the impact of your consumer and recovery community outreach activity? (●) Yes ( ) No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

Recovery and recovery support services for adults with SMI includes:

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.

Recovery and recovery support services for children with SED includes:

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. CBI services may be provided at the time a child or youth is identified for a service, particularly to meet an urgent or emergent need during their course of treatment.

There are three (3) levels of CBI services available to children and youth.

CBI Level I is delivered using the Multisystemic Therapy (“MST”) treatment model adopted by the Department of Behavioral Health which is 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 has a long-term relationship and who is willing to participate in treatment.

CBI Level II is delivered using the Intensive Home and Community-Based Services (“IHCBS”) model adopted by the Department of Behavioral Health which is an intensive, time-limited mental health service for youth up to age 21 with serious emotional disabilities and their families, provided in the home, school and community where the youth lives, with the goal of stabilizing mental health concerns, and safely maintaining the youth in the least restrictive, most normative environment.

CBI Level III is delivered using the Intensive Home and Community-Based Services (“IHCBS”) model adopted by the Department of Behavioral Health which is an intensive, time-limited mental health service for youth up to age 21 with serious emotional disabilities and their families, provided in the home, school and community where the youth lives, with the goal of stabilizing mental health concerns, and safely maintaining the youth in the least restrictive, most normative environment. This is a short-term service that is offered for up to 90 days.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state. i.e., RCOs, RCCs, peer-run organizations

Recovery Support Services (RSS) covers the provision of non-clinical services for individuals in treatment or in need of supportive services to maintain their recovery. DBH has incorporated recovery support services as a core required service for all certified treatment providers.? Additionally, DBH certifies two stand-alone RSS providers that work with individuals in need of recovery support services outside of the treatment domain.? In the District of Columbia, adults with SMI and youth with SED are eligible for the same non-clinical recovery support as individuals in substance use treatment. Our system of care encourages integrated and coordinated care between substance use and mental health providers. Consumers seeking SUD Recovery must be assessed and admitted to SUD certified treatment or RSS provider.??

At this time, via an 1115 waiver, RSS services are Medicaid billable and can include: 1. Recovery Support Evaluation; 2. Recovery Support Individual; 3. Recovery Support Group; 4. Recovery Support HIV; 5. Recovery Case Management. Many of these supports can also be provided by peers

5. Does the state have any activities that it would like to highlight?

Over the last two years, DBH and DHCF have embarked on a rate study to determine the need for the increase in rates for behavioral health services in the district.? To that end, DBH has also looked at aligning services across mental health and

substance use.? The result DBH is proposing that recovery support (SUD) and community support (MH) are become an overarching service with clearly defined services underneath.?

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

Technical assistance is not needed at this time.

Footnotes:

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in **Olmstead v. L.C., 527 U.S. 581 (1999)**, provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with M/SUD conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with M/SUD needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights **(OCR)** cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

1. Does the state's Olmstead plan include:

Housing services provided	(•) Yes	( ) No
Home and community-based services	(•) Yes	( ) No
Peer support services	( ) Yes	(•) No
Employment services.	(•) Yes	( ) No

2. Does the state have a plan to transition individuals from hospital to community settings? (•) Yes ( ) No

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

The District of Columbia recently created a new Olmstead Plan focused on housing, healthcare, and employment. The Office of Disability Rights (ODR) is the lead agency on implementing the Olmstead Plan. ODR has collaborated with many DC agencies to create a plan the adheres to the mandate of the Olmstead Decision.

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

There are no areas of technical assistance needed at this time.

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Footnotes:

Environmental Factors and Plan

18. Children and Adolescents M/SUD Services –Required for MHBG, Requested for SUPTRS BG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SUPTRS BG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[1]. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[2]. For youth between the ages of 10 and 14 and young adults between the ages of 25 and 34, suicide is the second leading cause of death and for youth and young adults between 15 and 24, the third leading cause of death.[3].

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[4].

Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[5].

According to data from the 2017 Report to Congress[6] on systems of care, services:

1. reach many children and youth typically underserved by the mental health system.
2. improve emotional and behavioral outcomes for children and youth.
3. enhance family outcomes, such as decreased caregiver stress.
4. decrease suicidal ideation and gestures.
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and

employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

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[1]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[2]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

[3]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[4]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[5]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

[6] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery of children and youth with SED? (●) Yes ( ) No

b) The resilience of children and youth with SED? (●) Yes ( ) No

c) The recovery of children and youth with SUD? (●) Yes ( ) No

d) The resilience of children and youth with SUD? (●) Yes ( ) No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:

a) Child welfare? (●) Yes ( ) No

b) Health care? (●) Yes ( ) No

c) Juvenile justice? (●) Yes ( ) No

d) Education? (●) Yes ( ) No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization? (●) Yes ( ) No

b) Costs? (●) Yes ( ) No

c) Outcomes for children and youth services? (●) Yes ( ) No

4. Does the state provide training in evidence-based:

a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? (●) Yes ( ) No

b) Mental health treatment and recovery services for children/adolescents and their families? (●) Yes ( ) No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult M/SUD system? (●) Yes ( ) No

b) for youth in foster care? (●) Yes ( ) No

c) Is the child serving system connected with the FEP and Clinical High Risk for Psychosis (CHRP) systems? (●) Yes ( ) No

d) Does the state have an established FEP program? (●) Yes ( ) No

Does the state have an established CHRP program? (●) Yes ( ) No

e) Is the state providing trauma informed care? (●) Yes ( ) No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

The Adolescent Substance Abuse Treatment Expansion Program (ASTEP) is where the District of Columbia's adolescent substance use treatment providers are categorized. ASTEP has made substance use treatment more accessible by giving adolescents, as well as their families and caregivers, the ability to go directly to any ASTEP treatment provider to be assessed for substance use

treatment. Every adolescent accessing substance use treatment through ASTEP will be screened for indicators of a mental health disorder as well. Adolescents can choose the program that best fits their lives; whether the program they choose is closest to home, offers convenient hours, or provides recovery support services to help them maintain sobriety, in conjunction with the District's 1115 Behavioral Health Transformation Waiver, DBH will integrate the evidence-based practice under the District's State Plan Amendment (SPA). This service will remain under the ASTEP continuum; however, this service will also expand into the ASURS continuum for individuals 18-25, the TAY Population. ?

The Department of Behavioral Health continues to assess and enhance the current array of services to meet the mental health needs of the District's children and youth in foster care. ?In addition to efforts to build capacity, DBH and Child Family Services Administration (CFSA) developed a process for connecting children and families with Core Service Agencies soon after removal occurs. If a child is currently receiving services or recently enrolled with a mental health provider, the provider is notified of removal and invited to participate in a Review, Evaluate, and Direct (RED) Family Team Meeting teaming process which occurs within 72 hours of the removal. During the RED Team Meeting, details of the cases are discussed; providers begin engagement with family members and schedule appointments at a time most convenient for families which improves the timeliness of service initiation. ?CFSA and DBH recognize that having providers engaged earlier in the process when children are entering care, will increase access to care in a timely manner. The DBH staff co-located in CFSA's Office of Well-Being ?closely track this data which shows children are linked to a CSA within same day of request. In FY23, DBH and CFSA have continued to collaborate to better serve the mental health needs of foster children in the District.?

TAY is working with the Adolescent Substance Abuse Treatment Expansion Program (ASTEP) to ensure capacity for TAY youth who are experiencing SUD concerns. TAY providers have youth development leads (YDLs) (young adult peer workers) poise to conduct GAIN SS assessments that help to identify young adults that could benefit from SUD services, supports, and treatments. To expand services to the young adult population, TAY seeks to incorporated Dialectical Behavioral Therapy, or DBT into the array of TAY service offered to address the? effective treatment for drug or alcohol addiction. Using a? dialectical process,? opposing ideas are synthesized to create a new concept.? A comprehensive approach to treating addiction that includes mindfulness, interpersonal effectiveness, distress tolerance and emotion regulation.?

In an effort to decrease recidivism amongst children and youth that engage in juvenile delinquent behaviors, the Department has continued it's partnership with Court Social Services to offer two diversion programs- The Juvenile Behavioral Diversion Program (JBDP) which is a voluntary program that links court-involved juveniles under the age of 18 with appropriate community-based mental health services and supports and Here Opportunities Prepare you for Excellence (HOPE) Court which is a specialty court for court-involved males and females, that are at risk or involved in sexual exploitation.? Both diversion programs, through the court, connect youth to specialized mental health and social support services and have the possibility to? dismiss charges if the program is successfully completed. ?

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.?

The Department of Behavioral Health and the Department of Health Care Finance, DC's state Medicaid agency, began partnering in 2020 to plan for the full integration of behavioral health services in the Managed Care Organizations (MCO) service delivery.?

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

The Department and CFSA continue to collaborate on other programs to address the needs of children and families in in-home and out-of-home care. DBH continues to have one co-located staff at CFSA to assist with linkage, trouble shooting and supports referrals for DBH Evidence-Based Practices services from CFSA social workers, private agency social workers, and collaborative staff.???

The Department also provides training on behavioral health services to the staff at the 10 Success Centers managed by CFSA. ? DBH is partnering with CFSA and other District entities on the "Thriving Families, Safer Children" initiative to transform the child welfare system to ?a child and family well-being model where the District's community- based organizations, advocates, District residents, CFSA and other DC government agencies take a unified approach to well-being in order to prevent involvement in the child welfare system, providing supports and resources to maintain families intact in the community. ??

As a part of the School-Based Behavioral Health expansion, the School Year 2022-2023 landscape of DC Public and DC Public Charter schools was 253. ?

In FY22/FY23, as part of system redesign efforts and transition to managed care, DHCF contracted with PCG to complete comprehensive rate studies including the review of 53 behavioral health services to include child and youth services. In addition, DBH continues work with DHCF to update the State Plan Amendment (SPA) and the District regulations to reflect rates and best practices. ?

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

The Substance Use Disorders (SUD) Prevention team needs technical assistance particularly as it pertains to developing a strategic plan. This need is critical especially with the scope of prevention expanding to include harm reduction, and with the desire to increase outreach to and engagement of adult populations.???

In addition, technical assistance is needed for conducting risk assessments from early childhood through Transition Age Youth.?

Footnotes:

Environmental Factors and Plan

19. Suicide Prevention - Required for MHBG

Narrative Question

Suicide is a major public health concern, it is a leading cause of death overall, with over 47,000 people dying by suicide in 2021 in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following:

1. Have you updated your state's suicide prevention plan in the last 2 years? ○ Yes ◉ No

2. Describe activities intended to reduce incidents of suicide in your state.

On July 15, 2022, the day before the formal introduction and launch of the new 988 telephone number, Mayor Muriel Bowser made the announcement via a press release and several social media platforms that the National Suicide Prevention Lifeline's Crisis Counseling Services would be available 24/7 to anyone experiencing a mental health crisis by dialing the three-digit number 988. This new form of access to services connects consumers to crisis counselors who are available to speak to them about suicide prevention, mental health, or substance use. Even for many years prior to the July, 2022, rollout of 988, the Department of Behavioral Health's Access Helpline (AHL) served and continues to serve as the only National Suicide Prevention Lifeline affiliate in the District of Columbia. AHL continues to uphold its certification through the American Association of Suicidology and AHL is one of 200 nationally recognized crisis centers that are run by government and independent nonprofit organizations. The AHL has been an integral part of national success since its debut. In the past year, there have been 5 million contacts made on a national level, and the average speed of response across all contacts has decreased from 140 seconds to 35 seconds. Additionally, Spanish text and chat services have been offered for the national 988. In the nine months following the launch of 988, the average in-state answer call rate was 92% which met or exceeded the national standard.? Mayor Muriel Bowser doubled the number of crisis counselors to meet the 38% increase in calls.? A glitch in a new communications system set up to improve?efficiencies inadvertently resulted in a back-up of calls and a 90-day drop in our in-state answer rate. We believe this issue has now been resolved, and 88% of calls were answered in-state so far in July.? We expect a quick return to meeting the national standard.???

AHL is a division placed within the Crisis Services division. A primary function of the AHL is to offer supportive counseling, preventative services for suicide, provide resources and referrals to community-based resources, when needed by phone. AHL also has the ability to trigger dispatch of mobile responders from DBH's Community Response Team regardless of the call's origin, whether from 988, a diversion from 911, or a direct call to the longstanding local line, 1-888-7WE-HELP or 1-888-793-4537) if an in-person response is needed.?

The 988 Lifeline also offers specialized services for LGBTQI+ young adults and aids people who use Teletypewriters. Since its debut, the AHL has been meeting with 988 TA in order to maintain a clear plan, identify challenges and resolve issues concerning national coordination, capacity, and communication strategies. The AHL testing phase is now complete, and DBH has obtained funding from Substance Abuse Mental Health Service Administration to continue the implementation of 988 in line with national standards.?

After a year since its successful inauguration, the AHL's 988 Lifeline is now available to receive calls, messages, and chats from consumers who require assistance. DBH has engaged in a wide variety of programs with the goal of lowering the suicide rate in the District of Columbia. The AHL formed an extensive group of internal and external stakeholders to form a coalition of local partnerships to assess readiness, refine an integrated roadmap for DC 988 services to ensure coordination, align ways to measure progress and success to ensure that 988's design reflects the consumer's needs and access to immediate services. The coalition serves as an advisory board and holds meetings on a regular basis. Federal funds in the amount of $840,000 have been allocated to the AHL in order to recruit and retain staff in order to meet the projected increased call volume and develop the chat and text functions that will be needed by all Lifeline affiliates within the next year.? We note AHL has experienced a 38% increase in Lifeline calls based on a comparison of the 3 months (April, May, June) prior to the July, 2022, launch and the same 3-month period in 2023.?

??

In addition, the District of Columbia's school mental health initiative offers two evidence-based programs for suicide prevention in schools across the District. Students in middle school and high school can participate in the Signs of Suicide program, which offers screening as well as prevention workshops that take place in the classroom. The Question, Persuade, and Refer (QPR) program was developed to minimize the number of fatalities caused by suicide by giving preventive training to empower communities. The Department of Behavioral Health made 500 seats available for this training in an effort to lend support for suicide prevention. This free workshop is available to anyone who serves District of Columbia school children QPR is a method

that focuses on how to intervene with a person who may be showing signs of wanting to commit suicide. Let's Talk is another program that is offered to primary school students. This program places more of an emphasis on risk factors that can be antecedents to suicidal ideation, such as being bullied.?

In August, 2022, the Government Performance Lab at the Harvard Kennedy School awarded technical assistance to the District of Columbia's Office of Unified Communications and the Department of Behavioral Health for a full calendar year. While the focus of their assistance has been directed to DBH's 911 Behavioral Health Call Diversion program, DBH is working with its other government partners to create a comprehensive set of alternative response options and look at the 988, the 911 BH Call Diversion Project to include the co-location of DBH call-takers at OUC, the expansion of mobile crisis team, and a new co-response pilot as part of a unified crisis response continuum.???

One final note.? DBH is currently partnering with the District of Columbia Department of Transportation (DDOT), the Office of the City Administrator, and several other partners to pursue the design and construction of a suicide-deterrent barrier at The William Howard Taft Memorial Bridge located in Northwest Washington, DC.? Data from the Office of the Chief Medical Examiner (OCME) and DDOT show that 26 people died by suicide at District bridges between January 2010 and June 2022, including 13 at the Taft Bridge.? Data show that physical barriers are the most effective deterrent and that other measures like patrols, closed circuit TV, or bridge phones that emphasize connecting people to care have demonstrated minimal impact.? DBH did however work with DDOT to install signs at each of the four pedestrian access points to the bridge featuring language pointing individuals needing care for themselves or a loved one can reach out by calling or texting 988 twenty-four hours a day, seven days a week and using approved messaging--"There is hope."? We engaged the 988 Coalition to solicit input regarding the design and location of signs at the bridge.? DBH remains actively involved as DDOT begins to seek approval for design proposals through several local and federal authorities, including the US Commission of Fine Arts, the National Park Service, USDOT, and several historical preservation entities including the District's State Office of Historic Preservation (SHPO).???

The AHL employs a public health strategy, resulting in participation in a Suicide Prevention Resource Center's Community of Practice and the formation of a DC Community Coalition for a second year. AHL is excited to participate in the 2023 Community of Practice (CoP) webinar series for the second year to assist state and territorial suicide prevention coordinators and a primary community partner in exploring and identifying strategies to strengthen statewide suicide prevention partnerships that can support a state- or territory-wide coalition. The CoP is affiliated with the national SPRC organization. SPRC's Community of Practice (CoP) on State and Territorial-wide Suicide Prevention Partnerships and Coalition Capacity who investigate coalition governance structures, membership development, rosters, and retention strategies, as well as strategic planning. The program is intended for a CoP team—a state or territorial suicide prevention coordinator and one primary community partner—with the capacity to scale partnership efforts or support a state-wide suicide prevention coalition. Through six interactive webinars, CoP teams investigate and identify strategies to strengthen the suicide prevention partnership infrastructure. Through specific activities between meetings, AHL's CoP team has sought to evaluate the capacity of existing coalitions or partnerships and identify the activities required to strengthen coordinated partnership efforts. The program is designed to examine current coalition and partnership efforts in light of the changes and challenges that have impacted coalition infrastructure, missions, and capacity, with a particular focus on the COVID-19 public health response and data equity the first year in 2022.??

Participants in the AHL's CoP connect with other national CoP teams to discuss strategies that can be used to develop and maintain coalition and partnership efforts, strengthen member buy-in, and advance comprehensive suicide prevention efforts. This year's activities involve the following:?

• Engaging with a primary community partner to co-facilitate all CoP activities;??

• Hosting a monthly meeting, CoP task?and webinar with DC's external collaborators. AHL CoP has ten members. The Washington DC VA Medical Center's Suicide Prevention Community Engagement Partnership Coordinator (SP-CEPC) is our co-partner. In November 2022, our COP launched a subgroup within their community coalition to address Veteran needs and requirements.??

?
The 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 Suicide Prevention Act was enacted in 2007 in response to the death of Joshua Omvig, a 21-year-old Army veteran who perished from a self-inflicted gunshot wound. The veteran with PTSD did not pursue treatment because he believed that doing so would harm his military career. The Suicide Prevention Act of 2007 shaped comprehensive suicide prevention programs throughout the VA healthcare system in response to this untimely mortality. 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.?

3. Have you incorporated any strategies supportive of Zero Suicide? ○ Yes ◉ No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? ○ Yes ◉ No

If yes, please describe how barriers are eliminated.

5. Have you begun any prioritized or statewide initiatives since the FFY 2022 - 2023 plan was submitted? ○ Yes ◉ No

If so, please describe the population of focus?

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

None needed at this time

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

Footnotes:

Environmental Factors and Plan

20. Support of State Partners - Required for MHBG

Narrative Question

The success of a state's MHBG and SUPTRS BG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The State Medicaid Authority agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations.
- The state's agency on aging which provides chronic disease self-management and social services critical for supporting recovery of older adults.
- The state's intellectual and developmental disabilities agency to ensure critical coordination for individuals with ID/DD and M/SUD conditions.
- Strong partnerships between SMHAs and SSAs and their counterparts in physical health, public health, and Medicaid, Medicare, state and area agencies on aging and educational authorities are essential for successful coordinated care initiatives. While the State Medicaid Authority (SMA) is often the lead on a variety of care coordination initiatives, SMHAs and SSAs are essential partners in designing, implementing, monitoring, and evaluating these efforts. SMHAs and SSAs are in the best position to offer state partners information regarding the most effective care coordination models, connect current providers that have effective models, and assist with training or retraining staff to provide care coordination across prevention, treatment, and recovery activities.
- SMHAs and SSAs can also assist the state partner agencies in messaging the importance of the various coordinated care initiatives and the system changes that may be needed for success with their integration efforts. The collaborations will be critical among M/SUD entities and comprehensive primary care provider organizations, such as maternal and child health clinics, community health centers, Ryan White HIV/AIDS CARE Act providers, and rural health organizations. SMHAs and SSAs can assist SMAs with identifying principles, safeguards, and enhancements that will ensure that this integration supports key recovery principles and activities such as person-centered planning and self-direction. Specialty, emergency and rehabilitative care services, and systems addressing chronic health conditions such as diabetes or heart disease, long-term or post-acute care, and hospital emergency department care will see numerous M/SUD issues among the persons served. SMHAs and SSAs should be collaborating to educate, consult, and serve patients, practitioners, and families seen in these systems. The full integration of community prevention activities is equally important. Other public health issues are impacted by M/SUD issues and vice versa. States should assure that the M/SUD system is actively engaged in these public health efforts.
- SAMHSA seeks to enhance the abilities of SMHAs and SSAs to be full partners in implementing and enforcing MHPAEA and delivery of health system improvement in their states. In many respects, successful implementation is dependent on leadership and collaboration among multiple stakeholders. The relationships among the SMHAs, SSAs, and the state Medicaid directors, state housing authorities, insurance commissioners, prevention agencies, child-serving agencies, education authorities, justice authorities, public health authorities, and HIT authorities are integral to the effective and efficient delivery of services. These collaborations will be particularly important in the areas of Medicaid, data and information management and technology, professional licensing and credentialing, consumer protection, and workforce development.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? (●) Yes ( ) No

2. Has your state identified the need to develop new partnerships that you did not have in place? (●) Yes ( ) No

If yes, with whom?

The Department of Behavioral Health (DBH) has developed new partners as well as participated in new projects with existing partners. The new initiatives include:

Healthy Futures Treatment Pilot - During FY 22 and FY23,?Healthy Futures, the DBH early childhood mental health consultation program, began a treatment pilot for young children and families in 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. DBH collaborated with the Office of the State Superintendent of Education (OSSE) to identify the eight centers to begin the treatment pilot. Center directors now are identifying children who need support and working with the Healthy Futures clinicians to screen and connect with parents.??

Early Childhood Innovative Network (ECIN) is part of the Children's National Health System to develop new strategies to support

and improve services in child development centers and schools. During FY23, the Healthy Futures program partnered with ECIN to support their teacher wellness research program CPR2 (Compassion, Practice, Relationships and Restoration). Healthy Futures clinicians partnered with ECIN to deliver CPR2 to teachers in a select number of child development centers.?

The Healthy Futures program partners with the Office of the State Superintendent of Education (OSSE) to support their Quality Improvement Network (QIN). The QIN focuses on building high quality, comprehensive early childhood development and family engagement services for infants and toddlers. The Healthy Futures early childhood clinical specialists work with QIN coaches in 14 early childhood development centers and 17 home providers.?

The Healthy Futures program partners with OSSE to support the Pre-K Enhancement and Expansion Amendment (PKEEP) program, PKEEP supports Community-Based Organizations (CBOs) to enhance high- quality pre-K education services in existing pre-K programs. Healthy Futures supports PKEEP in the 27 child development centers that are currently participating in the program.?

Children's National Hospital established the DC Autism Collaborative (DC-AC), a multidisciplinary, public-private coalition of professionals and community leaders to increase early and equitable access to high-quality Autism Spectrum Disorder (ASD) diagnosis, treatment, and coordinated care. The Healthy Futures program has partnered with Children's National Hospital in creating and delivering community workshops and disseminating educational materials to the early childhood community.?

Attachment Biobehavioral Catchup (ABC) - In FY22, as part of the Healthy Futures Pilot Initiative funded by American 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.? The training was facilitated by the University of Delaware, the national training entity. 9 individuals from the Department of Behavioral Health (DBH), Core Service Agencies, and Medstar Georgetown were identified to complete certification to become ABC Coaches.?

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. Additionally, the District has a Coordinating Council on School Behavioral Health which is co-chaired by the DBH Director and a Non-Government leader. The members of the Coordinating Council on School Behavioral Health are from various partner organizations and agencies which also include Child and Family Services Administration, Children's Law Center, Children's National Health System, and Department of Health. Under the guidance of the Coordinating Council on School Behavioral Health, implementation continues co-creating a Comprehensive School-Based Behavioral Health System. This Comprehensive School Based Behavioral Health System is a strategic collaboration between school personnel, community behavioral health providers, students and families to create a positive school culture that provides timely access to high-quality, reliable supports for children, youth, and their families. Teams offer a full array of trauma-informed, culturally-responsive, evidence-based tiered interventions to promote wellness, identify challenges early, and offer treatment services when necessary so that all children and youth succeed and thrive.?

The Department of Behavioral Health and the Department of Health Care Finance, DC's state Medicaid agency, began partnering in 2020 to plan for the full integration of behavioral health services in the Managed Care Organizations (MCO) service delivery.?

Additionally, the Office of the State Superintendent of Education (OSSE) and DBH work together to ensure that transition-age youth (TAY) that are disconnected are linked with and have access to behavioral health services. DBH and the Department of Human Services (DHS) continue to work to expand behavioral health linkages and service opportunities in DHS housing and drop-in center TAY-focused programs.??

Relatedly, TAY Services has identified a needed partnership between the Department of Rehabilitative Youth Services (DYRS) and DBH. Like the work done with the Child and Family Services Administration (CFSA), TAY has identified a need to better support young adults with behavioral health concerns that are connected to DYRS. Lastly, TAY services identified a need for a defined partnership with the Department of Disability Services (DDS). We have recognized that there are several young adults with disabilities who have behavioral health concerns. DBH is committed to providing tailored support.??

To address early psychosis experienced by young adults, DBH is examining a formal partnership with the Early Psychosis Intervention Network (EPINET). As we strengthen our prevention and treatment of psychosis, our aim is to improve early identification, clinical assessment, intervention effectiveness, and recovery outcomes for young adults experiencing their first symptoms of psychosis. it is hoped that this relationship will identify new strategies that support early psychosis care, improve the quality of services, and benchmark needs and gaps needed to support young adults.??

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

The Healthy Futures leadership team participates in ongoing community of practice and coordination meetings with OSSE and Children's National Hospital. These meetings bring together participants from each program to maintain the effectiveness and efficiency of the programs and partnerships. As the lead in the Healthy Futures treatment pilot a monthly community practice is

held with the directors of the participating eight child development centers and the Healthy Futures clinicians to delineate the referral process and discuss ongoing treatment goals.?

Each school leader identifies a school-hired staff person to serve in the role of the School Behavioral Health Coordinator (SBHC). The SBHC provides leadership and coordination of each school's behavioral health team. The Department of Behavioral Health's (DBH) School Behavioral Health Program is comprised of DBH-hired and Community Based Organization-hired (CBO-hired) providers who implement multi-tiered prevention, early intervention and treatment services within DC public and public charter schools. The DBH-hired and CBO-hired providers are integrated into the school's behavioral health team and work to implement a Comprehensive School Behavioral Health Model. The school's behavioral health team annually completes a school-centric assessment that informs the annual development of a School Strengthening Work Plan that serves as the operational mechanism for implementing integration and coordination of the school behavioral health services provided by each behavioral health provider in the school across the levels of prevention, early intervention, and treatment services. The School Strengthening Work Plan is to be revisited at mid-year and revised throughout the school year, as appropriate.?

DBH TAY is working to place more TAY-focused teams (transition facilitators (TF) and youth development leads (YDL)) in educational and other spaces utilized by young adults. Despite the support provided by DBH's Children's Services Division to schools, TAY has recognized a greater need to create programs that straddle the adult and children services from a young adult perspective. We have been working to ensure that programs are designed to match the experiences and needs of young adults.??

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

Technical assistance is not needed at this time.

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Footnotes:

Environmental Factors and Plan

21. State Planning/Advisory Council and Input on the Mental Health/Substance use disorder Block Grant Application- Required for MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SUPTRS BG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created **Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.**[1]

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with M/SUD problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

[1] **https://www.samhsa.gov/grants/block-grants/resources [samhsa.gov]**

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

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

The Executive Committee met with the Department's Policy and Grants teams on 8/18/23 to discuss the District's behavioral health needs and to review the components in the draft of the block grant. The Committee agreed that the draft of the grant application addressed community needs that they had prioritized.

The Executive Committee also met on 8/26/23 at their regularly scheduled meeting. The Chair, who had not been present during the session on 8/18/23, agreed that the block grant's components aligned with the Council's concerns, as he had expressed in the Chair's letter of support. The Committee also clarified that they were not requesting any technical assistance at this time.

2. What mechanism does the state use to plan and implement community mental health treatment, substance misuse prevention, SUD treatment, and recovery support services?

The District of Columbia Department of Behavioral Health (DBH) serves as the State Mental Health Authority (SMHA) and the District of Columbia Single State Agency (SSA) for substance use disorders. As the SMHA, DBH certifies community based providers to provide mental health services and supports to children, youth, and adults across the District of Columbia. Services include prevention, early intervention, and treatment services to ensure comprehensive services across the entire continuum.

As the SSA DBH: 1) operates four community prevention centers each serving two of the 8 District wards; 2) provides services and contracts with community providers for substance use disorder (SUD) services and supports; 3) assesses and refers adults seeking treatment for SUD to appropriate services; 4) conducts mobile van visits communities throughout the District to conduct assessment, referral, and HEP-C and HIV testing; 5) hosts annual prevention symposium; 6) sponsors adults, young adults and youth substance abuse campaigns (marijuana use, synthetic drug use, opioid use); and 7) provides recovery coaching and training.

Launched in 2018, LIVE. LONG. DC., the District's Strategic Plan to Reduce Opioid Use, Misuse, and Related Deaths, is the foundation for a city-wide effort to ensure equitable and timely access to high-quality substance use disorder treatment and RSS through a network of treatment services to meet demand consistent with the criteria of the American Society of Addiction Medicine; educate District residents and key stakeholders on the risk of opioid use disorder (OUD) and effective prevention and treatment; engage health professionals and organizations in the prevention and early intervention of substance use disorder among District residents; support the awareness and availability of, and access to, harm reduction services in the District of Columbia consistent with evolving best and promising practices; develop and implement a shared vision between the District's justice and public health agencies to address the needs of individuals who come in contact with the criminal justice system; and prepare for program sustainability through evaluation, planning, and performance

monitoring and training.

LIVE.LONG.DC. 2.0, which was finalized in March 2021, 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 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

3. Has the Council successfully integrated substance misuse prevention and SUD treatment and recovery or co-occurring disorder issues, concerns, and activities into its work? (●) Yes ( ) No

4. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)? (●) Yes ( ) No

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

The purpose of the Behavioral Health Planning Council is to advise DBH as follows:?

To ensure that individuals in need of behavioral health services have access to said services;?

To ensure that consumer/client and family directed services and supports for the prevention and treatment of behavioral health disorders maintain a focus on recovery and resilience;??

To advocate for District residents with serious emotional disturbances,?mental health issues and substance use disorders;??

To support the integration of mental health and substance use disorder prevention, treatment and recovery services and supports into overall health services;?

To reduce disparities in the prevention and treatment of mental health and substance use disorders;?

To strengthen the coordination and collaboration with relevant state and community organizations to develop systems of care; and??

To provide input for the development of the SAMHSA Mental Health and Substance Use Block Grants.??

The BHPC has achieved its objectives by sharing information, inviting ???? relevant agency presentations and participation and participated in Departmental endeavors when invited.??

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

Technical assistance is not needed at this time.

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Footnotes:

DISTRICT OF COLUMBIA
BEHAVIORAL HEALTH ASSOCIATION

August 16, 2023

SAMHSA Block Grant Review Panel
Transmitted through the District of Columbia Department of Behavioral Health

RE: FFY 2024-2025 Combined Block Grant Application

Dear Members of the Review Panel,

This letter concerns the work of the District of Columbia Department of Behavioral Health's Behavioral Health Planning Council regarding the Federal Fiscal Year 2024-2025 Combined Block Grant Application. The District's Behavioral Health Planning Council is charged, among other tasks, to serve as the District's required State Mental Health Planning/Advisory Council, and consistent with SAMHSA's encouragement to include consideration of Substance Use Disorders, also includes representation to address those needs.

The Department of Behavioral Health has cooperated to ensure that this application and implementation report included feedback from the Behavioral Health Planning Council, and the Behavioral Health Planning Council has, in turn, provided opportunities for its officers, committee chairs, members, and the general public to share insights into "the allocation and adequacy of mental health services within" the District. The Behavioral Health Planning Council has shared feedback with the Department of Behavioral Health consistent with SAMHSA's five key priority areas.

Preventing Overdose

The Behavioral Health Planning Council supports efforts to strengthen the District's overall spectrum of services addressing substance use disorders, including prevention, early intervention, harm reduction, treatment, and recovery supports. A robust system of services is key to preventing overdose in the District, and to reducing fatalities when overdoses occur. Discussions within the Behavioral Health Planning Council highlight several areas that the Department of Behavioral Health, along with other agency partners, are encouraged to address.

- Continue to direct resources to community education strategies. This includes targeted outreach in more vulnerable geographic areas and other hot spots. Targeted marketing should be considered for young people and their families, for adults, and for seniors. General information also should be offered in community settings like stores, corner shops, and bars(!).
- Street outreach approaches are needed for people who use substances in public places. There is not enough engagement. Some people who regularly come in contact with street substance use also appear unaware or unskilled addressing different stages of change.
- Build additional capacity for youth services. Youth who need sustained treatment currently are underserved, with only two active youth-specialized outpatient treatment organizations.
- Develop more comprehensive, and public-facing, surveillance and reporting. The District needs a data dashboard on non-fatality overdoses and should study differences between fatal and non-fatal overdoses to help improve adoption of approaches and services that reduce fatalities.
- Offer additional resources to move people into long-term housing. People need different recovery housing options, including housing-first models and sober living models. Regardless of housing status before entering treatment, people need to be able to discharge from residential treatment to long-term housing options that meet their needs and position them for sustained recovery.

Enhancing Access to Suicide Prevention and Crisis Care

The Behavioral Health Planning Council supports the District's efforts to build a more robust set of suicide prevention and crisis response services.

- The Behavioral Health Planning Council expresses special gratitude to the Department of Behavioral Health for an invitation to Behavioral Health Planning Council officers to help provide rapid-response advice about suicide prevention after a high-profile bridge jump resulted in a death by suicide. The District should continue efforts to construct suicide nets and other physical barriers at bridges and other areas where physical barriers can serve as a temporary deterrent. The District should also continue to post prominent reminders about "There is Hope" and 988 resources.
- Work across 911 dispatch, 988 call response, fire and emergency services, police, and the Department of Behavioral Health are generally welcome. More work needs to be done to find ways to transport people being involuntarily hospitalized without handcuffs. Tensions still exist when police respond unexpectedly to calls for mental health or substance use crisis response.
- Crisis care responses must be paired with timely access to care. There are not enough quickly available appointments for services. Multiple providers are not accepting new patients. There need to be more services for people not currently in the system, including people who don't have adequate coverage for treatment, both from uninsurance but also from underinsurance (especially those who have commercial coverage or Medicare plans that do not offer robust outpatient service coverage for people with higher levels of need). Medicaid disenrollments are a related significant current concern. Combined, these are substantial challenges for prevention and for follow up after crisis response.
- Call response times for 988 may be disrupting other call center response times, including crisis calls from people currently present in the District who have phone numbers with area codes other than 202 and calls from people who use the local crisis access number rather than calling 988. Multiple reports that people are waiting up to an hour without being connected to a live call-taker, if generally accurate, are unacceptable. DBH needs to work to reduce the wait time response for calls, or at least change the message "that someone will be with you shortly," and redirect callers to where they can receive assistance more quickly, or increase staffing to accommodate the volume of calls from all sources, not just calls from people with 202 area codes through 988.

Promoting Resilience and Emotional Health for Children, Youth, and Families

The Behavioral Health Planning Council endorses efforts that consider resilience and emotional health as 'whole child, whole family, whole community' activities.

- Behavioral health needs to be understood within a broader context. More support is needed in families that experience intergenerational behavioral health challenges, and support needs to be differentiated to account for where children are on the developmental spectrum. Parents need more support to talk to their children, including support acknowledging the behavioral health needs of their own that parents might have wanted not to acknowledge, to downplay, or to ignore. We also need to acknowledge and address undiagnosed but widespread toxic stress and community trauma. Parents also need more support with child care, while addressing their own needs or the needs of other family members.
- Place-based care is important, especially school behavioral health services. School behavioral health services need to address both emotional disturbance and substance misuse among students. As noted above, a lack of youth outpatient SUD treatment capacity is a major concern, and school behavioral health services need more capability and capacity to address youth SUD. Parents and students need to be aware of school behavioral health services and how to access those services and participate.

- Youth voices matter. Youth need to be part of service planning, across the services for youth prevention, early intervention, harm reduction, treatment, and recovery. Youth also need targeted outreach and engagement activities.

Integrating Behavioral and Physical Health Care

The Behavioral Health Planning Council encourages continuing efforts to support integration of behavioral and physical health care. This includes integration across systems, within organizations, and in development of plans of care and engagement in services for individual service recipients.

- For individuals, assessments and evaluations need to identify co-occurring conditions. Appropriate primary care providers and specialists need to be identified, and referrals need to be followed through to successful connection.
- Within organizations and at the systems level, there need to be better coordinated plans and fewer barriers across organizations. Health insurance plan staff, behavioral health and physical health providers, and social service providers all need to coordinate through consultations and information sharing. Organizations need to make better use of electronic tools, including health information exchange, to avoid duplication of evaluations and laboratory testing. Otherwise, duplication puts time, emotional, and financial burdens on people receiving services.
- Special attention is needed at points of transition across age groups. As people 'age out' of services, they can become disengaged, even though these are often times that skilled interventions are particularly helpful. Transitions from early childhood to pre-school, pre-school to school age, young adulthood to adulthood, and adult to senior all need attention and careful assessment of what services may be needed and how they can be provided, possibly by an entirely new set of providers, possibly paid for in different ways. Special supports may also be needed for those who appear unaware of their own behavioral health needs, as well as for those who find themselves living alone, perhaps for the first time or perhaps unexpectedly.
- Third-party services, like mediation, can be constructive when people seeking services feel talked down to or ignored, or when disputes arise about authorization or payment for services. Technological literacy and computing and high-speed internet access among people seeking services also needs to be taken into consideration, ensuring that people have multiple means to enroll, access, and participate in services, along with paid helpers to support navigation of unfamiliar systems or tools.

Strengthening the Behavioral Health Workforce

The Behavioral Health Planning Council encourages efforts to address extreme workforce challenges.

- All levels of workforce skill need to be deployed in ways that best use those skills. Licensed staff need to be focused on providing services at their highest level of licensure, and the Department of Behavioral Health, along with other agencies, needs to work to remove administrative burdens or mandatory staffing requirements for licensed professionals when people with lower levels of licensure or without any licensure could safely complete the same tasks. Independently licensed professionals, in particular, need to be available so the vast majority of their time is spent delivering clinical services for which their licenses make them uniquely qualified.
- Staff members across settings, levels of care, and functions need to be more skilled at identifying co-occurring disorders and connecting people to all of the services needed across their behavioral and physical health needs and their social needs. Staff members also need to be more skilled at screening, observing, and responding appropriately to behaviors enacting possible underlying conditions, including

evidence of self-harm, self-isolation, or hoarding behaviors, among other signals that may point to additional underlying concerns.

- Peers remain a critical, and critically underdeveloped, part of the behavioral health workforce. Additional baseline training and additional time in internships or practicum experiences are needed, and the Department of Behavioral Health should ensure that all minimum requirements are met for peers who complete the Department's certification training program to meet national peer certification standards. Providers and peers also need to have a better shared understanding of peer services, including methods that peers use in multiple settings as well as distinct roles that different types of peers might play in different settings. For example, peers across settings may take actions intended to build alliance, help people receiving services to understand choices and consequences, or share helpful experiences from their own journeys, while peers who work in hospitals, in SUD residential treatment, in mobile crisis teams, or on ACT teams may have very different roles, responsibilities, and expectations for their own performance and for the type and manner of support they may receive from supervisors.

The Behavioral Health Planning Council is grateful to SAMHSA for encouraging the planning council feedback to be taken into consideration during the block grant planning and review process. We are also grateful to the District's Department of Behavioral Health for supporting regular meetings of the Behavioral Health Planning Council and its committees. We continue to encourage the Department of Behavioral Health to make the best use of all available resources to address needs and concerns raised through the work of the Behavioral Health Planning Council, with thanks to the Department of Behavioral Health for modifications made to this application in response to our feedback as well as acknowledgement that this feedback might also inform use of other resources, including the State Opioid Response grant, District opioid settlement funds, Medicaid payments, or such other funds as the District has available, including appropriated funds from District taxpayers.

Please don't hesitate to contact me with any questions, comments, or concerns by phone at 202-929-3757 or by email at Mark.LeVota@DCBehavioralHealth.org.

Sincerely,

Mark LeVota
Executive Director, District of Columbia Behavioral Health Assocation
Chair, District of Columbia Department of Behavioral Health Behavioral Health Planning Council

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF BEHAVIORAL HEALTH

Department of Behavioral Health Behavioral Health Planning Council (BHPC)
In-Person/Virtual Meeting
June 30, 2023, 10:00am-12:00pm

MINUTES

Meeting Called to Order at 10:09am

BHPC Members: Alvin Hinkle, Charles Gervin**,** Elizabeth Maldonado, Eric Scharf, Esther Ford, Gail Advent, Hilary Kascer, Jacyln Verner, Jean Harris, Jennifer Moore, Luis Diaz, Mark LeVota, Masi Sithole, Nadine Parker, Nicole Denny, Nicole Gilbert, Roz Parker

DBH: Barbara Bazron, Camil Douthit, Crystal Williams, Denise McKain, Jean Moise, Laquita Howard, Marina Soto, Melody Calkins, Mia Olsen, Philippa Stuart, Randy Raybon, Renee Evans-Jackman, Richard Bebout, Sharon Hunt, Toussaint Tingling Clemmons, Trina Logan

DC Government: Jenifer Joyce (DHCF)

Public Attendees: Lauren Swank, Elyssa Clauson, Nicholas Weil, Rachael Shpak

Department of Behavioral Health Updates – (Barabara Bazron, DBH Director)

- Announced new Chief Clinical Officer, Jonathan Shepherd, MD, to start 8/14; Dr. Shepard is board certified in Child and Adolescent Psychiatry and Adult Psychiatry.
- Acknowledged the importance and history of the Juneteenth holiday.
- The Medicaid MCO carve-in date has been moved from 10/1/23 to 4/1/24. Delay due to protests leading to delay in the ratification of the MCO contracts by six months.
- Provided a snapshot of the FY 24 DBH budget that reflects at 2.2% increase from FY 23. Details in slide deck.
- Informed BHPC of the Opioid Litigations Proceeds Act of 2022 from which the District will receive $49 million over 18 years. A 21-member Commission will recommend to the Mayor how the funds should be spent. Dr. Bazron and Mr. Lavota will be on the Commission. The Mayor will appoint members who are in recovery or family of those in recovery to the Commission. Application link is in the slide-deck.
- Reported on the June 28th Public Roundtable on the District's Opioid/Fentanyl Crisis. Highlighted the need for enhanced role of peers and the increased need for long-term housing for those in recovery.

- Esther Ford asked for clarification on Peer Support Education. Dr. Bazron noted DBH will be adopting a national curriculum. Trina Logan noted ongoing peer training, but to adopt the national standards we will need to increase the number of required supervised hour to 500.
- Esther Ford asked about additional funds for BH outreach to Wards 1,5, and 7. Dr. Bazron clarified that this was Council's addition, but that DBH does outreach to all Wards.
- Dr. Bazron clarified that the Sobering Center will be located at 35K St. NE and that she will announce to the BHPC when it is open.

Dr. Bazron provided time for questions and input from the BHPC:

- Jean Harris noted need for screening for co-occurring disorders. Dr. Bazron confirmed that DBH does stress this.
- Hilary Kascer noted need for addressing Hoarding Disorder.
- Charles Gervin noted a need for more outreach and education, bringing in more partners.
- Gail Advent noted a need for more education about our services, and on educating parents about drug use.
- Elizabeth Maldonado noted need for assistance with Medicaid renewal now that Covid is over. Jennifer Joyce of DHCF dropped in a link for resources in the chat. Attached in packet.
- Masi Sithole asked how DC and the US are doing in relation to Africa, China, and other countries around the world regarding handling the Opioid crisis. Dr. Bazron noted she has recently been to Africa as a subject matter expert.

Systems Needs Review and BHPC Observations – (Mark LeVota, BHPC Chair)

- Mark LeVota framed discussion into three categories: service needs for MH, SUD, and Co-occurring disorders; needs across the age spectrum; and needs across the spectrum of services from prevention, early intervention, and harm reduction onward. Requested this time for BHCP to provide insights for SAMSHA Combined Block Grant and to Dr. Bazron.

  - Elizabeth Maldonado - Coordination of care, being referred out if a service like community support is needed. Coordinating with NAMI, etc.
  - Charles Gervin - Getting good care currently requires "a lot of leg-work." Need better coordination to ensure a "cohesive network."
  - Esther Ford - Providers are full. Need more psychiatrist, especially since COVID.
  - Jean Harris- Need to better engage people not in the system; need to ensure appropriate assessments/next steps for other systems.
  - Elizabeth Maldonado - Blood work is not authorized as often as necessary (some need monthly blood tests).
  - Charles Gervin – We're moving toward an greater sense of what behavioral health means; "it's about behavioral" (not MH or SUD solely), requires a broader community; "the general health of the community"; a greater network to distribute information on what is

healthy behavior for the community; a greater conversation with all of the providers and a recognition that they are one community.

- Mark LeVota - What about services across the age continuum?
  - Masi Sithole - We need greater peer participation.
  - Jean Harris - Transitions from one age group to another are challenging.
  - Nicole Gilbert (CFSA) - Challenges exist around engaging youth and keeping them connected. We need more engagement specialists/dedicated staff. Expand SUD interventions in the schools.
  - Gail Advent - Two areas get most attention (gap infant/early childhood and seniors). Need better transitions. Need a full spectrum of life perspective.
  - Elizabeth Maldonado - Need more resources for day care for seniors.
  - Esther Ford - Many people in the system for years don't know they have a MH diagnosis. Seniors are different, has never seen a pamphlet for older adults regarding mental health.
  - Hilary Kascer - Need Hoarding Disorder resources.
- Mark LeVota - Will defer conversation about the spectrum of care due to time. Requested members submit ideas in chat.

Proposed Bylaws Amendments (Mark LeVota, Chair)]

- Mark Levota - Move to consider proposed bylaws amendments as a block.
  - Seconded by Esther Ford
- Mark LeVota- Proposed discussion of amendments?
- Seconded by Esther Ford
  - Masi Sithole– Asked about possible additions. Chair noted need to seat people for the start of Fiscal Year on October 1st. Then we could discuss further changes.
  - Hilary Kascer - Noted she added editorial changes in the chat. Chair considers this a technical change that would not need a separate vote.
  - Masi Sithole - Requested addition of a table of contents. Chair noted a revised copy of the bylaws will be circulated.
  - Jean Harris – Wants clearer definition of "community members with lived experience." If a member has lived experience but be associated with DBH; is that still counted? Chair responded that the required 51% cannot be government employees. Suggested we determine if the bylaws are being appropriately followed.
  - Charles Gervin - Are we all working with the same definition of 'lived experience'? Chair responded that bylaw 3.1.a distinguishes this, but we could review later.
  - Masi Sithole - Does the 51% apply to the officers. Chair responded that this is not currently in the bylaws, but we could review in the future.

- Mark LeVota – Noted quorum is present. Requested vote on accepting bylaws amendments. No objections were noted. Amendments were accepted.

Public Comments (Mark LeVota, Chair)

- Nicholas Weil noted dial-in instructions on the website didn't work correctly. Chair noted that the Executive Committee will discuss meeting format.
- Renee Evans-Jackman (Director, DBH Grants Management) granted time for presentation.
    - Combined Block Grant Application has recently been released.
    - Will require a letter signed by the BHPC Chair.
    - Draft to BHPC to review in August.
    - Slide 3 has areas of focus to review for Application.

Standing Committee Reports

- Mark LeVota noted there were no reports for this meeting.

Meeting Adjourned at 11:57am.

Environmental Factors and Plan

Advisory Council Members

For the Mental Health Block Grant, **there are specific agency representation requirements** for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Health (MH) Agency.
State Medicaid Agency

Start Year: 2024 End Year: 2025

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Gail Avent	Parents of children with SED			
Tia Brumstead	State Employees			
Ramon Carmona	State Employees			
Ann Chauvin	Providers			
Nicole Denny	Youth/adolescent representative (or member from an organization serving young people)			
Luis Diaz	State Employees			
Theresa Early	State Employees			
Esther Ford	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Charles Gervin	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Nicole Gilbert	State Employees			
Tonia Gore	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Jean Harris	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Alvin Hinkle	State Employees			
Hilary Kacser	Others (Advocates who are not State employees or providers)			
Mark LeVota	Others (Advocates who are not State employees or providers)			

Elizabeth Maldonado	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Jennifer Moore	Others (Advocates who are not State employees or providers)			
Ifeoma Muoka	State Employees			
Drema Ogletree	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Rosalind Parker	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Nadine Parker	Providers			
Jo Patterson	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Eric Scharf	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Debby Shore	Providers			
Rachel Shpak	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Jaclyn Verner	Others (Advocates who are not State employees or providers)			
Harry Willis	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			

*Council members should be listed only once by type of membership and Agency/organization represented.

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Footnotes:

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2024 End Year: 2025

Type of Membership	Number	Percentage of Total Membership
Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	7	
Family Members of Individuals in Recovery (to include family members of adults with SMI)	4	
Parents of children with SED	1	
Vacancies (individual & family members)	2	
Others (Advocates who are not State employees or providers)	4	
Total Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services), Family Members and Others	**18**	**62.07%**
State Employees	7	
Providers	3	
Vacancies	0	
Total State Employees & Providers	**10**	**34.48%**
Individuals/Family Members from Diverse Racial and Ethnic Populations	9	
Individuals/Family Members from LGBTQI+ Populations	1	
Persons in recovery from or providing treatment for or advocating for SUD services	0	
Representatives from Federally Recognized Tribes	0	
Youth/adolescent representative (or member from an organization serving young people)	1	
Total Membership (Should count all members of the council)	**29**	

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Footnotes:

Environmental Factors and Plan

22. Public Comment on the State Plan - Required

Narrative Question

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

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a) Public meetings or hearings? ○ Yes ◉ No

b) Posting of the plan on the web for public comment? ◉ Yes ○ No

If yes, provide URL:

https://dbh.dc.gov/page/behavioral-health-services-block-grants

If yes for the previous plan year, was the final version posted for the previous year? Please provide that URL:

https://dbh.dc.gov/page/behavioral-health-services-block-grants

c) Other (e.g. public service announcements, print media) ○ Yes ○ No

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

Not requesting any technical assistance at this time.

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Environmental Factors and Plan

23. Syringe Services Program (SSP) - Required if planning for approved use of SUBG Funding for SSP in FY 24

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2024

Narrative Question:

The Substance Abuse Prevention and Treatment Block Grant (SABG) restriction[1,2] on the use of federal funds for programs distributing sterile needles or syringes (referred to as syringe services programs (SSP)) was modified by the **Consolidated Appropriations Act**, 2018 (P.L. 115-141) signed by President Trump on March 23, 2018[3].

Section 520. *Notwithstanding any other provisions of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: Provided, that such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law.*

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SABG to fund elements of an SSP other than to purchase sterile needles or syringes. States interested in directing SABG funds to SSPs must provide the information requested below and receive approval from the State Project Officer. Please note that the term used in the SABG statute and regulation, *intravenous drug user* (IVDU) is being replaced for the purposes of this discussion by the term now used by the federal government, *persons who inject drugs* (PWID).

States may consider making SABG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SABG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to PWID, SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers[4]. SAMHSA funds cannot be supplanted, in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

In the first half of calendar year 2016, the federal government released three guidance documents regarding SSPs[5]: These documents can be found on the Hiv.gov website: **https://www.hiv.gov/federal-response/policies-issues/syringe-services-programs**,

1. **Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016** from The US Department of Health and Human Services, Office of HIV/AIDS and Infectious Disease Policy **https://www.samhsa.gov/sites/default/files/grants/ssp-guidance-for-hiv-grants.pdf ,**

2. **Centers for Disease Control and Prevention (CDC)Program Guidance for Implementing Certain Components of Syringe ServicesPrograms,2016** The Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Division of Hepatitis Prevention **http://www.cdc.gov/hiv/pdf/risk/cdc-hiv-syringe-exchange-services.pdf,**

3. **The Substance Abuse and Mental Health Services Administration (SAMHSA)-specific Guidance for States Requesting Use of Substance Abuse Prevention and Treatment Block Grant Funds to Implement SSPs http://www.samhsa.gov/sites/default/files/grants/ssp-guidance-state-block-grants.pdf ,**

Please refer to the guidance documents above and follow the steps below when requesting to direct FY 2021 funds to SSPs.

- **Step 1** - Request a Determination of Need from the CDC
- **Step 2** - Include request in the FFY 2021 Mini-Application to expend FFY 2020 - 2021 funds and support an existing SSP or establish a new SSP
  - Include proposed protocols, timeline for implementation, and overall budget
  - Submit planned expenditures and agency information on Table A listed below
- **Step 3** - Obtain State Project Officer Approval

Future years are subject to authorizing language in appropriations bills.

End Notes

[1] Section 1923 (b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-23(b)) and 45 CFR § 96.126(e) requires entities that receive SABG funds to provide substance use disorder (SUD) treatment services to PWID to also conduct outreach activities to encourage such persons to undergo SUD treatment. Any state or jurisdiction that plans to re-obligate FY 2020-2021 SABG funds previously made available such entities for the purposes of providing substance use disorder treatment services to PWID and outreach to such persons may submit a request via its plan to SAMHSA for the purpose of incorporating elements of a SSP in one or more such entities insofar as the plan request is applicable to the FY 2020-2021 SABG funds ***only*** and is consistent with guidance issued by SAMHSA.

[2] Section 1931(a(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 U.S.C.§ 300x-31(a)(1)(F)) and 45 CFR § 96.135(a)(6) explicitly prohibits the use of SABG funds to provide PWID with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the Federal Register (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

[3] Division H Departments of Labor, Health and Human Services and Education and Related Agencies, Title V General Provisions, Section 520 of the Consolidated Appropriations Act, 2018 (P.L. 115-141)

[4] Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(a)) and 45 CFR § 96.127 requires entities that receives SABG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(b)) and 45 CFR 96.128 requires "designated states" as defined in Section 1924(b)(2) of the PHS Act to set- aside SABG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (42 U.S.C. 300x-28(c)) and 45 CFR 96.132(c) requires states to ensure that substance abuse prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to, health services.

[5]***Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016*** describes an SSP as a comprehensive prevention program for PWID that includes the provision of sterile needles, syringes and other drug preparation equipment and disposal services, and some or all the following services:

- Comprehensive HIV risk reduction counseling related to sexual and injection and/or prescription drug misuse;
- HIV, viral hepatitis, sexually transmitted diseases (STD), and tuberculosis (TB) screening;
- Provision of naloxone (Narcan?) to reverse opiate overdoses;
- Referral and linkage to HIV, viral hepatitis, STD, and TB prevention care and treatment services;
- Referral and linkage to hepatitis A virus and hepatitis B virus vaccinations; and
- Referral to SUD treatment and recovery services, primary medical care and mental health services.

Centers for Disease Control and Prevention (CDC) Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016 includes a **description of the elements of an SSP** that can be supported with federal funds.

- Personnel (e.g., program staff, as well as staff for planning, monitoring, evaluation, and quality assurance);
- Supplies, exclusive of needles/syringes and devices solely used in the preparation of substances for illicit drug injection, e.g., cookers;
- Testing kits for HCV and HIV;
- Syringe disposal services (e.g., contract or other arrangement for disposal of bio- hazardous material);
- Navigation services to ensure linkage to HIV and viral hepatitis prevention, treatment and care services, including antiretroviral therapy for HCV and HIV, pre-exposure prophylaxis, post-exposure prophylaxis, prevention of mother to child transmission and partner services; HAV and

HBV vaccination, substance use disorder treatment, recovery support services and medical and mental health services;

- Provision of naloxone to reverse opioid overdoses
- Educational materials, including information about safer injection practices, overdose prevention and reversing an opioid overdose with naloxone, HIV and viral hepatitis prevention, treatment and care services, and mental health and substance use disorder treatment including medication-assisted treatment and recovery support services;
- Condoms to reduce sexual risk of sexual transmission of HIV, viral hepatitis, and other STDs;
- Communication and outreach activities; and
- Planning and non-research evaluation activities.

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Footnotes:

Washington DC does not use Block Grant funds for Syringe Services Program

Environmental Factors and Plan

Syringe Services Program (SSP) Information – Table A - Required if planning for approved use of SUBG Funding for SSP in FY 24

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2024

Syringe Services Program (SSP) Agency Name	Main Address of SSP	Planned Dollar Amount of SUBG Funds to be Expended for SSP	SUD Treatment Provider (Yes or No)	# of locations (include any mobile location)	Naloxone Provider (Yes or No)
No Data Available					

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Footnotes: