

## I: State Information

### State Information

#### Plan Year

Start Year:

2014

End Year:

2015

#### State DUNS Number

Number

14384031

Expiration Date

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

Agency Name

District of Columbia Department of Behavioral Health

Organizational Unit

Office of Strategic Planning, Policy & Evaluation

Mailing Address

64 New York Avenue, N.E., Third Floor

City

Washington, D.C.

Zip Code

20002

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

First Name

Juanita Y.

Last Name

Reaves

Agency Name

District of Columbia Department of Behavioral Health

Mailing Address

64 New York Avenue, N.E., Second Floor

City

Washington, D.C.

Zip Code

20002

Telephone

202-671-4080

Fax

202-673-7053

Email Address

juanita.reaves@dc.gov

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

From

To

#### IV. Date Submitted

NOTE: this field will be automatically populated when the application is submitted.

Submission Date

Revision Date

#### V. Contact Person Responsible for Application Submission

First Name

Last Name

Telephone

Fax

Email Address

Footnotes:

# I: State Information

## Assurance - Non-Construction Programs

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Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

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Name	<input type="text" value="Stephen T. Baron"/>
Title	<input type="text" value="Director"/>
Organization	<input type="text" value="D.C. Department of Behavioral Health"/>

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Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Footnotes:**

See signed Assurance Form in Application Attachment.

# I: State Information

## Certifications

### 1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

- a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
- d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

### 2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 45 CFR Part 76 by:

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

For purposes of paragraph (f) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management  
Office of Grants Management  
Office of the Assistant Secretary for Management and Budget

### 3. Certifications Regarding Lobbying

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

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

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

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

### 4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA)

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

### 5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

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Name	<input type="text" value="Stephen T. Baron"/>
Title	<input type="text" value="Director"/>
Organization	<input type="text" value="D.C. Department of Behavioral Health"/>

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

#### Footnotes:

See signed Certifications Form in Application Attachment.



# I: State Information

## Chief Executive Officer's Funding Agreements (Form 3) - Fiscal Year 2014

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

Title XIX, Part B, Subpart I of the Public Health Service Act		
Section	Title	Chapter
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66



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

Name of Chief Executive Officer (CEO) or Designee

Stephen T. Baron

Title

Director, D.C. Department of Behavioral Health

Signature of CEO or Designee<sup>1</sup>: \_\_\_\_\_ Date: \_\_\_\_\_

<sup>1</sup> If the agreement is signed by an authorized designee, a copy of the designation must be attached.

**Footnotes:**

See signed Chief Executive Officer Form in Application Attachment.

# I: State Information

## Disclosure of Lobbying Activities

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

[Standard Form LLL \(click here\)](#)

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Name	<input type="text" value="Stephen T. Baron"/>
Title	<input type="text" value="Director"/>
Organization	<input type="text" value="D.C. Department of Behavioral Health"/>

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Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Footnotes:

Not Applicable.  
See signed Disclosure of Lobbying Activity Form in Application Attachment.

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## II: Planning Steps

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

Narrative Question:

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Provide an overview of the State's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic and sexual gender minorities.

**Footnotes:**

Planning Step 1 is attached.

## *Planning Step 1: Service System Strengths and Needs to Address Specific Populations*

### **OVERVIEW OF THE DISTRICT OF COLUMBIA**

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

**Population:** According to the U.S. Census Bureau, the 2012 population estimate for the District of Columbia is 632,323. The District's land area is 61.05 square miles with 10,357.46 persons per square mile. The median age is 33.6. The population age breakdown includes:

Age	Percent of Population	Number of Persons
Under 5 years old	6.1%	38,876
5-18 years old	17.3%	109,480
65 years old and over	11.4%	71,889

The gender breakdown is as follows:

Gender	Percent of Population	Number of Persons
Female persons	52.7%	333,282
Male persons	47.3%	299,041

The race/ethnic breakdown is as follows:

Race/Ethnicity	Percent of Population	Number of Persons
African American or Black persons	50.1%	316,482
White persons	42.9%	271,323
White persons not Hispanic	35.5%	224,327
Persons of Hispanic or Latino Origin	9.9%	62,726
Asian persons	3.8%	24,034
American Indian and Alaska Native persons	0.6 %	3,488
Native Hawaiian and Other Pacific Islander persons	0.2%	1,131
Persons Reporting 2 or More Races	2.5%	15,865

Source: U.S. Census Bureau, Population Division (Release Date: June 2013)

**Households:** There were 298,908 housing units in 2011 (American Community Survey/ACS 2011, 1-year data). According to the ACS 2011, 1-year data, the homeownership rate was 41.2%. The housing units in multi-unit structures was 61.5%. The median value of owner occupied housing units was \$422,400. There were 268,670 households with 2.15 persons per household. The per capita money income in the past 12 months was \$44,578. The median household income was \$75,603; and the percent of persons below the poverty level was 18.7%.

## **DEPARTMENT OF BEHAVIORAL HEALTH PLANNING**

Historically, the mental health and substance use disorder systems have existed separately within the District of Columbia government. Effective October 1, 2013, the Department of Mental Health will merge with the Addiction Prevention and Recovery Administration in the Department of Health to integrate treatment and services for residents with mental health and substance use disorders. Mayor Vincent C. Gray formed the new Department of Behavioral Health (DBH) to improve the health and well-being of residents who receive mental health and substance use treatment and supports. Research shows that integrated treatment produces better outcomes for individuals with co-occurring mental health and substance use disorders. Without integrated treatment, one or both disorders may not be addressed properly. The overall vision of an integrated system is to effectively serve individuals with co-occurring disorders whether they are seeking help for substance use disorders or mental health conditions. It is estimated that annually about 22,000 adults and children receive mental health treatment while about 12,000 residents receive substance use disorder treatment. Over the next year, the new Department will develop an infrastructure within the mental health and substance use disorder programs to support integrated service delivery. Residents who only seek mental health treatment or only substance use treatment will continue to be served by the new Department.

FY 2013 was the initial planning phase for establishing the DBH. The activities included: 1) creating a Planning Committee, developing a work plan, adopting Guiding Principles and the Charter, establishing work groups and reporting requirements, and identifying data requirements; 2) conducting work group meetings including developing work plans and schedule of deliverables, and monthly report to the Planning Committee; 3) developing a strategy for communication and engagement of partners and the general public; 4) addressing infrastructure issues such as contracts and procurement, billing and claims, certification and accountability; and rules and policy; 5) launching the new Department on October 1, 2013 with consumer/client services continuing and uninterrupted with same mental health or substance use disorder provided; 6) on an ongoing basis continue evaluation of services and identification of gaps, provide training on assessment and treatment of co-occurring disorders, and address a host of other issues; and 7) competitively acquire consultant services to facilitate the development of the DBH. During the FY 2013 fourth quarter a consultant was brought onboard to provide technical assistance for the development and implementation of the DBH.

## **BEHAVIORAL HEALTH PARTNERS**

### **Department of Health Care Finance**

The Department of Health Care Finance (DHCF), formerly the Medical Assistance Administration under the Department of Health, is the District of Columbia's state Medicaid agency. The mission of DHCF is to improve health outcomes by providing access to comprehensive, cost-effective and quality healthcare services for residents of the District of Columbia. In addition to the Medicaid program, DHCF also administers insurance programs for immigrant children, the State Child Health Insurance Program (S-CHIP or CHIP) and Medical Charities (a locally funded program). The services include:

- DC Healthcare Alliance- offers a full range of health care services for its members. Benefits include: inpatient hospital care, outpatient medical care (including preventive care), emergency services, urgent care services, prescription drugs, rehabilitative services, home health care, dental services, specialty care, and wellness programs.
- DC Healthy Families- provides free health insurance for District residents and their children.
- Medicaid- DC Medicaid is a healthcare program that pays for medical services for qualified people. It helps pay for medical services for low-income and disabled people. For those eligible for full Medicaid services, Medicaid pays healthcare providers. Providers are doctors, hospitals and pharmacies who are enrolled with DC Medicaid.
- Right Rx Initiative- provides decision and administrative support to clinicians to facilitate ease of prescribing and appropriate use of medications by Medicaid beneficiaries.

## **Department of Health**

The mission of the Department of Health (DOH) is to promote and protect the health, safety and quality of life of residents, visitors and those doing business in the District of Columbia. The responsibilities include: identifying health risks; educating the public; preventing and controlling diseases, injuries and exposure to environmental hazards; promoting effective community collaborations; and optimizing equitable access to community resources. The divisions include:

- Center for Policy, Planning and Evaluation- assess health issues, risks and outcomes through data collection, surveillance, analysis, research and evaluation; perform state health planning functions; and assist programs in the design of strategies, interventions and policies to prevent or reduce disease, injury and disability in the District.
- Community Health Administration- improve health outcomes for targeted populations by promoting coordination within the health care system, enhancing access to prevention, medical care and support services, and by fostering public participation in the design and implementation of programs for District of Columbia women, infants, children (including children with special health care needs) and other family members. In addition, provide chronic and communicable disease prevention and control services, community-based forums and grants, expert medical advice, health assessment reports, and pharmaceutical procurement and distribution, disease investigations and disease control services to District residents, workers and visitors so that their health status is improved.
- Health Emergency Preparedness and Response Administration- ensure the delivery of the highest quality emergency medical and trauma care services through the provision of regulatory oversight of all emergency medical services provided in the District; plan, implement and direct public health emergency preparedness and response; conduct disease surveillance and investigate disease outbreaks in order to minimize the spread of disease; and provide laboratory services in support of public health programs and to detect bioterrorist agents.

- Health Regulation and Licensing Administration- provides services, administration and regulatory oversight through the following programs: Health Professional Licensing Administration; Pharmaceutical Control Division; Health Regulation Administration; Animal Disease Prevention Division; Food Protection Division; and Rodent Control Division.
- HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA)- is the core District government agency to prevent, reduce transmission, and provide care and treatment to persons with these diseases. HAHSTA partners with health and community-based organizations to offer testing and counseling, prevention education and intervention, free condoms, medical support, free medication and insurance, housing, nutrition, personal care, emergency services, direct services at its STD and TB clinics, and other services for District residents and the metropolitan region. HAHSTA administers the District's budget for these programs, provides grants to service providers, monitors programs, and tracks the incidence of HIV, AIDS, STDs, Tuberculosis and Hepatitis.

### **Other Partners**

Some of the other partners that have a District-wide and/or agency cluster oversight role include the: Office of the Chief Financial Officer, Office of the City Administrator, Office of the Deputy Mayor for Health and Human Services, Office of the Chief Technology Officer, DC Metropolitan Police Department, and the DC Superior Court.

There are also a host of sister agency partners and include but are not limited to the: Department of Human Services, Child and Family Services Agency, Department of Youth Rehabilitation Services, Department on Disability Services, Office of the State Superintendent of Education, DC Public Schools, and Department of Corrections.

The specific initiatives that the Department has established with the Behavioral Health Partners is discussed throughout the section on Behavioral Health Populations and Services.

## **BEHAVIORAL HEALTH POPULATIONS AND SERVICES**

The behavioral health populations, programs, initiatives and services are organized by: 1) the Mental Health Block Grant statutory reporting criteria; and 2) the Substance Abuse and Mental Health Services Administration (SAMHSA) Eight (8) Strategic Initiatives.

### **Criterion 1: Comprehensive Community-Based Mental Health Service Systems**

#### ***SAMHSA Strategic Initiative #1: Prevention of Substance Abuse and Mental Illness***

**Early Identification and Intervention Services:** A number of services have been implemented under the Child and Youth Services Division System of Care. Their purpose is to eliminate and/or reduce risk factors associated with mental health and behavior issues in infants, toddlers, and school age children. They include services for: 1) women/mothers identified as depressed with children age birth to 2 (Healthy Start Project); 2) children 0-5 in child development centers

with a focus on child and family-centered, and program consultation (Healthy Futures); 3) parents and children age 6 and under who have shown emotional and disruptive behavior across various social settings (Parent Infant Early Childhood Enhancement Program); 4) children in grades Kindergarten through First to enhance school related competencies and reduce social, emotional and school adjustment difficulties (Primary Project); 5) prevention, early intervention, treatment services provided by the School Mental Health Program; and 6) intervention services for children and youth including Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) for ages 0-6 and Child Parent Psychotherapy for Family Violence (CPP-FV) for ages 4-18.

**Substance Use Prevention Services:** The range of prevention related services include:

- 1) coordinate the Prevention Policy Consortium, which consists of 15 different District agencies, that provide guidance on the development and implementation of a strategic prevention plan;
- 2) maintain the Prevention Resource Clearinghouse that provides educational materials and information relevant to maintaining healthy living free of alcohol, tobacco, and other drugs and reducing factors that place youth, families and communities at risk;
- 3) bring substance abuse information and educational resources directly to District neighborhoods and communities in the DBH Mobilizer van;
- 4) provide training and technical assistance for youth, families, schools and communities in the use of evidence-based strategies and best prevention practices to reduce alcohol, tobacco and other drug abuse;
- 5) fund and monitor substance abuse prevention grants and contracts that include the four (4) D.C. Prevention Centers and services designed for populations and communities at higher risk and cover each of the District's eight (8) wards; and
- 6) manage programs that prevent and reduce tobacco use among children and youth and ensure compliance with federal and District laws.

**Dually Certified Programs:** There are six (6) certified mental health rehabilitation services (MHRS) providers that are also certified as substance abuse treatment facilities and programs. These programs are briefly described below.

Community Connections, Inc.- has a range of supportive services and treatment that includes residential programs. Adult services include mental health and co-occurring substance abuse treatment. Most have histories of violence and victimization, incarceration, homelessness, and/or major medical concerns. The Child and Adolescent Services Program is child-centered, family-focused, and community based. The substance use disorder treatment certification is for Levels I and II general and intensive outpatient substance abuse treatment services for adults.

Hillcrest Children and Family Center- is a free-standing outpatient mental health facility that provides a full range of services in a variety of settings designed to meet the psychological needs of children, adolescents, and families who are confronted with emotional issues. The services are provided in their homes, school, and community environments. The two (2) substance use disorder treatment certifications are for Levels I and II outpatient substance abuse treatment services for youth and adults.

Latin American Youth Center (LAYC)- serves immigrant Latin youth by operating a regional network of youth centers and public charter schools. LAYC offers multilingual, culturally sensitive programs in five (5) areas: 1) educational enhancement; 2) workforce investment; 3) social services; 4) art and media; and 5) advocacy. The substance use disorder treatment certification is for Level I outpatient substance abuse treatment services for youth.



Life Stride, Inc.- is a free-standing mental health clinic that provides a variety of psychiatric, clinical and social/leisure activities and supports within natural settings in the community. The populations served include children/youth, adults, older adults, and persons who are homeless. Mental health residential services are also provided. The substance use disorder treatment certification is for Level I outpatient substance abuse treatment services for adults.

Neighbors Consejo- serves the Latino community by focusing on chronic homelessness, mental health, terminal disease, domestic violence, and low income individuals. The programs and/or services include: residential; transitional; computer/ESL literacy; employment; civic engagement; life skills; outpatient; case management; environmental stabilization-housing; access to recovery after care; and mental health services. The substance use disorder treatment certifications include: 1) Levels I and II intensive outpatient substance abuse services for adults; 2) Level III non-hospital residential substance abuse treatment services for adults; and 3) access to recovery support services.

Washington Hospital Center Outpatient Behavioral Health Services- offers a full continuum of inpatient and outpatient psychiatric services and substance abuse treatment including: psychiatric and intensive outpatient programs; chemical dependency intensive outpatient; senior and older adult outpatient programs; outpatient medical counseling; core service agency (CSA) services; and intensive day treatment and day services.

**Review of Dually Certified Programs:** The National Association of State Mental Health Program Directors, through its SAMHSA contract, coordinated technical assistance services for the Department with Kim Mueser and Lindy Fox, well known for their research on integrated treatment for dual disorders. They suggested that the Department conduct program assessments with the six (6) providers who are dually certified. This process began in March 2013 and by June 2013 three (3) providers were assessed: Community Connections, Inc.; Life Stride, Inc.; and Neighbors Consejo. The purpose was to: 1) determine the current level of integration among the mental health and substance use disorder services; 2) rate the programs on the degree to which they could be considered co-occurring competent or enhanced; and 3) determine the opportunities and challenges for these programs to become co-occurring competent or enhanced.

On June 26, 2013, the consultant team provided on-site technical consultation. This included a morning session with the mental health and addiction leadership team to discuss: 1) the newly forming Department of Behavioral Health; 2) lessons learned from other jurisdictions and from the assessment of the dually certified local agencies; 3) overall strategy for moving toward an integrated system of care; and 4) plans for follow-up consultation sessions including orientation and training for mental health and addiction staff. The afternoon session was an orientation and discussion on treating dual disorders with the mental health and substance use chief executive officers (CEOs). The following day a similar session was held with the clinical directors and clinical administrators. One day training sessions were held with the clinical supervisors and frontline staff on July 16-17, 2013.

## **Health, Mental Health, and Rehabilitation Services**

### **Mental Health Rehabilitation Services (MHRS) Program and Other Services**

The Department contracts with community based providers for mental health services and supports. It also certifies each provider to ensure conformity to federal and District regulations and monitors quality of care. The MHRS include: 1) diagnostic/assessment; 2) medication/somatic treatment; 3) counseling; 4) community support; 5) crisis/emergency; 6) rehabilitation/day services; 7) intensive day treatment; 8) community based intervention (CBI); and 9) assertive community treatment (ACT). There are approximately 35 certified MHRS providers. These providers can be contacted directly or assistance can be obtained by calling the Department's Access HelpLine (AHL). This 24-hour, 7-day-a-week telephone line is staffed by mental health professionals who can refer a caller to immediate help or ongoing care. The AHL can also activate mobile crisis teams to respond to adults and children who are experiencing a psychiatric or emotional crisis and are unable or unwilling to travel to receive mental health services. The annual average number of AHL inbound calls for the period FY 2011 through the FY 2013 third quarter is 16,838.

Community Support vs. Case Management Services- Under the MHRS program the Department and its providers bill for Community Support and not Case Management. The Department strives to create an effective, welcoming, community support system that is based on the consumer's strengths and choices, promotes recovery through the attainment of individualized goals to help the consumer develop the skills to live the best possible quality of life, and provides aggressive outreach to maintain consumers in the community. The Department provides community support to consumers in a number of ways using its own practitioners and private providers. It is based on the individual consumer's (child/youth or adult) treatment needs as determined through the individualized recovery planning process where attainable and mutually agreeable goals and objectives are developed. Each consumer is assigned a clinical manager and qualified practitioner to coordinate consumer care, often across multiple provider agencies and to provide rehabilitation services, treatment and supports. The consumer's clinical manager is responsible for assessing with the consumer each of the consumer's major life domains and the areas of need that will be addressed.

Mental Health Services Division (MHSD)- This Division provides specialized mental health services that are not otherwise readily available within the Department's service system or the private sector. The MHSD programs include: 1) a same day urgent care clinic; 2) multicultural services; 3) intellectual/developmental disability and deaf /hard of hearing services; 4) pharmacy services; and 4) outpatient competency restoration services.

Same Day Urgent Care Services- This service is intended to intervene to prevent relapse or full-blown crisis by alleviating presenting problems. Promotion of emotional health is enhanced beyond the services typically provided by a community clinic that serves individuals with major mental illnesses. This is achieved as follows: 1) adult and child consumers may walk-in unscheduled and be evaluated the same day; 2) same day access to a psychiatrist; 3) psychotherapy services are available on a scheduled basis through the Residents' Clinic; and 4) on site pharmacy that serves individuals without insurance and all walk-in consumers who see a psychiatrist to have their prescriptions filled that day. The annual average number of new intakes for adult and child consumers served by the Same Day Urgent Care Clinic for the period FY 2011 through the FY 2013 third quarter is 2,187 for adults and 405 for children.

The majority of intake consumers seen are assigned to the private clinics in the provider network for ongoing care, since except for the specialty teams, long-term community support is not provided. The MHSD specialty teams are Multicultural Services and Intellectual/Developmental Disabilities/ Deaf/Hard of Hearing Services.

Multicultural Services- This team serves consumers originally from outside of the United States. It serves ethnic and regional groups from Asian/Pacific Islands who speak Vietnamese, Chinese, Korean, Thai, Burmese, Urdu and Persian languages. This group makes up 6% of the population served. Ethiopians of different ethnic backgrounds make up 23-24% of the consumer base. The three (3) major Ethiopian languages spoken by consumers are Amharic, Oromo and Tigrinya. Approximately 60% of the multicultural consumers are Spanish speaking from Central and South American countries. The remaining are consumers from other African, American, Middle Eastern and European countries who are English or French bi-lingual. The annual average number of consumers served in the Multicultural Services program for the period FY 2011 through the FY 2013 third quarter is 352.

Intellectual/Developmental Disability Services (IDD)/ Deaf /Hard of Hearing Services- This program responds to the psychiatric, rehabilitation, and support service needs of individuals with IDD and mental illness diagnoses. The IDD component focuses on the provision of mental health services and psychiatric treatment to the adult mentally ill and intellectually/developmentally disabled population in a community-based treatment and supportive care environment as an alternative to institution-based psychiatric care. It also works closely with the Department on Disability Services (DDS) on joint service planning for consumers who are also enrolled in DDS. This program also ensures that deaf /hard of hearing consumers receive the full array of MHRS based on individual need that includes but is not limited to counseling, psychotherapy, community support, medication, etc. They also receive supports such as outreach, home visits, referral to employment, and other services. MHSD staff provides assistance during the diagnostic/crisis screening of children if requested, and provides clinical consultation and education regarding the psychosocial aspects of deafness and the specialized communication needs of deaf/hard of hearing clients/consumers. The annual average number of consumers served in the IDD/Deaf/Hard of Hearing Services program for the period FY 2011 through the FY 2013 third quarter is 197.

Deaf-REACH, one of the mental health rehabilitation services providers, also specializes in serving this population. It is the only agency in the District whose mission is specifically to serve deaf individuals facing serious mental illness, developmental disabilities, or other challenges. Programs and services include: community residence facilities, supported independent living, community support, supported employment, HIV prevention, day habilitation, and pre-vocational services.

Pharmacy Services- The purpose of this service is to provide safety net pharmacy services to uninsured residents of the District. This involves dispensing medication, medication counseling, and drug interaction counseling. The annual average number of unduplicated consumers served by the Pharmacy Services program and the annual average number of prescriptions filled for the period FY 2011 through the FY 2013 third quarter is 2,987 consumers and 19,726 prescriptions.

Outpatient Competency Restoration Program (OCRCP)- This program was developed in 2005 to respond to the Incompetent Defendant's Criminal Commitment Act of 2004. Its mission is to assist defendants, found incompetent to stand trial by the District of Columbia Superior Court, in attaining competence in the least restrictive setting of a community based competency restoration program. It serves defendants with mental illness, mild to moderate mental retardation, borderline intellectual functioning, and substance use disorders. The annual average number of consumers served in the OCRCP for the period FY 2011 through the FY 2013 third quarter is 62. These individuals participated in an average of nine (9) weekly group sessions.

HIV Screening- During the fourth quarter of FY 2013, as part of the District's 12 Cities Grant, MHSD became an HIV Screening site and provides pre- and post- screening counseling.

### **Substance Abuse Treatment Services**

Adult Substance Abuse Treatment Services: There are approximately 42 programs certified to provide substance abuse treatment in the District of Columbia. For residents who do not have insurance, who have DC Medicaid, or whose insurance does not cover substance abuse treatment services, the Department administers the Drug Treatment Choice Program (DTCP).

To access adult services, an individual must visit the Department's Assessment and Referral Center (The ARC). Upon arrival at The ARC, the client signs in, meets with a nurse, and participates in a comprehensive assessment and evaluation to determine the appropriate level of treatment and maintenance care through a continuum of substance abuse treatment services including: outpatient, intensive outpatient, residential, detoxification and stabilization, and medication assisted therapy. After a completed assessment, the client may choose a treatment provider from the list of DTCP treatment programs. Typically, a client begins treatment within one day. There is **no waiting list** for treatment in the District of Columbia.

HIV Screening- The ARC is also an HIV Screening site.

Adolescent Substance Abuse Treatment: The District of Columbia offers four (4) locations where young people can go to seek help for a drug or alcohol issue. If the individual lives in D.C. and needs help or just wants to talk to someone about his/her drug or alcohol use, he/she can contact one (1) of the treatment providers that are available through a provider network.

Through the Adolescent Substance Abuse Treatment Expansion Program (ASTEP), youth may access services directly from the substance abuse treatment provider of his/her choice within the network. In many instances, the providers are near their homes, schools, or jobs.

### **Emergency Services**

Same Day Urgent Care Clinic: operated by the Mental Health Services Division was previously described.

Comprehensive Psychiatric Emergency Program (CPEP): provides emergency psychiatric services for persons 18 years and older. This 24-hour program includes: crisis assessment and

stabilization; acute psychiatric and medical screening and assessment; observation and intensive psycho-pharmacological and psychotherapeutic services. There are four (4) components:

1) psychiatric emergency services; 2) extended observation beds; 3) adult mobile crisis services; and 4) homeless outreach services (see Criterion 4).

CPEP's Psychiatric Emergency Services (PES) and Extended Observation Beds (EOB)- includes two (2) observation beds (used for consumers who may need additional time to stabilize before discharge to the community) and two (2) restraining beds (reserved for persons who present a danger to self or others). These individuals are usually escorted by police and admitted involuntarily. Restrained consumers require one-on-one observation and monitoring and in some instances, require staff to handle their violent or combative behavior. The annual average number of individuals receiving psychiatric emergency services for the period FY 2011 through the FY 2013 third quarter is 3,586.

CPEP's Adult Mobile Crisis Services (MCS)- is staffed by a multidisciplinary team and offers crisis intervention and medical support to adults who are mentally ill in their homes, community facilities, and in the street . The daily hours of operation are 9:00 a.m. - 1:00 a.m. MCS works closely with the police.

The primary activities include: 1) respond to adults throughout the District who are experiencing a psychiatric crisis and are unable or unwilling to travel to receive mental health services; 2) spend as much time as needed with consumers to ensure crisis stabilization, make an appropriate disposition, and provide necessary follow-up services; 3) be available to address the concerns of the individual in crisis, family members, concerned citizens, mental health providers, and other referring agencies; and 4) offer a range of services including but not limited to on-site crisis intervention and stabilization, assessment for voluntary and involuntary hospitalization, and linkage to other services such as ongoing mental health care, crisis beds, substance abuse detoxification and treatment, and medical care. The annual average number of adults receiving face-to-face mobile crisis services for the period FY 2011 through the FY 2013 third quarter is 1,336.

Child and Youth Mobile Crisis Services (MCS)- The Child and Youth Services Division contracts with Catholic Charities for mobile crisis services for children and youth ages 6 to 21. This service is called Child and Adolescent Mobile Psychiatric Services (ChAMPS). The youth ages 18-21 who are served are committed to the Child and Family Services Agency (child welfare system). The annual average number of children/youth receiving mobile crisis services for the period FY 2011 through the FY 2013 third quarter is 548.

In addition to the CYSD contracted child and youth mobile crisis services, there is also a contract with Children's National Medical Center for child emergency services.

### **Other Activities Leading to Reduction of Hospitalization**

There are a number of programs and initiatives in place that lead to reduced hospitalizations.

Crisis Stabilization- Each core services agency (CSA) must have an on-call system for crises and provide a crisis plan for each consumer in their Individual Recovery Plan (IRP). The Access HelpLine also receives referrals for crisis services.

Crisis Beds- Two (2) providers are funded for a total of 15 crisis beds. These include eight (8) at Jordan House and seven (7) at Crossing Place. The annual average crisis bed utilization rate for the period FY 2011 through the FY 2013 third quarter is 88%.

Peer Transition Specialists (PTS)- The Peer Transition Specialists (PTS) initiative resulted from a collaboration between the Office of Consumer and Family Affairs, Saint Elizabeths Hospital, and the Integrated Care Division, and is aimed at helping consumers leave the Hospital. The role of the PTS is to assist individuals in the care of the Hospital, who have been determined ready for discharge, make a smooth transition to community living. The PTS are able to draw upon lived experiences as well as their training to provide encouragement and support to those who are returning to the community. During most of FY 2012, there were five (5) PTS. As of the FY 2013 third quarter there are three (3) Peer Specialist Interns.

Assertive Community Treatment (ACT)- This evidence-based practice provides intensive, integrated, rehabilitative, community based services for adults with serious mental illness (SMI). ACT consumers typically have experienced multiple psychiatric crises, housing and employment instability, and have been unable to maintain linkages to traditional clinic-based mental health services. ACT services are provided to consumers in accordance with an individual recovery plan (IRP) developed in collaboration with the consumer, ACT team, and other involved service providers, family members or community support systems. For the period FY 2011 through the FY 2013 third quarter, the annual average number of ACT providers is seven (7), the annual average number of operating teams is 15 and the annual average number of consumers served is 1,300.

The ACT program conducts fidelity assessments on an annual basis utilizing the Dartmouth Assertive Community Treatment Scale (DACTS); results are tabulated and provided to ACT providers. During the FY 2013 first quarter, fidelity reviews were completed on 14 teams. The findings showed that 71% (10 out of 14 teams) scores were in the acceptable range (a score of 4.0 or higher). Teams with low fidelity scores developed an improvement plan. Also, any system-related issues identified through the fidelity process were addressed in an overall ACT work plan throughout the course of the fiscal year.

In February and March FY 2013 a random targeted community services review (CSR), a Department review to assess the services and providers, was conducted for new consumers assigned to the ACT level of care. Each ACT team participated in the CSR to assess the degree of collaboration, coordination and integration of services for the consumer and how the consumer rated his/her support with the new provider. While the final sample was relatively small (18 consumers), the findings provide information about system performance, areas that work well, and areas that need improvement. The ratings across the practice measures for system performance were well within the acceptable range. The areas that are working include: 1) team efforts to engage and support consumers and build positive rapport with some previously resistant individuals; 2) regular team meetings and engaging family and collateral providers; and 3) consumers feel like contributing members of the team, leading to high satisfaction with

services. Areas that need improvement include: 1) several teams lacked a vocational specialist or a means of addressing consumers' interest in pursuing employment or career development; 2) some teams used morning meetings only for status reports and efforts lacked cohesion or understanding that the services to consumers became fragmented; and 3) some consumers reported a relationship with only one ACT staff person.

Also, during FY 2013 the ACT program initiated activities related to the development of an ACT Scorecard by engaging in data gathering and review. The various sources of data included: Team/Fidelity scores, focused Community Services Review scores, Mental Health Statistics Improvement Program Surveys, and e-Cura claims based data regarding timeliness of service. The ACT Scorecard will be developed and piloted during FY 2014 with full implementation completed in FY 2015.

Integrated Care Division (ICD)- At the time it was created in FY 2009, the ICD located in the Department's Office of Programs and Policy, purpose was to reduce the inpatient census/reduce re-admissions at Saint Elizabeths Hospital by identifying consumers who needed a comprehensive array of services that included mental health, non-mental health, and informal supports to integrate to their fullest ability in their communities and with their families. ICD coordinated, managed, and evaluated the care for these consumers to improve their quality of life and tenure in a community setting.

Since its inception, ICD has expanded to incorporate children and youth populations, continuity of care work in community hospitals, post discharge tracking and monitoring, and movement of consumers from higher levels of care to lower levels of care in the community using the evidence based program and practice Critical Time Intervention. As a result, a new vision and purpose was created to reflect this reality. The ICD works to transition consumers from one level of care to another whether the change is moving into or out of hospitals, nursing homes or community residence facilities. It also works to integrate systems for seamless service delivery and improved consumer outcomes for the most vulnerable consumers in the mental health system.

Federal and District Performance Continuity of Care Indicators- Complying with federal and the *Dixon* Settlement Agreement led to the establishment of baseline measures to effect adult and child System of Care improvements to meet the following performance targets: 1) decrease the number of children/youth and adults re-admitted to inpatient care within 30 days of discharge; 2) decrease the number of children/youth and adults re-admitted to inpatient care within 180 days of discharge; 3) 70% of children/youth and adults discharged from inpatient care must be seen within seven (7) days in non-emergency outpatient setting; and 4) 80% of children/youth and adults discharged from inpatient care must be seen within 30 days in non-emergency outpatient setting.

## ***SAMHSA Strategic Initiative #2: Trauma and Justice***

### **Trauma Focused Initiatives**

**Evidence Based Practices:** During FY 2012, the Child and Youth Services Division in partnership with Evidence Based Associates (EBA), under the Families First evidence-based practice (EBP) initiative trained, coached, and provided technical assistance for a cadre of core

services agencies (CSAs) that included: Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Child Parent Psychotherapy for Family Violence (CPP-FV), and Multi-Systemic Therapy for Youth with Problem Sexual Behaviors (MST-PSB).

In FY 2013, TF-CBT training and consultation activities continued. As of January 2013, twenty-four (24) of 27 clinicians trained in TF-CBT successfully completed all the training and began accepting referrals for this service.

Five (5) agencies are being trained in CPP-FV: 1) Adoptions Together (the Child and Family Services Agency Post Permanency Family Center; 2) Hillcrest Children and Family Center; 3) Latin America Youth Center; 4) Universal Healthcare Management Services; and 5) the government-operated Parent Infant Early Childhood Enhancement (P.I.E.C.E.) program. Monthly clinician, supervisor and senior leader CPP-FV telephone consultation with the trainer and the developer continues. There are 16 clinicians and five (5) supervisors engaged in the training process, which is scheduled to be completed September 2013.

Also, during FY 2013 training began for two (2) additional models: 1) Transition to Independence Process (TIP) System, a community-based model for improving the outcomes of youth and young adults with emotional/behavioral difficulties; and 2) Trauma Systems Therapy (TST), a treatment model for children and adolescents who have been exposed to trauma. With regard to TIP, the Department in partnership with EBA announced a pre-application webinar for prospective core service agency (CSA) applicants interested in applying for TIP training. This event was led by STARS Training Academy, the Department and EBA staff. It is a pre-requisite for a 2-year TIP Learning Collaborative process beginning July 1, 2013 through June 30, 2015.

The Department's Child and Youth Services Division in partnership with EBA will host the third annual D.C. Evidence Based Practice Summit, *Celebrating True System of Care Collaboration Through Evidence-Based Practice Implementation*, on September 27, 2013. The purpose is to highlight evidence-based programs making a difference for children, youth and their families.

In FY 2014, the Child and Youth Services Division plans to provide training in the Child and Adolescent Functional Assessment Scale (CAFAS), an empirically based tool to assess a youth's functioning across critical life domain and whether functioning improves over time. All child-serving agencies in the District will implement the CAFAS in FY 2014 to enhance integrated treatments across agencies.

**Mental Health Block Grant Sub-Grantee Projects:** Several of the FY 2012- FY 2013 Mental Health Block Grant funded community based projects and a District agency addressed trauma related issues. Also, noted by reference only are FY 2013-FY 2014 projects selected but the grant award is pending.

### ***Adult Projects***

Advocates for Survivors of Torture and Trauma- Strengths Based Model Psychotherapy Groups for Torture Survivors project provided 2-hour weekly psycho-therapy sessions (women group and co-ed group) serving 51 participants (35 women and 16 men) who showed decreased



symptoms, ability to develop social skills, access community services, and improved English fluency.

The FY 2013- FY 2014 project to be awarded to this organization is *Healthy Living Initiative for Torture Survivors*.

N Street Village- Trauma-Informed Care Project used the Trauma Recovery Empowerment Model (TREM) with two (2) groups: 1) 20 female clients and residents managing mental illness and/or addiction histories, trauma survivors, and had chronic physical health issues; and 2) staff training. The participant outcomes include 90% maintained mental stability; 70% maintained sobriety, and 85% had no new contact with the criminal justice.

So Others Might Eat Behavioral Health Services (SOME, Inc.)- Standardizing Trauma Informed Opportunities Project (STOP) assessed the organization's capacity to deliver trauma-informed behavioral health care at the clinical program and the client level. SOME developed a universal instrument for identifying trauma in all new clients and implemented clinical trauma group called Managing Adversity and Trauma Symptoms (MATS).

The Women's Collective- LIFTing Women Coping with HIV, Trauma and Substance Use project used the Living in the Face of Trauma (LIFT) intervention to assist 10 African American women cope with HIV infection, childhood and other trauma, and substance use. The women showed improved coping, reduced psychological distress, and eliminated or reduced sexual transmission risk behavior and substance abuse.

The FY 2013- FY 2014 project to be awarded to this organization is *Living in the Face of Trauma (LIFT): An intervention for Women Coping with HIV, Trauma, and Substance Use*.

### ***Child and Youth Projects***

Youth Court of the District of Columbia, Inc.- Substance Abuse Screening Program identified substance abuse and behavioral issues at the initial referral to Youth Court (a diversionary program from further penetration into the juvenile justice system). Youth ages 12-17 that have been diverted for possession of marijuana, an open container of alcohol, or underage drinking are screened and receive appropriate follow-up. Of the 64 youth referred for services, 12 received inpatient or outpatient services and completed the program.

The FY 2013- FY 2014 project to be awarded to this organization is *Youth Court Substance Abuse Initiative Project*.

Office of the State Superintendent of Education- Nonviolent Crisis Intervention Training for individuals from various District government and local agencies. The training includes a 4-day workshop on crisis prevention and intervention. The participants learn the skills and strategies for safely managing assaultive and disruptive behavior. As of July 2013, 11 trainers were certified as Crisis Prevention and Intervention Instructors, and 60 local education agency/school level participants were certified to implement/perform nonviolent crisis intervention techniques.

## **Suicide Initiatives**

Capital CARES Grant- The FY 2012 and FY 2013 purposes, activities and outcomes are combined in the description that follows. This grant extended suicide prevention efforts in the District by building upon the work funded by the STOP Suicide grant; and through educating the community about suicide prevention and potential warning signs via community outreach, social marketing and trainings. The activities include: 1) gatekeeper training for the D.C. Metropolitan Police Department (DC MPD), schools, clergy, primary care providers, etc.; 2) screening through collaboration with public and private partners; and 3) social marketing. The grant expected outcomes include: 1) create a city-wide infrastructure of linked supports for suicide prevention; 2) increase awareness of the extent of the problem, signs, and symptoms and appropriate response for suicide (e.g., violence exposure, gang involvement, unprotected sex, HIV/AIDs exposure, substance abuse); 3) identify and link youth at risk of suicide to services; 4) build capacity for referrals and ensure availability of care for youth at risk for and during a suicidal crisis; 5) reduce suicide attempts by District youth; 6) comprehensive, accurate and current data collection and reporting about suicide attempts; 7) target of 1,000 youth reached annually through mini-grant events; 8) target of QPR to 1,000 people annually; and 9) expose every District resident to some suicide prevention materials by 2015.

Collaboration with Washington Metropolitan Area Transit Authority (WMATA) on Suicide Intervention and Public Awareness Program- In May 2012, WMATA and DMH signed a memorandum of understanding (MOU) for suicide intervention training services and a dedicated crisis intervention Hotline. DMH'S role included: 1) conducting a train-the-trainer suicide prevention training for 20 WMATA staff by providing instruction in Applied Suicide Intervention and Skills Training (ASIST) and Tell Ask Listen Keep Safe (safeTALK); 2) participating in training the WMATA staff (station managers, vehicle operators, and supervisors); and 3) providing appropriate immediate crisis intervention and appropriate referrals for ongoing outpatient services for both District and non-District residents. At the end of FY 2012, 21 staff were trained. A WMATA Lifeline was also established in the Department's Access HelpLine.

The training continued during FY 2013. Staff in the Department's Care Coordination Division and in the Comprehensive Psychiatric Emergency Program, co-trained with WMATA staff. The WMATA staff now conduct the training. The Department would assist with getting WMATA staff trained as trainers, and remain available for future training needs. As of the FY 2013 third quarter, there were 841 calls to the WMATA Lifeline.

## **Disaster Mental Health**

The Office of Disaster Mental Health Services formally began in 2007 to lead the emergency preparedness efforts. With the guidance of the Emergency Preparedness Coordinating Committee, the Director of Disaster Behavioral Health Services implements plans that ensure that the Department is prepared to quickly mobilize and provide behavioral health services to the community in the event of a disaster or emergency. This includes developing specific strategies that address safety and continuity of operations (COOP) for inpatient, outpatient, community, emergency, and administrative functions to support these operations.

The Department operates a certification training program for emergency behavioral health responders. The Disaster Behavioral Health Responder Certification program includes a set of core training sessions that teach skills/competencies in the attitudes, knowledge, and skills necessary to provide evidence-based, culturally appropriate, and timely services to survivors. Participants who successfully complete post-session testing within a calendar year are eligible to apply. Emergency Behavioral Health Response Teams will be deployed during wide spread community incidents from severe weather to hazardous material spills to terrorist attacks or during high surge or regional disasters.

During FY 2013, an initiative began to expand the Disaster Services capacity by providing training to interested community members. Participating members are eligible to apply to response teams following successful completion of the seven (7) core training courses and three (3) auxiliary training modules of their choice. The training will occur annually until 150 persons are trained.

### **Court and Criminal Justice System Initiatives**

Court Urgent Care Clinic- The Department will continue to support the operation of the Court Urgent Care Clinic at the District of Columbia Superior Court that has been operational for several years and has served more than 1,200 individuals. The ready access to services on site at the District Superior Court building allows judges to refer individuals to immediate treatment who have been charged with misdemeanor crimes and appear to have a mental health or substance use disorder. The annual average data for the period FY 2011 through the FY 2013 third quarter is 348 referrals seen, 205 referrals discharged (closed), and 99 open cases.

Mental Health Community Court- The Department will continue to work closely with the Presiding Judge to link adults charged with nonviolent crimes to mental health treatment under court supervision.

Juvenile Behavioral Diversion Program (JBDP)- The Department will continue to work with the Courts to support the diversion court for youth established 2011. With the agreement of the U.S. Attorney, a youth can choose to participate in mental health treatment rather than be prosecuted for certain misdemeanor offenses. In calendar year 2012, there were 64 youth enrolled in the program. As of June 30, 2013, there were 22 youth enrolled in the program with five (5) cases pending.

Prison Re-entry Center- The Department staff located at the Department of Employment Services will continue to work with the Court Services and Supervision Agency for the District of Columbia (CSOSA) to connect District residents returning from prison with mental health and substance use disorder providers.

Outpatient Competency Restoration (OCRCP)- The program staff will continue to conduct psychoeducational groups and competency evaluations for the Court to determine whether an individual is competent to stand trial.

Jail Services- The Department staff co-located at the D.C. Jail, will continue to link individuals to mental health providers and work to keep individuals already enrolled linked to services while in jail. In FY 2014 the Department expects to also have staff co-located at the Women's Jail.

Crisis Intervention Officers (CIOs)- Since its inception this program has had as its goal the training of law enforcement on how best to respond to individuals with a mental illness. It began in April 2009 and through April 5, 2013, in collaboration with the D.C. Metropolitan Police Department (MPD), 570 patrol officers and other law enforcement agency staff have been trained. The participants are taught de-escalation techniques and how to refer to services when arrest is not required.

### ***SAMHSA Strategic Initiative #3: Military Families***

**Community Resource and Referral Center (CRRC)**: The Washington D.C. Veterans Affairs Medical Center's CRRC is a service center for homeless at-risk veterans. It is the first of its kind in the Washington D.C. area and will serve as a 24/7 hub to combat homelessness among veterans. It is one of 17 Centers the Department of Veterans Affairs plans to strategically locate across the nation. These facilities centralize federal and local partners to provide services to veterans.

Although not a shelter, the CRRC provides services to assist veterans and their family members. The building includes a Primary Care Clinic, a complete kitchen, laundry and shower facilities, a food pantry and a play room for children, as well as a host of other community services (e.g., Veterans administration programs, other federal assistance programs, employment assistance, vocational rehabilitation specialists, mental health professionals, life transitions counselors, local mental health and housing providers, legal assistance and others).

The Department's Homeless Outreach Program (HOP) continues to connect veterans to services (Veterans Affairs and other services) and now is able to make referrals to the Social Worker at the CRRC. The HOP is especially pleased with the CRCC outreach and their staff willingness to come out in the community to meet the veterans, which may mean on the streets, a park, etc.

### ***SAMHSA Strategic Initiative #4: Recovery Support***

#### **Health and Mental Health**

Medical and Dental Services- are provided through the provider network, the Department's Mental Health Services Division, Saint Elizabeths Hospital, and the District's community health system.

Primary Care Physician Linkage- During FY 2012, the Office of Accountability (OA) implemented two (2) quality improvement initiatives related to the integration of primary and behavioral health care. They included: 1) co-morbidity reviews to ensure that medical/physical, as well as psychiatric care needs are fully integrated and documented in the record of persons in the care of Saint Elizabeths Hospital; and 2) medical co-morbidity to increase the number of consumers that community programs link to primary care providers. With regard to the latter initiative, the providers were required to monitor this linkage and during the annual OA quality reviews documentation of the linkage to a primary care physician was reviewed.

Integration of Behavioral Health in Primary Health and Other Settings- Several FY 2012- FY 2013 Mental Health Block Grant community based funded projects integrated behavioral health

into primary health and other settings. Also, noted by reference only are FY 2013-FY 2014 projects selected but the grant award is pending.

La Clinica Del Pueblo- is a federally qualified community health center (FQCHC) serving the Latino community in the District. It is one of the certified substance abuse treatment facilities and programs. Men, women, youth and children receive linguistically and culturally appropriate health and education services including: primary care, mental health and substance use disorder services, HIV/AIDS care, interpreter services, and health education and outreach. Mental Health Block Grant funds were awarded to support the *Mi Familia (My Family) Project* that included two (2) cycles of this 14-week program with separate groups for children, adolescents and adults, as well as the incorporation of individual, couples, and family therapy. During the project period 106 unduplicated individuals and 28 unduplicated families were served.

The FY 2013- FY 2014 project to be awarded to this organization is *Mi Familia* (expands integration of mental health into primary care setting).

Mary's Center for Maternal and Child Care, Inc.- is also a FQCHC serving primarily low-income, immigrant families by providing comprehensive and integrated health care, education, and social services. A large portion of the services are devoted to pregnant women and their infants. It is also a mental health rehabilitation services provider. Mental Health Block Grant funds were awarded for a *Screening, Brief Intervention and Referral to Treatment (SBIRT) Pilot Project* with the adolescent population. Out of the 75 positive screens, 20 were referred to mental health and 8 to substance abuse treatment. The other 47 received case management from the Family Support Workers.

The FY 2013- FY 2014 project to be awarded to this organization is *SBIRT* (expands to all client populations).

Miriam's Kitchen- is a community-based feeding program and social services agency annually serving 4,000 men and women who are homeless in the District. The Therapeutic Thursdays initiative incorporates a range of interventions ranging from individual (1:1 connections with a staff psychiatrist, or outreach worker or case managers), a small group (*Tuff Stuff* trauma support group) to a larger group (yoga, creative writing group or Life Skills class) options. Mental Health Block Grant funds supported the *Therapeutic Thursdays Project*, which provides on-site psychiatric services for men and women who are chronically homeless. The psychiatrists saw 10-15 clients per week, engaging approximately 705 clients in the project.

The FY 2013- FY 2014 project to be awarded to this organization is *Hospitality, Health and Housing* (physical and behavioral health).

Other FY 2013- FY 2014 Pending Award Projects- that address primary and behavioral health issues include: 1) N Street Village *Smoking Cessation Project*; 2) So Others Might Eat (SOME) *Motivational Interviewing: A Goal Based Approach to Assessment and Intervention with Homeless Individuals*; and 3) Volunteers of America Chesapeake, Inc. *Bridging the Mental & Physical Health Gap Program*.

## Home

Department Housing Division- oversees a range of programs and services to help people with mental illness either obtain affordable housing and/or avoid losing their home. These programs include: 1) development of affordable housing units; 2) supported independent living; 3) transitional living; and 4) community residence facilities. The Department provides funding for housing for approximately 3,000 consumers.

As part of the *Dixon* Settlement Agreement, The Technical Assistance Collaborative, Inc. developed a housing strategic plan that was finalized in September 2012. This process involved evaluating the current system of supported housing to identify strategies to ensure a continuum of community-based housing and support services that meet consumer needs, are built on best practices, consistent with priority population needs, and cost-effective. The planning process included stakeholders, mental health system staff, and other partners. The result of this work is the 5-year Supportive Housing Strategic Plan FY 2012- FY2017, a document that establishes the guiding strategies for future activity in permanent supportive housing and contains specific actions to be implemented. The FY 2012 target for housing subsidies was 100 subsidies/vouchers over the FY 2011 baseline of 1,396. The award of 186 housing subsidies supported reaching the goal of 1,496 housing subsidies by the end of FY 2012. At the end of the FY 2013 second quarter, total housing capacity was 1,575.

### Mental Health Block Grant Sub-Grantee Projects:

Department Housing Division- *Permanent Supportive Housing for Special Populations Project* provided rental subsidies for transition age young adult consumers moving into the adult system; persons being released from jail; and persons in need of intensive services in order to remain in the community. The targeted 52 individuals were housed in single, 1-bedroom units, paid an average monthly rent of \$818.00, with a 12-month subsidy expense per person of \$9,816. The Mental Health Block Grant funds help to offset the total cost of their housing by paying 59%.

The FY 2013- FY 2014 project to be awarded to this Division is also *Permanent Supportive Housing for Special Populations*.

The Institute of Urban Living, Inc.- *Hyacinth's Place Project* provided the 15 female residents age 18-70 with mental health and substance abuse recovery and other activities to support them in the community. Ten (10) residents became emotionally stable enough to participate in therapeutic groups and do chores. The seven (7) substance using residents are clean. Some residents have regular involvement with their families.

The FY 2013- FY 2014 project to be awarded to this organization is also *Hyacinth's Place*.

Open Arms Housing, Inc.- hired a *Peer Support Specialist* to assist the 16 female residents with activities and living issues. The Peer Support Specialist conducted recreational activities and 1:1 meetings with residents around rules, daily living skills, and conflicts. As a result 73% of the residents participate in any activity with the Peer Support Specialist and others show increased participation including outside activities.

The FY 2013- FY 2014 project to be awarded to this organization is *Open Arms Housing: Integration of Peer Support Services*.

Other FY 2013- FY 2014 Pending Award Projects- that address housing related issues include: 1) Community Connections *Recovery Champions: Expanding Recovery Support in Residential Communities*; and 2) District Alliance for Safe Housing (DASH) *Mental Health and Family Wellness Programming*.

## **Purpose**

General Educational Services- Educational services for children and youth are coordinated through the Office of the State Superintendent of Education (OSSE), the D.C. Public Schools and the Public Charter Schools. These services for adults are available in the Washington, D.C. community to address individual needs and various disabilities. There is a full range of educational opportunities, from basic literacy through the general equivalency degree (GED) and college. The University of the District of Columbia has opened a community college, which provides more educational opportunities for District residents.

Department Training Institute- Provides education and training services on a variety of issues related to the adult and child systems of care. It also offers recurring introductory and overview trainings for providers, consumers, and staff. These trainings occur on a quarterly to bi-annual basis. During FY 2012, the consumer recovery courses included: 1) Exploring Peer Support Career Paths; 2) Self Employment; 3) Incorporating the 10 Peer Concepts into Your Daily Practice; and 4) Using a Recovery Model in Daily Practice. During FY 2013 Wellness Recovery Action Plan (WRAP) training was conducted.

Consumer Action Network- Serves as the peer advocate organization and offers help with filing a grievance and support throughout the grievance process. The FY 2012-FY 2013 trainings include: 1) Rights and Recovery; 2) Provider Training (advanced directives, peer advocacy, communicating with persons with mental illness, confidentiality); 3) Educational Outreach (participation in community events and display literature about mental health consumer rights, CAN services, and engage in discussions); and 4) Focus Groups (convened annually to get consumer input about their needs and how to improve mental health services and supports).

Ida Mae Campbell Wellness and Resource Center- Established through a Department contract began as a peer- run resource center for individuals living with mental health challenges. Its activities during FY 2012 and FY 2013 include: 1) center based activities (peer support groups/ Double Trouble Group, employment search support, resource/referral/education, social activities); 2) host to a number of events (healing from childhood abuse for women via video presentation and discussion of issues, health and wellness day, dealing with race related issues); 3) weekly men's group; 4) Wellness Recovery Action Plan; 5) facilitated community support groups; 6) advance directive training; 7) suicide prevention in partnership with the mental health system; 8) Office on Human Rights presentation; and 9) Trauma-Informed Care Conference as part of the annual Mental Health Month event.

Youth Vocational Rehabilitation- The Department on Disability Services, Rehabilitation Services Administration (DDS/RSA) works closely with the school system to identify youth, some of whom are referred to the Supported Employment provider network.

Department Supported Employment Program- The Department will continue to contract with six (6) core service agencies (CSAs) to provide specialized supported employment services. In 2012 a Performance Event Screen was developed and implemented that CSAs completed when creating consumer treatment plans. In accordance with Department policy, the CSAs continue to complete the event screen for each individual when completing the 180-day treatment plan, or more often when necessary, to confirm that consumers were assessed, offered and referred to supported employment services when appropriate. Staff monitor the completion of the event screen by CSAs for accuracy of information. They also monitor a centralized wait list for consumers who are waiting for available openings at supported employment programs.

The Department's goal is to increase both the number of people referred and the number of people who actually receive supported employment services. The activities during FY 2013 included: 1) providing ongoing technical assistance to CSAs on correctly completing the supported employment services performance event screen; and 2) billing by providers for Medicaid reimbursable supported employment services.

Also, FY 2013- FY 2014 Mental Health Block Grant funds were used to support the Supported Employment Expansion Initiative. This project awarded sub-grant agreements to four (4) of the certified Supported Employment providers to hire one (1) new Employment Specialist (50% of full-time salary). These providers will be able to: 1) serve additional consumers, and 2) bill the Rehabilitation Services Administration (RSA) and Medicaid, which will allow them to cover the cost of the full-time position once the Block Grant funding ends. The new staff will provide all aspects of supported employment services and carry a caseload of 20 consumers. This will add 80 new slots to the service capacity.

### **Mental Health Block Grant Sub-Grantee Projects:**

FamilyLinks Outreach Center, Inc.- the *Outreach Center* is open bi-monthly on Saturdays and provides a half day program for 30-35 adults with serious mental illness. The activities include: 1) presentations on a variety of topics such as health, current and historical events, and sports; 2) stretch exercises; 3) arts and crafts; 4) sing-a-longs and occasionally dance; and 5) field trips to expose the participants to new experiences. Individuals from the community volunteer their expertise in various areas including health and nutrition, arts and crafts, music and singing. Also, a meal is provided.

The FY 2013- FY 2014 project to be awarded to this organization is also the *FamilyLinks Outreach Center*.

The Spoken Word- Lens and Pens Creative Expression Project provided weekly workshops on creative writing, photography, and visual arts for forensic inpatients and outpatients at Saint Elizabeths Hospital to support community reintegration. The newsletter *Reflections* included their poetry and creative writing. Also, their poetry and art work was displayed at the Art Museum of the Americas in the District.



The FY 2013- FY 2014 project to be awarded to this organization is also *Lens and Pens Creative Expression*.

Other FY 2013- FY 2014 Pending Award Projects- that address recovery support issues include:

1) Advocates for Justice and Education, Inc. *D.C. Behavioral Health Access Project*; 2) Columbia Heights Shaw Family Support Collaborative *PESP Recovery Support Project*; 3) Fihankra Akoma Ntoaso (FAN) *Positive Youth Development Alumni and Caregiver Support Programs: Supporting Emotional Health Amongst Teens in Foster Care*; and 4) The Center for Self Discovery *Teens Run DC 9th Grade Recruitment and Expansion to Middle Schools*.

### **Department Mental Health Block Grant Funded Project:**

Young Adult and Adult Initiative- the *D.C. Recovery Academy Pilot Project* began in FY 2013 and serves District residents age 18-35, living with mental illness and may also have co-occurring substance use disorders, who need individualized supports to be successful in community-based educational and employment activities. It is an integrated rehabilitation day service providing structured classes focusing on skill teaching and rehabilitation. Supported employment and supported education transitional activities are fully integrated into the rehabilitation day program. On-site Employment Specialists, Supported Education Specialists and Transition Specialists, who are subject matter experts not only in teaching targeted curriculum-based classes but also in successfully transitioning clients to work and school in the community, are integral to the program design. Clients choose from three (3) educational tracks: Employment, Education, or Recovery from Co-occurring Disorders. Each track has specific course recommendations for clients to consider when registering for classes. Upon completion of the pilot phase, a review will be conducted to determine the next steps, which is expected after September 2013.

### **Community**

**Office of Consumer and Family Affairs (OCFA):** As part of its advocacy role on behalf of consumers and families, the OCFA has continued to support: 1) consumer-run organizations, 2) consumer employment opportunities, 3) the certified peer specialist certification program, 4) the annual Olmstead Conference; and 5) family and consumer education.

### ***SAMHSA Strategic Initiative #5: Health Reform***

Health Reform Implementation- The Health Reform Implementation Committee (HRIC) is a three (3)-member body whose main function is to advise the Mayor on implementation of the health care reform laws, and to coordinate its execution in the District of Columbia. The members include the: Director of the D.C. Department of Health Care Finance; D.C. Department of Insurance, Securities and Banking; and the Director of the D.C. Department of Health. The HRIC has six (6) subcommittees: 1) communications; 2) exchange operation; 3) health delivery system; 4) insurance; 5) information technology (IT); and 6) Medicaid expansion and eligibility.

Health Information Exchange- The District of Columbia Health Information Exchange (DC HIE) is tasked with improving care coordination and lowering costs through the use of health information technology. In 2010 the DHCF was awarded a grant from the Office of the National

Coordinator for Health Information Technology (ONC) to create DC HIE. It is staffed and managed by DHCF and governed by a 21- member volunteer Policy Board appointed by the Mayor of the District. The Board includes representatives from District-based hospitals and health systems, health centers, and District government agencies. All Board meetings are open to the public with agendas published a week in advance in the District of Columbia Register.

Since DC HIE is state designated, it is not aligned exclusively with any hospital or health system or electronic health record (E.H.R.) platform. Its services are open to all clinical providers. DC HIE plans to connect with the state designated HIEs in Maryland (CRISP) and Virginia (ConnectVirginia). Connection may include the ability to send a Direct message between HIEs. A DC HIE and CRISP connection may also include the ability for District-based physicians to receive an alert when selected patients are admitted, discharged or transferred to acute care hospitals located in Maryland. Similarly, Maryland-based physicians would have the ability to receive an alert when selected patients are admitted, discharged or transferred to acute care hospitals in the District. Because patients and providers routinely travel between state borders in the Washington area, collaboration between state designated HIEs to provide for the free flow of clinical information is strongly encouraged by ONC.

The service DC HIE has available now is Direct Secure Messaging (Direct). It is an easy-to-use, fast and secure electronic communication service for clinical providers and others who regularly transmit and/or receive protected health information (PHI). Direct looks and operates like email, but with security features such as point-to-point encryption required for PHI. Direct is not a brand name or a company, Direct is a transmission standard developed by the ONC. DC HIE contracts with Orion Health for its Direct, one of the most widely deployed HIE companies in the world.

In the coming months DC HIE will offer modules that will allow: 1) ease of access and use; 2) intuitive user interface; 3) real time information; 4) enhance peer to peer communication; 5) manage disruptive communication; 6) powerful functionality; 7) image viewer; 8) timeline view; 9) access to DC HIE from multiple platforms.

Health Benefit Exchange Authority (HBX)- The mission of the D.C. HBX Authority is to implement a health care exchange program in accordance with the Patient Protection and Affordable Care Act (PPACA), thereby ensuring access to quality and affordable health care to all District residents. Beginning in 2014, significant health insurance reforms will be implemented including the establishment of Health Benefit Exchanges nationwide.

The D.C. HBX Authority is a quasi-governmental agency of the District government charged with implementing and operating the District's HBX. The Health Benefit Exchange is an online marketplace for District residents and small businesses to: 1) compare private health insurance plans; 2) learn if they are eligible for tax credits or subsidies to purchase private insurance or qualify for public health programs such as Medicaid; and 3) enroll in a health plan that best meets their needs. The D.C. HBX will enable individuals and small employers to find affordable and easier-to-understand health insurance and assist small employers in purchasing qualified health plans for their employees. Enrollment in the District's Health Benefit Exchange will begin October 2013 with coverage starting January 1, 2014.

The District awarded Infosys Public Services, a U.S.-based subsidiary of Infosys, a 1-year contract to develop its new health benefit exchange, bringing the District in line with federal health care reform requirements. It will be the prime systems integrator for the exchange, which will serve nearly one quarter million District residents. The Exchange, known as the District of Columbia Access System (DCAS), is a health and human services solution that will provide seamless healthcare coverage and replace the District's legacy Medicaid and eligibility systems with new technology that will provide a wide array of services in compliance with the new healthcare law.

Health Homes Planning- The Centers for Medicare and Medicaid Services (CMS) awarded funding to the District of Columbia to design a person-centered system of care that aims to improve the health outcomes of individuals with chronic health care needs through improved care coordination and care management. As noted in the Affordable Care Act, health home services are intended to integrate primary, acute, mental and behavioral, and social services that are timely, of high quality and based on individualized plans. Ultimately, this 'whole-person' approach to health care aims to decrease preventable emergency room use, hospital re-admissions and long term care reliance, while spending less money.

The District Department of Health Care Finance (DHCF) and the Department of Health (DOH) partnered with the Department to design health homes tailored to the needs of chronically ill Medicaid beneficiaries who, through better care management and coordination, would most likely experience improved health outcomes and reductions in ER visits and avoidable hospital admissions. Through the analysis of DC Medicaid claims and encounter data, mental health conditions were found to be the primary diagnosis for most individuals who frequently use inpatient hospital and ER services, particularly among individuals with bipolar disorder or schizophrenia. Co-occurring physical health conditions, such as diabetes and heart disease, were also prevalent in those with SMI. Initially, Medicaid beneficiaries with a severe mental illness (SMI) are eligible for enrollment in a DC Medicaid Health Home to receive Health Home services.

Providers certified by the Department as core services agencies (CSAs) are eligible to be Health Home providers in the DC Medicaid program. The Department is continuing to define Health Home provider certification requirements; however, the District plans to require that each Health Home employ staff that will ensure that a consumer's care is integrated-- specifically: a Team Leader, a Nurse Care Manager and a Care Coordinator. Health Homes will receive a bundled payment for providing Health Home services-- with the expectation that care coordination services are provided consistent with consumers' needs.

Health Management Associates has been hired to assist with this process. In 2013, District government leadership will seek federal approval from CMS, via a SPA, to establish Health Homes beginning in 2014.

### ***Strategic Initiative #6: Health Information Technology***

**D.C. Department of Health Care Finance (DHCF)**: The DHCF has responsibility for key health information technology (HIT) activities within the District of Columbia. DHCF was awarded a Medicaid Transformation Grant to develop a Medicaid Patient Data Hub to support electronic health record (EHR) technology and health information exchange for Medicaid

enrollees. As the single state agency responsible for the administration of the Medicaid program for the District, DHCF has also received funding from the Centers for Medicare and Medicaid Services (CMS) to develop a Statewide Medicaid HIT Plan (SMHP) to administer the federally-sponsored incentive program to foster the adoption of EHRs by eligible providers and eligible hospitals.

Medicaid EHR Incentive Program (MEIP)- was established under the provisions of the Health Information Technology for Economic and Clinical Health Act (HITECH) under the American Recovery and Reinvestment Act of 2009, Pub. L. 111-5, and key components of the Patient Protection and Affordable Care Act of 2010, Pub. L. 111-148. The HITECH Act provides for incentive payments to certain health care professionals and hospitals that meet specific eligibility requirements when they adopt, implement, upgrade and meaningfully use certified EHR technology. DHCF is responsible for the MEIP in the District. Providers who wish to receive a MEIP payment through the District must first register at CMS' website and select "District of Columbia" as their state of attestation. CMS activated registration for the District on July 1, 2013, which is the same date that registration at the District level was activated. The District's registration site is known as the District of Columbia State Level Registry.

Medicaid Patient Data Hub (PDH)- DHCF retained a contractor to design, develop and deploy the PDH, which will enable it to leverage HIT and EHR technology to improve the provision of services paid for by DHCF for its enrollees, reduce the cost of unnecessary care, and ultimately improve the health status of beneficiaries. The PDH is designed for use primarily by DHCF program staff and clinicians.

**District of Columbia Primary Care Association (DCPA)**: is a health action organization serving medically vulnerable residents. It has three (3) initiatives related to HIT that supports the capture and exchange of patient data within health care facilities and also among participating regional providers to improve quality and efficiency of care.

Electronic Health Records (EHRs) Initiative- completed EHR implementation with six (6) community health centers in 2008 and now provides comprehensive EHR support services, including hosting, training, and application maintenance to participating health centers.

D.C. Regional Health Information Organization (DC RHIO)- launched in March 2010 to connect EHRs across participating facilities in the D.C. metropolitan area, allows health center and hospital providers to view consolidated medical histories and clinical information for shared patients. The DC RHIO is now expanding to include new participants and has been designated to serve as the foundation for the D.C. State Health Information Exchange (HIE).

D.C. Regional Extension Center (DC REC)-now known as *eHealthDC* will assist 1,000 primary care providers throughout the District in implementing integrated EHR systems and achieving "meaningful use" of EHR technology.

### ***SAMHSA Strategic Initiative #7: Data, Outcomes, and Quality***

**Provider Scorecard**: The Provider Scorecard is a Department tool designed to help users of public mental health services in the District of Columbia select a provider that best meets their

needs. Through a rigorous application process, community based providers are certified to deliver mental health services for children, youth and adults. As part of its ongoing oversight to ensure high quality services, the Department developed the Provider Scorecard to rate providers on service delivery. The Provider Scorecard rates the quality of service delivery in assessment, treatment planning, and coordination of care. It also examines financial compliance with federal and local regulations and laws.

To be included, a provider must demonstrate paid claims for a minimum of 15 consumers for services delivered during all four (4) quarters of the review period. As such, every certified community provider may not be included in each review period.

**Sampling Methodology:** The Provider Scorecard comprises two domains—a Quality domain and a Financial domain. The primary source of data for the Quality domain of the Provider Scorecard is extracted from the annual quality reviews conducted by the Office of Accountability. These reviews consist of site visits and chart abstractions made at each community provider. The samples for these reviews are randomly chosen. The numbers of reviews conform to industry sampling practice based on the size of the population seen by a provider. For 1-300 clients, 15 charts are reviewed; for 301-1,000 clients, 20 charts are reviewed, and for providers with more than 1,000 clients, 25 charts are reviewed.

The Financial section includes the results of the Department’s claims audit process and monitoring of provider compliance with financial regulations.

**Review Period:** The FY 2012 Provider Scorecard is based on data elements from FY 2012 (October 1, 2011 through September 30, 2012) except in the case of the MHRS Claims Audit results. Since claims audits are conducted retrospectively the claims audit results used for the Scorecard will be the most recent fiscal year audit completed across all CSAs. The FY 2010 MHRS Claims Audit results were used for the 2012 Provider Scorecard, and included claims for dates of service October 1, 2009 through September 30, 2010. The FY 2012 Provider Scorecard was posted on the Department website on June 11, 2013.

**Applied Research and Evaluation (ARE) Unit:** The ARE Unit within the Department’s Organizational Development Division has been providing data since October 2009. This Unit implements both measurement and capacity-building activities that enhance the use and application of data to improve system functioning and quality of care. It facilitates the best use of data within the Department and addresses specific questions with research and evaluation methodology. ARE is comprised of a multidisciplinary team of individuals with a primary emphasis on collecting and using data from particular program areas. By looking at the data across programs, program staff are able to identify resources and strategies being used by other programs to enhance their data collection, utilize methods and IT infrastructure, or collaborate with other program areas.

The primary activities include: 1) conduct data analyses and develop reports for federal, state and local programs; 2) keep abreast of the literature and national trends; 3) provide accurate and timely reports; and 4) support quality improvement efforts. Enhancements have been made to capture data for the following programs and/or activities: Care Coordination; School Mental

Health Program; Child and Family Services Agency (CFSA) initiatives; Housing; Supported Employment; Psychiatric Residential Treatment Facility; Community-Based Intervention; and evidence-based practices.

ARE has developed a data reports and deliverable schedule to provide the following reports on a monthly, quarterly or annual basis: LOCUS/CALOCUS; Key Performance Indicators; Client Level Outcomes Assessment; Child and Youth Services Division Reports; CFSA Utilization; ChAMPS Performance Statistics; Child and Youth Services Dashboard; Crisis Intervention Officer Monitoring; Integrated Care Evaluation; Mental Health Statistics Improvement Program (MHSIP); and the Uniform Reporting System (URS) Tables.

**Data Infrastructure Grant:** The Department is a recipient of the SAMHSA, Center for Mental Health Services (CMHS) State Mental Health Data Infrastructure Grant (DIG) for Quality Improvement. The ARE Unit oversees this grant. The DIG enables the Department to engage in data collection and reporting on National Outcome Measures (NOMS). The NOMS address issues related to: 1) service capacity; 2) psychiatric bed utilization; 3) evidence-based practices; 4) client perception of care; 5) employment/school attendance; 6) criminal justice involvement; 7) stability in housing, 8) social connectedness; and 9) level of functioning. This data is reported through the Uniform Reporting System (URS) Tables. Presently, the focus of DIG is to support client level data reporting for selected NOMS. Through the DIG data reporting requirements, the Department will strengthen: 1) the quality of reporting; 2) performance accountability for selected NOMS; and 3) capability to report assessment of service provision and improvement at the individual client level.

**Reporting Work Group:** This group was formed to develop a comprehensive centralized and fully automated data access and delivery system that meets Department information needs. The goal of this group is threefold: 1) provide a common language for requesting and reporting data; 2) ensure that departmental reporting requirements are met; and 3) integrate internal and external databases to facilitate extraction and reporting of data across data sources to provide a comprehensive analysis of health care delivery in the District of Columbia. This group has established a charter and formed five (5) core functional areas to accomplish the charge it has been given. The functional areas referred to as teams include the following:

- Process- establish a reporting process that defines request format, report location, report catalogue, and reporting protocols.
- Requirements- determine departmental data reporting requirements, considering internal and external data sources to meet requirements, and coordinate definition of reports.
- Lexicon- develop a compendium of common terminology to be used to request and report data and to communicate business activities within the Department.
- Code Standardization- define and document coding standards to be used in the development of all reports and reporting components.
- Reporting Infrastructure- research, define, and develop a centralized easy to use data delivery system that integrates specified internal and external data sources to provide data that meets departmental data report requirements.

During FY 2012, the reporting group continued to define reporting needs and expand and refine the SharePoint Reporting Group site. The group moved to meeting weekly with Department leads to ensure that the final product includes department-wide representation and has made

significant progress in raising the visibility of this group as well as meeting group objectives. Lastly, the group is progressing with an eye on the development of the new Integrated Care Management System (iCAMS), which is going through the pre-development and developmental phases. Much of its work will facilitate the configuration of the new system.

**Implement the Care Management Application:** In FY 2013, the Department began the implementation of an Integrated Care Applications Management System (iCAMS) to service the District's public mental health system. The data system is expected to replace several primary data systems (e-CURA, Anasazi and Panacea Rx) as well as several secondary data systems that include the grievance, housing and emergency services data trackers. The goal of iCAMS is to centralize the documentation and reporting of information related to consumers and providers in order to support the decrease of manual processes and the support for multiple systems. Additionally, the product is expected to result in an increase of information sharing, monitoring, reporting and evaluation as well as support the provision of appropriate and timely services to consumers.

The iCAMS project kick off was May 7, 2013. Implementation of iCAMS involves collaboration between Department implementation team and the identified vendor for the iCAMS product. The project champion (Chief of Administrative Operations) as well as the project contracting officer technical representative (Chief Information Officer) have assembled an implementation team to oversee the day to day operations of this project. This team is comprised of three (3) staff whose areas of concentration are technical, clinical and business process/claims. The implementation team has met with the Department programs to gather requirements and ensure that that the product will meet the needs of the multi-faceted public mental health system. The initial release of iCAMS is expected to take place within the third quarter of FY 2014, and the system is expected to be fully operational by the end of FY 2014.

**Saint Elizabeths Hospital Data Analysis and Reporting:** Provides ongoing quantitative data to the hospital, the Department, and other stakeholders in order to enhance the quality of clinical practice and performance. The data analysis and reporting activities include: 1) risk management and unusual incident investigations; 2) hospital wide data collection; 3) database development and management; 4) data analysis and presentation; 4) in-depth studies; 5) performance improvement initiatives and implementation; and 6) audit development and implementation.

**Performance Related Information for Staff and Managers (PRISM) Report-** monthly data publication that documents 12-month trends related to: census, admissions and discharges; key performance indicators; unusual incidents; medications; restraint and seclusion; demographics and length of stay of individuals in care; and clinical practice.

**Trend Analysis-**yearly data publication that presents trends in census, admission, discharge and transfer information, demographic characteristics of the individuals in care, length of stay, readmissions, clinical profile captured in all five (5) axes of DSM-IV-TR, medication related data, and unusual incidents. Analysis results are presented visually in charts or tables, along with bullet points describing key findings and interpretations in every section.

### **Client Perception of Care**

### **Mental Health Statistics Improvement Program (MHSIP) Surveys-Adults and Youth:**

During FY 2013 the Department completed both the 2011 and 2012 annual MHSIP surveys that included the MHSIP survey for adults 18 and older, and the Youth Services Survey for Families (YSS-F) for children and youth 17 years younger. These surveys assess the perception of care for individuals who received mental health services within the public mental health system, as well as an analysis of its relationship to service utilization. A summary of the major preliminary findings relative to these two (2) issues include the following:

- YSS-F 2011- African-American youth exhibited significant differences from the youth of other races/ethnicities. Specifically, self-identification as an African-American youth is a positive predictor of reporting Overall Satisfaction, Satisfaction and Outcomes received from the Department, relative to self-identification as any other race or ethnicity.
- YSS-F 2012- Youth who have been diagnosed with ADHD and other diagnoses have negative predictions for Improved Functioning. Youth diagnosed with psychotic disorders negatively predict Improved Functioning and Outcomes versus those who have mood disorders and ADHD or other diagnoses.
- YSS-F 2012 National Average (obtained from the Uniformed Reporting System (URS) tables)- The YSS-F 2012 positive responses exceeded the national average scores for Outcomes and Participation in Treatment.
- MHSIP 2011- Regarding service utilization, Med Somatic is a negative predictor of improved Functioning and Social Connectedness. Also, consumers who received between 1 and 36 service contacts of Community Support negatively predict better perception of Social Connectedness, relative to consumers who do not receive community support.
- MHSIP 2012- Consumers who are between the ages of 18 and 34 negatively predict positive Outcomes and negatively predict the perception of improved Social Connectedness.
- MHSIP 2012- Consumers diagnosed with psychotic disorders positively predict improved Outcomes and the perception of improved Social Connectedness, relative to those with mood or “other” diagnoses.
- MHSIP 2012- Consumers between the ages of 35 and 49 positively predict the perception of satisfactory Participation in Treatment.
- MHSIP 2012- Consumers between the ages of 18 and 34 are less satisfied with their services overall; display less ability to connect socially with family members and friends; and have a lower perception of satisfaction regarding their treatment outcomes.
- MHSIP 2012 National Average- MHSIP 2012 positive response results consistently fall below the national average positive response scores for each domain, with the exception



of Outcomes and Participation in Treatment, where the District of Columbia Department of Mental Health exceeds the national average.

The MHSIP Survey report is being reviewed. It will be completed and disseminated in October 2013.

**Community Services Review (CSR):** The Department's CSR unit conducts an annual system-wide assessment of program services. The CSR Unit's role has included providing logistical support for Department reviewers and helping to provide reviewer training. It has also provided focused reviews and created targeted technical assistance interventions to assist the provider network with clinical practice issues.

The Department achieved substantial compliance with the Dixon Exit Criteria Adult standard for acceptable system performance in the 2011 CSR. The primary activities to improve the overall system performance of the child/youth CSR during FY 2012 included: 1) develop core practice principles that support quality practice, especially as defined by the CSR; 2) provide technical assistance to four (4) child/youth providers with low scores by the Department and Human Systems and Outcomes (HSO) designed for practice improvement and a fifth provider also received substantial assistance; and 3) regular meetings of the Department Committee for Practice Improvement and Integration of the CSR. In May 2012 the Child/Youth CSR was conducted with assistance from HSO. The 89 cases reviewed included joint reviews with the Child and Family Services Agency (CFSA) for 24 cases receiving services in both systems. The Department conducted 60% of the case reviews and HSO conducted the remaining. The projected target of 65% overall system performance was met. The CSR Unit also hosted a training from HSO on Clinical Case Formulation that was developed as a result of needs identified during the earlier round of technical assistance.

During FY2013, the CSR unit provided training and technical assistance to providers identified as needing targeted assistance based on areas of strength and areas in need of improvement identified during the FY2012 CSR. Trainings included Clinical Case Formulation, and Five Core Elements of Quality Practice. Technical assistance was individualized based on past CSR data, but focused on case review, supervision coaching, and providing domain specific feedback for cases based on CSR indicators. The CSR unit also provided logistical support for a review of 86 cases in May 2013. The projected target of 70% overall system performance was met which also satisfied the Dixon Settlement Agreement requirement.

#### ***Strategic Initiative #8: Public Awareness and Support***

**D.C. Mental Health First Aid Expansion Project:** During FY 2011, the D.C. State Mental Health Planning Council (D.C. SMHPC) introduced Mental Health First Aid, an evidence-based public education program about the risk factors and warning signs of mental health problems, their impact, and common treatments as part of the inaugural Judge Aubrey E. Robinson, Jr. Memorial Mental Health Lecture Series. A 4-hour Kick-Off meeting, four (4) community orientation sessions, and two (2) 12-hour Certificate Courses that trained 42 people were conducted during the initial project phase.

In FY 2012, the Department received funding through the State Homeland Security Grant program to expand Mental Health First Aid over the next two (2) fiscal years. The project included training for 30 instructor candidates by the National Council for Community Behavioral Healthcare (National Council), and a series of 12-hour Certificate Courses conducted by the National Council and the newly certified instructors. During FY 2012, there were 28 certified instructors. Manuals were purchased to support the training activities. By the end of FY 2012, a total of 129 persons were trained in the Certificate Program.

During FY 2013 Mental Health First Aid training continued and was supported by several activities.

- The Department Training Institute integrated Mental Health First Aid into its course offerings and coordinates the registration for the Department certified instructors. The Training Institute also assumed responsibility for distributing the manuals to the certified instructors based on confirmation of scheduled courses and trainees.
- The Mental Health First Aid Law Enforcement Customized Version was integrated into the District of Columbia Metropolitan Police Academy curriculum for new recruits. One of the police officers trained as a certified Mental Health First Aid instructor and a Department trained instructor who were both also trained in the law enforcement version, began conducting these trainings.
- One of the certified Mental Health First Aid instructors was instrumental in getting her organization, the Washington Center for Aging Services, to make the training part of their staff orientation.

Some of the trained instructors continued to teach the 12-hour Certificate Program course. At the end of the FY 2013 third quarter, 645 people had been trained. This diverse group of trainees includes Department staff; mental health rehabilitation services providers; Child and Family Services Agency foster parents, social workers and other staff; Washington Center for Aging Services staff; D.C. Metropolitan Police Recruit Classes (Police Version MHFA); It's Getting Better All The Time! Mental Health Outreach; D.C. Recovery Community Alliance staff; Catholic Charities of Washington D.C. Housing Division staff; American Association of Retired Persons (AARP) staff; mental health and other consumers; Howard University and other area university students; security guards; retirees; City Year (educational focus to help keep students in school and on track to succeed); United Planning Organization; faith-based organizations; general community members and others.

Also, during FY 2013 a certified Mental Health First Aid Instructor convened orientation sessions with the District's Risk Management Council and the District Building Emergency Response Team (BERT).

Other FY 2013 activities convened by the National Council include: 1) a Mental Health First Aid Reunion/Summit for certified instructors that included information, certification and teaching notes for the new 8-hour course; and 2) an additional 2.5 days of instruction to further certify 12 certified instructors in Youth Mental Health First Aid.

## **Mental Health Block Grant Sub-Grantee Project:**

Family Voices of the District of Columbia- The C.O.D. Initiative: Public Awareness Education -- Best and Promising Practices for a Stronger System of Care for Children and Youth with Co-Occurring Disorders Project, was a public awareness campaign to promote awareness and education of children and youth with co-occurring disorders and the resources available. It is estimated that approximately 300 families received some form of communication about co-occurring disorders and resources available for parents and children.

## **Criterion 2: Mental Health System Data Epidemiology**

### *Estimates of Need*

District Study Estimates: The study *Behavioral Health in the District of Columbia: Assessing Need and Evaluating the Public System of Care* (RAND 2010) provides prevalence estimates for behavioral health issues by using data from four (4) national surveys: behavioral risk factors; drug use and health; children's health; and youth risk behavior. The study found that the prevalence of mental health conditions in the District resembled national patterns for adults and youth. One exception is that, compared to children nationally, District youth appeared to have a higher percentage of parent reported behavioral problems. The RAND study is discussed in the section on unmet service needs and critical gaps in the current system.

National Study Estimates: The Department has reported in the Block Grant the estimates of the need for mental health services based on the original 1999 and 2003 edition of the *Study of Mental Health Need and Services in the District of Columbia*; conducted by the University of Texas. These estimates are based on the National Co-morbidity Survey (NCS) and related surveys and are projected to the District based on data from the U. S. Census.

The estimates for **Severe Emotional Disturbance (SED)** for all youth, including those in institutions, are:

7.67% (8070 cases) for 1990,
7.46% (9230 cases) for 1999 (projected), and
7.79% (8961 cases) for 2000 (from 2000 Census).

For the household population only, the estimates are:

7.41% (7644 cases) for 1990,
7.33% (8876 cases) for 1999 (projected), and
7.73% (8770 cases) for 2000 (from 2000 Census).

The estimates of **Serious Mental Illness (SMI)** are:

6.43% (32267 cases) for 1990,
5.81% (23020 cases) for 1999 (projected),
6.10% (27889 cases) for 2000 (from the Decennial Census).

For the household population, excluding those in institutions in group quarters, the estimates are:

5.20% for 1990,
5.04 for 1999 (projected), and
5.68 for 2000 (based on the decennial census).

The estimates for **Severe and Persistent Mental Illness (SPMI)** for the total adult population including those institutionalized or in group quarters are:

2.81% (14104 cases) for 1990,
2.60% (10308 cases) for 1999, and
2.73% (12472 cases) for 2000.

For the household population only, the estimates are:

2.27% (10489 cases) for 1990,
2.26% (8304 cases) for 1999, and
2.53% (10772 cases) for 2000 based on the new census.

### SAMHSA Required Measures

The data for the required SAMHSA National Outcome Measures (NOMs) and Uniform Reporting System (URS) tables will be submitted to SAMHSA and the National Research Institute in December 2013, pursuant to the reporting timeframe.

### **Criterion 3: Children's Services**

#### **Children's System of Care Planning Initiatives**

Children's System of Care Plan: A Comprehensive 3-5 Year Plan for Redesign- developed during FY 2010 with an implementation progress report in FY 2012, outlines specific actions to treat more children and youth; intervene at an earlier age; and expand community-based services shown to improve functioning in the family, at school and other interactions. With broad participation by District public and private organizations, community child-serving agencies and others, this planning initiative laid the groundwork for being able to receive a federal System of Care Planning grant.

System of Care Expansion Planning Team- the District of Columbia was awarded a SAMHSA System of Care Expansion Planning Team grant in FY 2012. The grant was administered by the Department's Child and Youth Services Division. It allowed the District to develop an inclusive team of families, child serving agencies, community stakeholders, providers, and advocacy groups to create a Strategic Plan designed to expand and strengthen the System of Care for children and youth with serious emotional disturbance (SED) and their families, or children and

youth at risk of mental health concerns. The Strategic Plan included: 1) development of an inclusive governance structure co-chaired by the Deputy Mayor for Health and Human Services and the Director of the Department of Mental Health; 2) strategies to expand the availability of evidence based practices and other service needs; 3) improved access to behavioral health services; 4) expanded services for transition age youth; and 5) increased community awareness of mental health services and decreased mental health stigma. The Strategic Plan was the basis for the application for a 4-year System of Care Implementation Grant. The Department was successfully awarded this grant beginning in FY 2013.

D.C. Children's System of Care Expansion Implementation Project- In FY 2013, the Department was awarded a 4-year SAMHSA grant to support the expansion and strengthening of the System of Care for children/youth with serious emotional disturbance and their families and children/youth at risk of mental health concerns. It is called the DC Gateway Project. This grant is focused on five (5) primary areas of expansion and strengthening:

1. Improved Access: Access to the right services on a timely basis is critical to an effective System of Care. Toward this end high fidelity wraparound slots are being increased. A universal access form is being developed along with training of community organization intake workers. This form will keep a family from having to tell their story multiple times and will support the linkage of families to a mental health assessment or service regardless of the point of entry.

Expansion of evidence-based practices (EBPs) to address the needs of children and youth is also essential. The Transition to Independence Process (TIP) is an EBP that supports the transition to adulthood for youth ages 16-24 who have mental health concerns. Training has occurred for the initial cohort of mental health providers, CFSA workers and community/parent organizations. The Department is also working closely with CFSA, who received a grant from the Administration for Child Youth and Families (ACYF), to implement Trauma Systems Therapy (TST) across the District. The DC Gateway Project is supporting the training of all Core Service Agency providers (community support workers, therapists, CBI providers) in trauma-informed care.

2. Integration of Primary Health Care and Behavioral Health: A collaborative effort with Children's National Medical Center, Unity Healthcare, Children's Law Center, DHCF, , DOH, the Department and the DC Chapter of the American Academy of Pediatrics is identifying a behavioral health screening instrument(s) to be administered at the time of a Well Child Check. Pediatricians will be trained on this instrument and provided a tool kit on how to access the appropriate services and receive consultation as needed.
3. Peer Support: Research has shown that support and service provided by a person with "lived experience" has a positive impact. A curriculum and training program is being developed to train parents as support specialists and in the future a similar program for youth to support youth will be developed. With this certification training program, some services provided by the Peer Support Specialist can be Medicaid reimbursable.
4. Functional Assessment: The Child and Adolescent Functional Assessment Scale (CAFAS) is being implemented across the District including the Department, CFSA,

DYRS, DHS, and the schools (OSSE, DCPS, and DC Public Charter Schools). This assessment provides the information necessary to know whether an intervention (s) or service is making a positive impact on a child's functioning in various life domains. This instrument will provide data that can be used to support an individual youth or family, a provider, a particular intervention strategy or a system wide analysis. The CAFAS data will be made available to each child serving system providing service to the youth to support cross system communication and collaboration.

5. Reinvestment: It is essential to identify from the beginning ways to sustain SOC services after the grant is ended. Toward that end a reinvestment plan is being developed that will reinvest savings from a decreased use of "high end" services into community based services that supports maintaining youth in their home and community. The initial focus is on decreasing the use of non-public schools and reintegrating youth currently in non-public settings back into their home school.

A sixth area of focus is Social Marketing. Community oriented events, social media, and outreach in the schools will focus on decreasing mental health stigma and increasing awareness of mental health needs and services. Toward this end, Youth Mental Health First Aid training is being provided to community organizations, family members and child serving DC agencies to increase awareness of youth mental health needs and increase the community's comfort and skill in engaging youth

### **Early Childhood Prevention and Intervention Projects**

Healthy Start Project- This project is a collaboration between the Department of Health, Maternal and Family Health Administration Healthy Start Program and the Department's Child and Youth Services Division. The purpose of the project is to: 1) provide needed health and mental health services to pregnant women; 2) reduce infant mortality; and 3) remove barriers to accessing quality health and mental health services for District high risk populations in Wards 5, 6, 7, and 8. The staff perform a diagnostic assessment with the women/mothers. The needs of the children are assessed on an ongoing basis through: observation, assessment and evaluation of the mother-child dyad, and bonding and attachment. The Department services include: 1) an extensive home visit component to work with parents in their natural environment; 2) individual and family therapy; 3) parenting psychoeducational groups; 4) referral and linkage to community-based programs for services as needed; 5) initial assessment and ongoing review of infant's developmental progress; and 6) psychiatric services including medication management and monitoring.

The data for the Healthy Start Program measures for the FY 2013 third quarter includes the following: 1) 19 new admissions; 2) 40 children/infants seen; 3) 159 home visits ; 4) 192 office visits; and 5) 2 psychiatric hospitalizations.

Parent Infant Early Childhood Enhancement Program (P.I.E.C.E.) – Early Intervention and Treatment- This Department program provides culturally competent community-based mental health services to infants, toddlers, preschool, and school age children (ages 6 and under), that are responsive to individual family needs. The target group includes children with significant emotional/behavioral concerns who are often disruptive in pre-school, early school or home

settings. The program provides comprehensive assessments and relies heavily on parental involvement in understanding and learning to manage disruptive child behaviors. The goal is to encourage optimal health and wellness by intervening early with comprehensive services designed to prevent emotional problems and/or reduce stressors within the parent(s) and family from adversely affecting the developing child. The program capacity is 120. The clinical services provided include: assessment/diagnosis; individual psychotherapy; group-parent psycho-educational and child behavior management groups; family therapy; art/play therapy; developmental/social emotional screenings; crisis intervention; psychological evaluations (only after admission and indicated need); and medication management (through the Department's Physicians' Practice Group). The assessment tools include: Children's Behavior Checklist, and Ages and Stages Questionnaire 3 (cognitive), and SE (social/emotional). The evidence-based practices include: 1) Parent Child Interaction Therapy (PCIT), 12 weeks- parent child observational training, and 2) Incredible Years, 22-weeks and will involve one (1) parent group.

The data for the P.I.E.C.E. program measures for the FY 2013 third quarter include the following: 1) 65 new admissions; 2) 115 active cases; 3) 364 individual sessions; 4) 853 family sessions; and 5) 16 home/school visits.

Early Childhood Mental Health Consultation Project (Healthy Futures)- This project began in May 2010 and involves child and family-centered program consultation for children age 0-5. In FY 2013, Healthy Futures was in 25 child development centers (CDCs) throughout the District. One (1) early childhood mental health specialist is placed in each child development center one (1) day per week to help identify children who need mental health interventions.

At the end of February 2013, the achievements included:

- 25 CDCs entered into agreements to receive Early Childhood Mental Health Consultation services through Project LAUNCH/Healthy Futures Program.
- 51 children were formally referred for child-specific consultation services.
- The Mental Health Consultants were providing programmatic consultation in 31 classrooms and partnered with classroom teachers to create classroom plans outlining specific goals and objectives.
- The Mental Health Consultants conducted 31 presentations to CDC staff and parents on social-emotional/behavioral health.
- 327 CDC staff received continuing education units from the training conducted by Mental Health Consultants.
- 198 observations were conducted by the Mental Health Consultants in the CDCs.
- 719 consultations were conducted with teachers in the CDCs by the Mental Health Consultants.
- 311 consultations were conducted with directors in the CDCs by the Mental Health Consultants.

Primary Project in the Child Development Centers and Community Schools- This Department project is an evidence-based, early intervention and prevention program for children ages pre-kindergarten through third grade who are demonstrating mild adjustment problems in the classroom. One-to-one, non-directive play sessions are provided to children at school by trained paraprofessionals under the supervision of the Primary Project Program Manager. Additionally,

all sites provide a continuum of service for children who screen positive for mental health services, as a mental health referral process is in place to meet their needs. Children who screen positive for mental health services are referred by the Primary Project Program Manager to the School Mental Health Program (SMHP) Supervisors/Program Manager for dissemination of a Mental Health Referral. Early Childhood Consultants (Healthy Futures) receive mental health referrals for children in the child development centers who screen positive for mental health services. SMHP clinicians receive mental health referrals for children in the schools who screen positive for mental health services. The Primary Project program data for School Year (SY) 2012-2013 through the end of March 2013 provide the following information: 1) 17 school sites; 2) 35 child development centers; 3) 2,664 teacher-child rating scale screenings; 4) 1,363 mental health intervention /positive for services; 5) 320 Primary Project service participations; and 6) 784 mental health referrals processed.

School Mental Health Program (SMHP)- In SY 12-13 the Department's SMHP provided services to 52 schools, 40 D.C. Public Schools and 12 Public Charter Schools. The program consists of 34 Tier 1 and 18 Tier 2 schools. The Department received funding to increase its program for SY 13-14 to an additional 19 schools.

The SMHP promotes social and emotional development and addresses psychosocial and mental health problems that become barriers to learning by providing prevention, early intervention, and treatment services to youth, families, teachers and school staff, as described below.

Primary Prevention (also known as Universal Prevention Services)- available to entire student body, school staff, or parents/guardians (depending on the target audience for a particular intervention). The aim is to prevent the development of serious mental health problems and to promote positive development among children and youth. Program examples include: staff professional development, mental health educational workshops for parents/guardians, school staff, or students, and evidence-based or informed school-wide or classroom-based sexual abuse prevention and violence prevention programs.

Early Intervention (also known as Secondary, Selective Prevention or Targeted Services)- students identified at elevated risk for developing a mental health problem are offered one (1) of a number of early intervention services. The aim is to prevent the escalation of identified risks and development of more serious mental health problems. These interventions could include: involvement in support groups, skill building groups, and training or consultation for families and teachers who work with identified children.

Treatment Services (also known as Tertiary Prevention or Indicated Prevention Services)- students in the general education population with an identified mental health concern resulting in disruption of academic and/or social-emotional functioning are offered a number of treatment services. The aim is to minimize the impact of the problem and help restore the child or adolescent to a higher level of functioning. Examples of these clinical services include: individual and family counseling, and therapeutic groups (e.g., grief and loss groups). Students needing more intensive services may be referred for community mental health services.

**Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)**



The former D.C. Community Services Agency (DC CSA) operated two (2) psychoeducational programs with support from the D.C. Public Schools. They included: 1) the Therapeutic Nursery served children ages 3-5, and 2) the Psychoeducation Program served children ages 6-12. These programs were transferred to the Child and Youth Services Division in FY 2010; however they ended by June 2010.

### **Wraparound Initiative**

This is a family-driven, team-based process for planning and implementing services and supports. Through the Wraparound process, Child and Family Teams create plans that are geared toward meeting the unique and holistic needs of children and youth with complex needs and their families. It is an effort to address the overreliance on the use of psychiatric residential treatment facilities (PRTFs) and non-public school placements for treatment and/or education of youth with intense mental, emotional, or behavioral health needs.

This initiative is a collaboration between the Department and District child-serving agencies that began with the care management contract to DC Choices in June 2008. The purpose of the contract is to implement community-based alternative services for District youth at risk for or returning from an out-of-home (PRTF) placement and for youth who have experienced multiple placements and/or hospitalizations.

During the FY 2013 first quarter, the contracts with DC Choices and the Collaborative Council were increased to accommodate a 20% increase. DC Choices was increased by 20 additional slots and the Collaborative Council by 10. The capacity may be increased again to ensure availability of wraparound at any given time.

In January 2013, the Department began bimonthly joint meetings with the Child and Family Services Agency (CFSA) and the Department of Youth Rehabilitation Services (DYRS) to discuss the needs of children and families referred for wraparound and to address any barriers that negatively impact the outcomes of those served.

The number of referrals for Wraparound continued to grow throughout FY 2013. The referral sources included CFSA, DYRS, Health Services for Children with Special Needs (HSCSN), and Court Social Services, and other community partners. At the end of the FY 2013 third quarter, 264 children and families were involved in Wraparound. This number included 142 through the schools and 122 through the community. The goal for FY 2013 is to involve 338 children and families in Wraparound.

### **Establishing a Primary Family-Run Organization**

Total Family Care Coalition (TFCC) has been awarded the contract as the lead family organization to support the implementation of the System of Care (SOC) Expansion Implementation grant awarded by SAMHSA. As the lead family organization, TFCC ensures that family members participate in all decision making, planning, and implementation of SOC initiatives. TFCC also ensures family participation in community events, educational programs, forums, etc. The contract includes the hiring of a Family Engagement Specialist/Trainer who engages a diverse group of parents and provides ongoing training and support to family and

youth participants including a monthly family forum. TFCC is actively engaged in the development of the curriculum and training for parent to parent peer support and will be similarly involved in the development of a youth to youth peer support program. The contract also includes the hiring a Youth Development Lead who engages a diverse group of youth, provides training and support to youth, and organizes and develops a YouthMove chapter. TFCC is involved in the various social marketing activities including co-facilitation of Youth Mental Health First Aid classes.

### **Residential Treatment Center Reinvestment Program (RTCRP)**

The RTCRP conducts clinical monitoring for District children and youth placed in Psychiatric Residential Treatment Facilities (PRTFs), which includes children and youth placed by the Child and Family Services Agency (CFSA) or any other fee-for-service Medicaid placements who have been referred by the District's PRTF Review Committee. The Committee determines medical necessity for all PRTF placements funded by fee-for-service Medicaid, including the continued need determinations for those children originally placed by Medicaid MCOs. Since February 2010 the Department has been monitoring all MCO children and youth upon their placement in PRTFs for whom the Committee determined met medical need. RTCRP primary activities include: 1) assure that each PRTF's clinical program adequately meets the psychiatric and behavioral needs of each child/youth; 2) assure appropriate and adequate lengths of stay through the monitoring of medical necessity for continued stay; 3) participate in discharge planning and working collaboratively with CFSA for their placements and other District agencies (i.e., Department of Youth Rehabilitation Services) as appropriate to assure services are in place upon discharge; and 4) monitor discharged youth for at least 6 months after discharge to support the child/youth's successful reintegration into the community. This has led to a decrease in the number of children and youth in PRTFs from 240 for the Dixon Baseline year (May 1, 2011 – April 30, 2012) to 164 (May 1, 2012 – April 30, 2013).

### **Child Choice Providers**

The Department continues to support the concept of a small cadre of Child Choice Providers. This network consists six (6) child/youth-serving core service agencies (CSAs): 1) Community Connections; 2) Family Matters; 3) First Home Care; 4) Hillcrest Children and Family Center; 5) MD Family Resources; and 6) Universal HealthCare. The services provided include timely diagnostic, clinical and support services for children/youth in the care and custody of the Child and Family Services Agency (CFSA) to ensure placement stability and to promote permanency. The Department's Child and Youth Services Division tracks and closely monitors the data on all CFSA youth referred to receive mental health services. CFSA continued to provide funding to support the Child Choice Provider program in FY 2013. The third quarter FY 2013 program data shows that there were: 1) 312 children/youth were referred and received mental health diagnostic assessment and treatment; 2) 244 (78%) were referred to a Child Choice Provider CSA; and 3) 68 (22%) were linked to a non- Child Choice Provider CSA.

### **Child and Youth Mobile Crisis Services**

The Children and Adolescent Mobile Psychiatric Service (ChAMPS) is operated via a contract with Anchor Mental Health of Catholic Charities. It provides immediate access to mental health

services for children and youth in crisis. The goal is to stabilize them within their homes or the community and avert inpatient hospitalization and placement disruptions. They are also linked to a Department mental health provider for ongoing treatment at an appropriate level of care after the crisis is stabilized. Services are geared toward children and youth 6-21 years of age. Those served ages 18-21 are committed to CFSA. The FY 2013 program data shows that there were: 1) 988 total calls; 2) 527 deployable calls; 3) 505 deployments; and 4) 395 unduplicated persons served.

### **Juvenile Behavioral Diversion Program (JBDP)**

In January 2011 the Superior Court of the District of Columbia created a Juvenile Behavioral Diversion Program (JBDP). The partner agencies include: 1) Family Court; 2) Court Social Services; 3) Department of Mental Health; 4) Office of the Attorney General; 5) Public Defender Service; and 6) multiple core service agencies (CSAs). The Family Court's Child Guidance Clinic's research lab examined data generated by JBDP participants for clues regarding the program's effectiveness over the last 2 years. This analysis focused on: 1) JBDP demographic information; 2) reliability and validity study of the Conners Comprehensive Behavior Rating Scales-Self Report in Juvenile Offenders; 3) recidivism study; and 4) ecological study ((family functioning, school experience, peers/friendship, leisure time use, attachment, community disorganization).

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

**Rural:** The District of Columbia is urban and does not include any rural areas. Therefore, there are no services targeted to rural populations.

**District of Columbia Homeless Services Initiatives:** The Department of Human Services (DHS) is the lead agency responsible for the coordination of homeless services in the District, and its policy is informed by the Interagency Council on Homelessness. DHS contracts with The Community Partnership for the Prevention of Homelessness (TCP), an independent non-profit corporation to administer the District's Continuum of Care services funded through the U.S. Department of Housing and Urban Development (HUD) on behalf of the city. The Department's Homeless Services Program works very closely with TCP.

**2013 Point in Time Study-** TCP conducted the 2013 Point in Time (PIT) census and survey of persons who are homeless in the District on January 31, 2013. The PIT is conducted in accordance with HUD reporting standards. This single day snapshot of the homeless services Continuum of Care (CoC) helps TCP and District government agencies identify gaps in the current portfolio of services and inform future program planning. TCP has completed the PIT annually since 2001.

A summary of the data from the 2013 PIT Survey provides the following profile of homelessness in the District of Columbia.

- 6,865 persons who were homeless were counted including:
  - 512 unsheltered persons (i.e. persons "on the street"),
  - 4,010 persons in Emergency Shelters, and
  - 2,343 persons in Transitional Housing facilities.
- The number of persons counted during 2013 PIT decreased by 1.4% from the PIT 2012.

- The number of unaccompanied individuals who are homeless decreased by 1.9% from 2012.
- The number of families decreased by 3.1% but due to the demand for shelter among larger families, the number of persons in families decreased by just 0.6%.
- This was the second time since 2001 that an overall, year-to-year decrease has been recorded during the District's Point in Time count.
- The number of unaccompanied persons who are homeless has decreased each year since 2010 though the number of families increased by 18% between 2011 and 2012.
- The Community Partnership credits the decreases seen in the 2013 count to the CoC's investment in Homelessness Prevention, Rapid Re-Housing and Permanent Supportive Housing resources.
- The count of unaccompanied persons now in Permanent Supportive Housing (PSH) has grown by 21% in the last year, and the count of families formerly homeless in PSH has increased by 9%.
- To date, 643 families and 762 unaccompanied persons are stably housed due to Prevention and Rapid Re-Housing programs funded by the District Department of Human Services, HUD and the Department of Veterans Affairs. These individuals and families were either homeless or would have become homeless if this assistance was not available.
- 1,764 of the unaccompanied persons and 83 adults in families assessed met HUD's definition of "chronic homelessness" – living with a disabling condition while being homeless for more than a year or four (4) times in 3 years.
- The median age of unaccompanied persons who are homeless was 51 years while the median age among adults in families that are homeless was 28.
- Six (6) unaccompanied minor children were counted in shelter and transitional housing; this was down from 13 counted during 2012 PIT and 26 counted in 2011.
- 1,868 children in families were residing with their parents in family programs, which is consistent with the 2012 count of 1,880.
- There were no unsheltered minor children or unsheltered families.
- 12% of adults surveyed who are homeless reported having served in the United States Armed Forces.
- 45% of unaccompanied adults who are homeless and 18% of adults in families reported that they have no income.
- 23% of adults surveyed who are homeless have histories of substance abuse or mental illness; one in 10 reported living with both conditions.
- 10% of adults who are homeless reported a chronic health problem, and 18% reported a physical disability.
- 15% of adults who are homeless reported they had histories of domestic violence, with 3% stating that domestic violence had directly caused their homelessness.

Permanent Supportive Housing Plan (Housing First)- The District of Columbia embraced the Permanent Supportive Housing (PSH) initiative to end chronic homelessness, and toward this end, DHS was charged with implementing a person-centric approach to implement this policy. Permanent supportive housing is a "housing first" approach and is defined as long-term, community-based housing that has supportive services for homeless persons with disabilities. The District's mental health consumers were also beneficiaries of this PSH initiative.

HUD and Department of Veterans Affairs (VA) Supportive Housing (HUD-VASH) Program- In 2008, HUD-VASH began a cooperative partnership that provides long-term case management, supportive services and permanent housing to vulnerable veterans who are homeless. The District effort is led by DHS. In 2009 the DHS program was awarded 205 vouchers. The VASH-Plus approach customized the process to reduce the wait times for being housed, bringing it in line with the housing first model. All of the vouchers have been awarded and any new vouchers are subject to the federal government budget decisions.

One of the mental health rehabilitation services providers, Pathways To Housing contracted with the VA to provide 50 vouchers for veterans who are homeless. The Department's Homeless Outreach Program (HOP) continues to refer veterans for housing vouchers via this program.

**Homeless Services:** The HOP engages consumers who are homeless with mental illness, and provides temporary care management to these individuals as they are linked to services provided by core service agencies (CSAs) and other community resources. All consumers served are homeless, either living in temporary shelters, on the streets, under bridges, abandoned dwellings and vehicles, or at high risk of becoming homeless.

The HOP community-based services include: engagement; assessment; crisis intervention; linkage to services; care coordination and follow-up; community consultation and education; and traveler's assistance. HOP provides outreach to individuals and families living on the streets and in both single adult and family shelters. Staff also advise and provide technical assistance and training to community providers that are unfamiliar or do not regularly work with the homeless population.

Services for Children/Youth and Families- HOP staff continues to make weekly outreach visits (or more often as needed) to all the family shelters including DC General Shelter (primary emergency shelter for families), Naylor Road (transitional family shelter), Park Road (transitional family shelter), Girard Street (transitional family shelter), and Spring Road (transitional family shelter). During these outreach visits, HOP staff provide the following services: 1) engagement, assessments, referrals to CSA or assertive community treatment (ACT) teams (usually by calling Access HelpLine and assisting with transportation to intake appointments); 2) crisis intervention, coordinating care with CSAs, schools, and other service providers; and 3) facilitate case conferences to develop treatment plans with multiple providers. Services are provided for the individual children and/or adults, or the family as a whole. HOP receives referrals from the Virginia Williams Family Resource Center where families go for initial intake into the family shelter system. HOP has also responded to referrals from DHS for families who are placed in hotels while they are awaiting placement at a family shelter. The FY 2013 program data shows that the unduplicated individuals who had been seen included: 1) 695 single adults; 2) 111 adult families; and 3) 89 families with children.

Role of Psychiatry Residents- Beginning in July of each year, psychiatry residents from Saint Elizabeths Hospital start a community psychiatry rotation. All the psychiatry residents complete a 12-week course curriculum to help them become more familiar with the mental health needs of persons who are homeless and the unique challenges of working with this population. The curriculum was designed by a former HOP staff member and the Comprehensive Psychiatric Emergency Program (CPEP) Medical Director. In July 2013, the HOP Supervisory Mental Health Specialist assumed a primary role in facilitating the course along with the CPEP Medical

Director and other guest presenters. In addition to the course, each resident will complete a quarterly rotation in the field. Typically, this involves the Psychiatry Resident (usually two (2) per quarter) serving at two (2) field sites: 1) a fixed site such as a drop-in center or a shelter; and 2) a site with a street outreach team as they conduct assessments wherever the client is (park bench, alleyway, etc.). Psychiatry Residents provide a range of services including diagnostic assessments, crisis intervention, case formulation/consultation, and other services such as letters to support client's claim for Social Security Disability. HOP also utilizes psychiatrists participating in the Forensic Fellows Program (supervised by the Department Chief Clinical Officer). These psychiatrists are typically already board certified, so in addition to the aforementioned services, the Forensic Fellows can also provide capacity assessments and court testimony for cases when HOP is seeking guardianship for consumers who are not able to adequately take care of their needs.

Hermano Pedro Day Socialization Program- The contractual period for this program was December 2007 through March 2013. It provided a drop in center service for individuals who are homeless to attend during the day when many night shelters are closed. It was designed to offer hospitality services such as laundry facilities, lockers, showers, clothing, breakfast, lunch, service referrals and socialization activities. The referrals included: food stamps; Medicaid; disability benefits; housing referrals; employment and GED; and linking individuals to mental health, health, and substance abuse services. In addition, the program provided counseling, transportation assistance, and socialization groups (anger management, addictions), and social activities (movies, etc.).

HOP Partnerships- HOP has a number of partnerships with District, local and federal organizations. These include but are not limited to the following:

- Addiction Prevention Recovery Administration (APRA)- HOP staff routinely referred consumers who are homeless in need of substance abuse treatment and services to APRA. HOP staff also provided mental health assessments for consumers who are homeless upon request by APRA staff. APRA and DMH will merge on October 1, 2013.
- Department of Human Services (DHS)- HOP staff complete vulnerability index surveys for consumers who are homeless in need of housing. Completed surveys are sent to DHS and the consumers may receive a housing voucher based on need (as scored on vulnerability survey) and availability of vouchers. If selected to receive a voucher, HOP works with DHS staff to coordinate this process (i.e. may provide consumer with transportation to view available units and/or assist in procuring necessary ID/paperwork). HOP will provide support throughout the transition to housing. HOP staff will also refer families who are homeless in need of shelter to the Virginia Williams Family Resource Center, and has provided mental health assessments and crisis intervention upon request for families at this Center.
- D.C. Metropolitan Police Department (MPD)- HOP staff participate in the Crisis Intervention Officers (CIO) training through an educational session on homelessness and services offered by the Department. The staff regularly request CIOs to partner with them and assist in responding to crisis situations, primarily FD-12s (involuntary

hospitalizations). MPD officers contact HOP regularly with referrals for consumers who are homeless they encounter in need of mental health assessment or supportive services.

- Fire and Emergency Medical Services (FEMS)- HOP staff partner with the Street Calls Unit to focus on consumers who are homeless and are high utilizers of 911 and emergency services. HOP staff also use FEMS to provide acute care or assess the severity of medically compromised individuals who are homeless and often refuse to seek treatment at a clinic or emergency room (ER).
- Office of the Attorney General (OAG)- HOP staff work with OAG on issues related to FD-12s, committed outpatient status (CMOP), and applications for guardianship when consumers who are homeless may no longer be able to provide adequate self-care and may need a guardian to assist in making decisions about their care.
- Office of the Chief Medical Examiner (OCME)- HOP staff assist in identifying consumers who are homeless and providing next of kin information.
- Executive Office of the Mayor (EOM)- HOP staff receive referrals regarding specific individuals from EOM and provides mental health assessments, linkage to services, crisis intervention, and/or care coordination (if consumer is within DBH system). As part of the District's "Homeless Protocol" to address situations where individuals who are homeless have established encampments on City owned land, HOP works with EOM to provide outreach and mental health support. Other agencies involved in the Homeless Protocol include human services, police, transportation, public works, and health.
- District of Columbia Council- HOP staff receive referrals regarding specific individuals from Councilmember's offices and provide mental health assessments, linkage to services, crisis intervention, and/or care coordination (if the consumer is within the Department).
- Veterans Administration (VA) - HOP staff work with the VA Hospital and the recently opened Community Resource and Referral Center (CRCC) to connect veterans who are homeless with services, primarily VASH housing vouchers, medical/mental health care, employment assistance, and substance abuse treatment. HOP attends the bi-monthly meeting of the VA Homeless Services Steering Committee. An outreach Social Worker from CRCC has attended HOP Emergency Rounds meetings where the most high risk clients living on the streets are discussed. HOP has been able to refer several cases to the outreach Social Worker who has been able to meet clients in the field, which is an area where the VA had been lacking.

### **Older Adult Initiatives**

Older Adult Needs and Service Transition Issues: The National Association of State Mental Health Program Directors, through its SAMHSA contract, coordinated technical assistance services on older adult issues for the Department with Dr. Stephen J. Bartels, a nationally

recognized geriatric psychiatrist, and Director of the Dartmouth Centers for Health and Aging. On August 24, 2012, Dr. Bartels facilitated a half day meeting to discuss the needs, strengths, challenges and opportunities for effective intervention with older adults in general, and a specific focus on service transition issues involving nursing homes. He presented some of his research and model on core principles for skills teaching, which has been successful in diverting individuals from nursing home care. The meeting participants included the Department Director and program staff, mental health advisory councils, the District’s federal Project Officer for the Mental Health Block Grant, long-term care advocates, and other District agencies.

The Department Director requested that Dr. Bartels conduct a second presentation and co-facilitate the discussion with the District inter-agency committee charged with developing a plan to address the issues raised in the *Thorpe vs. The District of Columbia Olmstead Case*. The plan focuses on supports and services necessary to enable disabled persons living in nursing home facilities to transition to integrated, community-based settings. This half-day meeting was convened on October 18, 2012.

**Older Adult Day Services Program:** In March 2013, the Department continued the technical assistance relationship with Dr. Bartels to explore developing an Older Adult Day Services Program. Two (2) models were discussed: 1) an outreach model, and 2) a skills training model. Dr. Bartels assisted the Department staff with scheduling a site visit to a program that was implementing aspects of the models discussed. On June 13, 2013 the Department Senior Deputy Director and the Adult Services Director visited the Boston VINFEN Corporation, lead organization for the Center for Medicare and Medicaid Innovation (CMMI) grant. They were able to discuss with leadership and management various aspects of program operations and implementation.

The Department staff determined that the next step would involve a review of the overall Day Treatment Service programs. An on-site technical consultation with Dr. Bartels was scheduled for August 22-23, 2013. The first day involved site visits to the day treatment facilities. On the second day, Dr. Bartels facilitated a meeting with providers to discuss: 1) positive aspects of program service delivery; 2) areas for improvement in program service delivery; and 3) curricula and/or other things that might be helpful for the programs. The day ended with a meeting with the Department Director.

**Criterion 5: Management Systems**

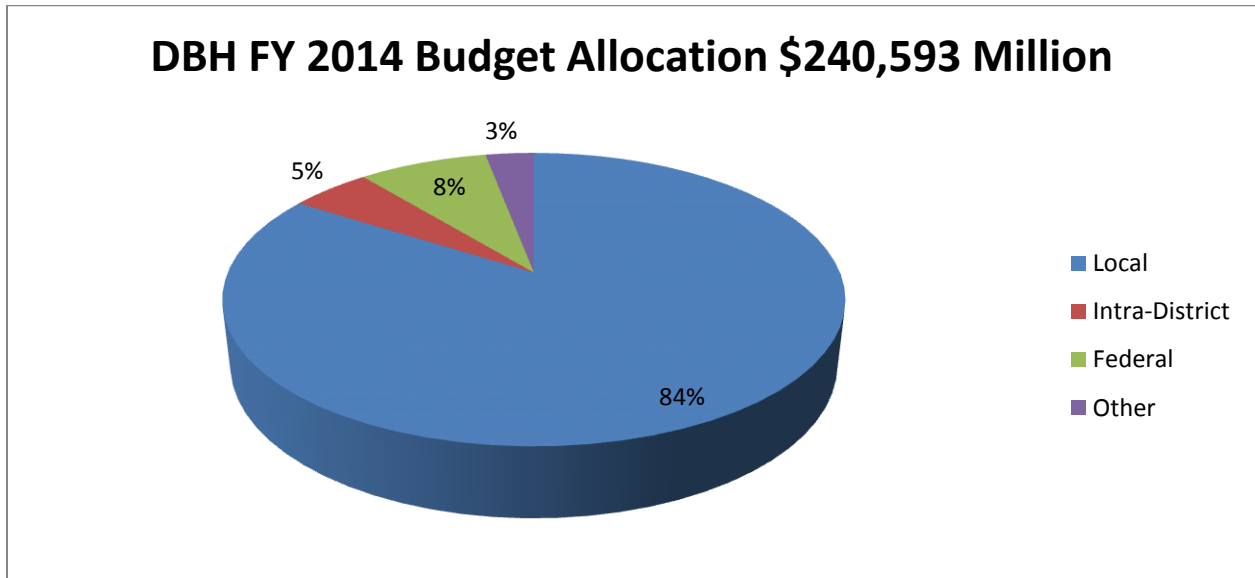
**Financial Resources:** The District of Columbia’s approved fiscal year 2014 Program budget for the Department of Behavioral Health is \$238,989 million dollars. The breakdown of the FY2014 Budget by program category for DBH is as follows:

Mental Health Authority	\$23,464	(10%)
Mental Health Financing/Fee for Services	\$29,294	(12%)
Mental Health Services & Supports	\$62,991	(26%)
Saint Elizabeth’s Hospital	\$83,809	(35%)
Addiction Prevention & Recovery Administration	\$39,431	(17%)

**Total Fiscal Year 2014 DBH Program Budget** **\$238,989**  
(Dollars in millions)

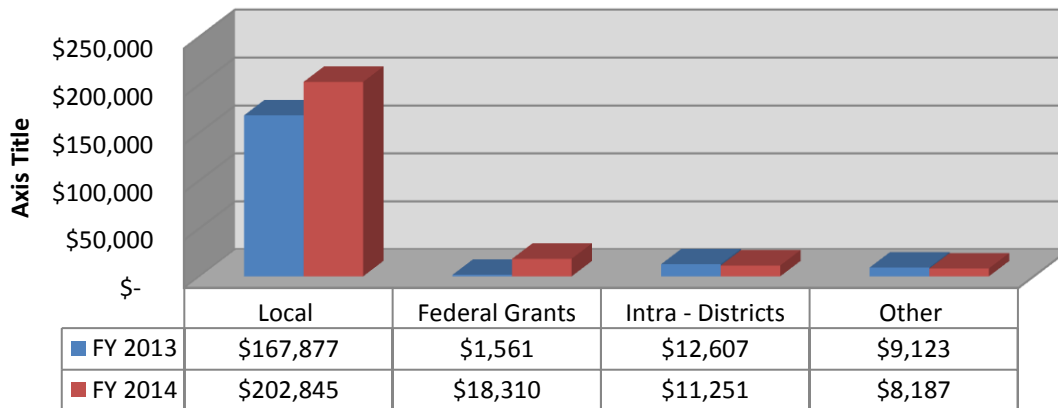


Revenue to support the budget comes from four major revenue sources. DBH's **Local** funds are the largest funding source, and accounts for \$202,845 million or 84% of the FY 2014 Budget.



DBH's fiscal year 2014 budget also has \$11,251 or 5% in **Intra-Districts**. The **Federal** funds cover \$18,310 or 8% of the budget and **Special Purpose Revenue funds/other** total \$8,187 or 3% of the FY 2014 budget.

**DBH**  
**FY 2013 vs. FY 2014**  
**Budget Comparison**  
(Dollars in Millions)



**Information Technology Resources:** The Department continues to invest in systems that facilitate its role as manager of the public mental health service delivery network, which includes being both a provider and purchaser of services. During FY 2013, the Department continued to focus on planning and development activities related to implementation of the Integrated Care Applications Management System (iCAMS). This system is expected to come online by the end of FY 2014.

**Staffing Resources:** The total number of Department staff as of August 2013 is 1,157. This includes: 1) Mental Health Authority (372), and 2) Saint Elizabeths Hospital (789).

**Filling Vacancies in FY 2013:** Critical vacancies/positions filled during FY 2013 included the following:

- Deputy Director for Office of Strategic Planning, Policy & Evaluation
- Director of Organizational Development
- Program Manager
- Program Analyst
- Program Support Assistant
- Home & Community Based Services Coordinator
- Mental Health Counselor
- Health Systems Specialist
- System of Care Interagency Coordinator
- System of Care Marketing Specialist
- Information Technology Project Manager
- Information Technology Specialist (INET)

- Contract Specialists
- Social Workers
- Medical Officers (Psychiatry)
- Assistant Chief Nursing Executive
- Nurse
- Nurse Consultant
- Nurse Practitioners
- Supervisory Psychiatric Nurses
- Psychiatric Nurses
- Clinical Psychologists
- Director of Hospital Operations
- Chaplain Resident
- Chaplain
- Supervisory Dietitian
- Recovery Assistants
- Reimbursement Specialist

**Human Resources Activities in FY 2013:** A number of significant human resource development activities were undertaken during FY 2013. These include:

- Conducted Benefits Entitlement and Information Sessions for employees
- In conjunction with the D.C. Office of Labor Relations, engaged in bargaining with four (4) unions for re-openers of contracts
- Management of the Mandatory Drug and Alcohol Testing Program for employees serving children and youth
- Management of retroactive payment for Recovery Assistant Positions
- Implemented Drug and Alcohol Testing for CDL Drivers
- Reviewed Departmental policies for Human Resources impact and revised as necessary
- Completed the Identification/Notification of Emergency and Essential Employees
- Completed required Human Resources Reports on the Voluntary Leave Transfer and Leave Bank Programs for DCHR
- Coordinated the Director's Annual Employee Recognition Program
- Coordinated mandated Ethics Training and Pledge for employees
- Coordinated Supervisory Training on the Family and Medical Leave Act
- Conduct ARPP/DEP regulatory activities
- Continue recruitment for identified key/critical positions including Manage the completion of the e-Performance cycle for employees
- Continue Random and Periodic Drug and Alcohol Testing
- Continue to actively participate in the District's Classification and Compensation Reform Project
- Manage Mayor's 2013 Summer Youth Program for the Department
- Continue and expand the number of Criminal Background and Traffic Records Checks for employees
- Manage the completion of required Telecommuting Agreements consistent with District policies

- Actively participate in the establishment of the new Department of Behavioral Health, which realigns staff from the Department of Health/Additional Prevention and Recovery Administration with the Department of Mental Health

**Training Mental Health Service Providers:** The Department’s Training Institute has evolved into a primary mental health workforce development training and community education medium for District agencies, human services providers, consumers, family members, and community residents. The Institute’s training series provides a wealth of information on a range of topics. Over the years, partnerships have been established with consumer, family member, community, academic, professional, and federal and local government agencies. An important feature of the Training Institute is the award of continuing education credits (CEUs) for several disciplines. A list of some of the course offerings for the past several years include:

Service Providers of Emergency Health Services

Disaster Certification Training- The Training Institute coordinates a Disaster Mental Health Certification that includes a series of nine (9) core and seven (7) elective courses. It is offered on an ongoing basis.

Core Courses:

- All Hazards Disaster Behavioral Mental Health
- Psychological First Aid
- Traumatic Loss & Grief
- Ethics in Disaster Behavioral Mental Health Services
- Behavioral Mental Health Rapid Assessment and Triage: PsySTART
- Children and Disasters
- Resilience for Disaster Mental Health Responders

Elective Courses:

- Department COOP/ Department Disaster Mental Health Response Plan and Roles
- Crisis Leadership and Risk Communication
- Mental Health & Co-Occurring Disorders
- Empowering Interactions in Emergencies and Disasters
- Chemical and Biological Threats
- Family Assistance Centers and Mass Casualties
- Advanced Trauma/CCP Program

Crisis Intervention Officer (CIO) Training- At the heart of the CIO initiative is the identification and development of experienced patrol officers to develop their skills to effectively and appropriately interact with persons who experience mental illness; as well as to work with other mental health and community support services to facilitate appropriate interactions and referrals with this population. A key component of the CIO Initiative is the 40-hour training program for law enforcement officers. This training includes: 1) basic information about mental illnesses and how to recognize them; 2) the local mental health system and local laws; 3) learning first-hand

from consumers and family members about their experiences; and 4) verbal de-escalation training, and role-plays.

The Training Institute also coordinates mental health crisis training for all police cadets enrolled in the District of Columbia Metropolitan Police Academy. The Department delivers training in basic mental health disorders, community mental health resources and the management of psychiatric crisis including legal issues surrounding involuntary hospitalization and the rights of consumers.

Conflict/Crisis Management:

- Advanced Conflict Management in Mental Healthcare: Sessions 1-3
- Conflict Management and Coaching for Mental Health Providers
- Nonviolent Crisis Intervention (NCI)
- Confidentiality, Duty to Warn and Duty to Protect
- Officer Agent Certification
- Safety and Home Visits

Suicide Prevention:

- Applied Suicide Intervention Skills Training (ASIST)
- More Than Sad: Suicide Prevention Education for Teachers and Other School Personnel
- Question, Persuade, and Refer (QPR): Instructor Training
- safeTALK: Suicide Alertness for Everyone
- Suicide Prevention: Question, Persuade and Refer (QPR)

Mental Health and Substance Use Disorder (Co-Occurring Disorders): The Training Institute sponsors an 18-module Co-Occurring Disorders Certification each year. The following courses are included in the certification:

- Introduction to Co-Occurring Disorders (COD)
- Principles of Integrated Treatment
- Mental Health and Substance Use Disorders: A Common Vocabulary
- Drugs of Abuse
- Stages of Change
- Motivational Enhancement
- Psychotic Disorders and COD
- Mood Disorders and COD
- Trauma and COD
- Screening for COD
- Assessment of COD
- Treatment Planning
- Psychopharmacology for COD
- Cognitive Behavioral Therapy & Relapse Prevention
- Contingency Management, Case Management
- Skills Training in the Treatment of COD
- Group Approaches
- Special Populations

#### Assessment/Case Management:

- Clinical Case Formulation: The Bridge from Assessment to Intervention Planning
- Level of Care Utilization System (LOCUS) Instructor Training
- Mental Health Diagnoses and Medications
- Mental Health First Aid
- Clinical Documentation: What is Community Support and How to Document it?
- Five Key Elements of Mental Health Practice

#### Cultural Issues:

- “Let’s Get in Rhythm Together”: A Workshop on Cultural Competence for Frontline Practitioners
- A Potential Explosion or An Explosion of Potential?: Working with the Latino Community
- CBI II and III: Cultural Competency & Strength-Based Engagement; Parenting Youth with Serious Emotional Disabilities From a Resiliency Perspective
- Cultural Competence for Frontline Staff: Music and Storytelling
- The Complexity, Value and Operationalization of Cultural and Linguistic Competence

#### Evidence-Based Practices:

- Assertive Community Treatment: Core Training
- Assertive Community Treatment: Practical Skills and Resources for Working in the Field
- Child and Family Services Agency Evidence-Based Practice In-Service Workshop
- Child Parent Psychotherapy Learning Collaborative: Sessions 1-3
- Functional Family Therapy (FFT) Clinical Training One
- Medicaid Reimbursable Supported Employment Services
- The DC Summit on Evidence-Based Programs for At-Risk Children and Youth

#### System of Care (Youth):

- Engaging Families and Children in Mental Health Services: The Access Challenge
- CBI II and III Model Overview
- CBI II and III: Cultural Competency and Strength-Based Engagement; Parenting Youth with Serious Emotional Disabilities From a Resiliency Perspective
- CBI II and III: Intersystem Collaboration and Child and Family Teaming; Educational and Vocational Functioning
- CBI II and III: Risk Assessment and Safety Planning; Family Systems
- CBI II and III: Strength-Based Eco-Systemic Assessment, Contextual Conceptualization, and Treatment Planning
- Child and Adolescent Level of Care Utilization System (CALOCUS) Instructor Training
- Harm Reduction Strategies for Youth
- Overview of Psychopharmacology in the Pediatric Population
- Providing Services to Runaway and Homeless Youth

#### Community Resources:

- Housing Programs – A Primer
- SOAR-SSI/SSDI Outreach Advocacy and Recovery
- The Public Mental Health System in Washington, D.C.

Ethical Practice:

- Contemporary Clinical Ethics and Risk Management
- Ethics in Contemporary Mental Health Practice

Special Populations:

- Addressing Issues Relevant to HIV and Mental Health in the District of Columbia
- What Mental Health Professionals Should Know about Working with HIV+ Consumers
- Mental Health and Nursing Homes
- The BASICS: Memory Loss, Dementia & Alzheimer's Disease

## II: Planning Steps

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

### Narrative Question:

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This step should identify the data sources used to identify the needs and gaps of the populations relevant to each Block Grant within the State's behavioral health care system, especially for those required populations described in this document and other populations identified by the State as a priority.

The State's priorities and goals must be supported by a data driven process. This could include data and information that are available through the State's unique data system (including community level data) as well as SAMHSA's data set including, but not limited to, the National Survey on Drug Use and Health, the Treatment Episode Data Set, and the National Facilities Surveys on Drug Abuse and Mental Health Services. Those States that have a State Epidemiological Outcomes Workgroup (SEOW) must describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with serious mental illness and children with serious emotional disturbances that have been historically reported. States should use the prevalence estimates, epidemiological analyses and profiles to establish substance abuse prevention, mental health promotion, and substance abuse treatment goals at the State level. In addition, States should obtain and include in their data sources information from other State agencies that provide or purchase behavioral health services. This will allow States to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

In addition to in-state data, SAMHSA has identified several other data sets that are available by State through various Federal agencies such as the Center for Medicaid and Medicare Services or the Agency for Health Research and Quality. States should use these data when developing their needs assessment. If the State needs assistance with data sources or other planning information, please contact [planningdata@samhsa.hhs.gov](mailto:planningdata@samhsa.hhs.gov).

### Footnotes:

Planning Step 2 is attached.



## ***PLANNING STEP 2: UNMET SERVICE NEEDS AND CRITICAL GAPS IN CURRENT SYSTEM***

The creation of the new Department of Behavioral Health (DBH) begins on October 1, 2013. The merging of the District's mental health and substance use disorder systems will be an ongoing process. During the course of the continued planning process that began after January 2013, the Department will be able to more clearly articulate Unmet Service Needs And Critical Gaps in the Current System. This section describes issues related to the District of Columbia's behavioral health system as presented in national and local studies.

### **NATIONAL BEHAVIORAL HEALTH STUDY ISSUES**

The 2010-2011 National Survey on Drug Use and Health provides information on mental health and substance use disorder issues in the District of Columbia. This SAMHSA sponsored Survey includes national and state-level data on the use of tobacco, alcohol, illicit drugs (including non-medical use of prescription drugs) and mental health in the United States.

Prevalence of Mental Health Issues: Some of the findings for the prevalence of mental health issues in the District of Columbia reported in the 2010-2011 National Survey on Drug Use and Health include the following:

- Serious Mental Illness in the Past Year among Persons Aged 18 or Older - overall rate 4.99, persons 26 or older have the lowest rate (4.60), and persons 18-25 have the highest rate (6.71).
- Any Mental Illness in the Past Year among Persons Aged 18 or Older - overall rate 22.61, persons 26 or older have the lowest rate (20.96), and persons 18-25 have the highest rate (29.92).
- Serious Thoughts of Suicide in the Past Year among Persons Aged 18 or Older - overall rate 4.03, persons 26 or older have the lowest rate (3.50), and persons 18-25 have the highest rate (6.34).
- At Least One Major Depressive Episode in the Past Year among Persons Aged 18 or Older - overall rate 7.03, persons 12-17 have the lowest rate (6.46), and persons 18-25 have the highest rate (8.24).

Prevalence of Substance Use Issues: Some of the findings for the prevalence of substance use in the District of Columbia reported in the 2010-2011 National Survey on Drug Use and Health include the following:

- Illicit Drug Use in the Past Month among Persons Aged 12 or Older - overall rate 13.56, persons 26 or older have the lowest rate (10.78) and persons 18-25 have the highest rate (25.51).

- Marijuana Use in the Past Month among Persons Aged 12 or Older - overall rate 11.15, persons 26 or older have the lowest rate (8.50) and persons 18-25 have the highest rate (23.08).
- Cocaine Use in the Past Year among Persons Aged 12 or Older - overall rate 3.04, persons 12-17 have the lowest rate (0.36) and persons 18-25 have the highest rate (3.97).
- Nonmedical Use of Prescription Pain Relievers in the Past Year among Persons Aged 12 or Older - overall rate 4.68, persons 26 or older have the lowest rate (3.88) and persons 18-25 have the highest rate (8.35).
- Alcohol Use in the Past Month among Persons Aged 12 or Older - overall rate 62.93, persons 12-17 have the lowest rate (14.16) and persons 18-25 have the highest rate (74.76).
- Binge Alcohol Use in the Past Month among Persons Aged 12 or Older - overall rate 32.20, persons 12-17 have the lowest rate (7.23) and persons 18-25 have the highest rate (50.36).
- Dependence or Abuse of Illicit Drugs or Alcohol in the Past Year among Persons Aged 12 or Older - overall rate 12.68, persons 12-17 have the lowest rate (6.71) and persons 18-25 have the highest rate (21.30).
- Tobacco Product Use in the Past Month among Persons Aged 12 or Older - overall rate 26.70, persons 12-17 have the lowest rate (7.62) and persons 18-25 have the highest rate (34.40).
- Cigarette Use in the Past Month Persons Aged 12 or Older - overall rate 23.24, persons 12-17 have the lowest rate (5.99) and persons 18-25 have the highest rate (28.18).

## **DISTRICT OF COLUMBIA BEHAVIORAL HEALTH STUDY ISSUES**

The RAND Corporation conducted a study of the District's behavioral health system that began in May 2009 and was published in October 2010. The two (2) documents are available on the RAND website: 1) *A Guide to the District's Behavioral Health System* ([http://www.rand.org/pubs/working\\_papers/WR777/](http://www.rand.org/pubs/working_papers/WR777/)), and 2) the report *Behavioral Health in the District of Columbia: Assessing Need and Evaluating the Public System of Care* ([http://www.rand.org/pubs/technical\\_reports/TR914/](http://www.rand.org/pubs/technical_reports/TR914/)).

To estimate the prevalence of mental health and substance use disorders, RAND primarily used data from four (4) surveys: 1) Behavioral Risk Factor Surveillance System; 2) National Survey of Drug Use and Health; 3) National Survey of Children's Health; and 4) Youth Risk Behavior Survey. To evaluate the utilization of behavioral health care services, administrative data from

three (3) sources was used: 1) e-Cura (the mental health billing system); 2) Medicaid managed care claims data from District managed care organizations; and 3) District of Columbia Hospital Association data. For information about the functioning of the behavioral health care system, stakeholder interviews and focus groups were conducted.

The study's key findings and recommendations in five (5) priority areas are summarized below. Several findings are related to unmet need and gaps in care for adults and children.

#### Prevalence of Behavioral Health Disorders

- The prevalence of mental health conditions in the District resembles patterns nationally, among both adults and youth. One exception is that, compared to children nationally, D.C. youth appear to have a higher percentage of parent reported behavioral problems.
- Suicide attempts among District high school students are more common than among high school students nationally, and prevalence appears to be rising in the District. Among high school students who attempt suicide, District youth are twice as likely to require medical care because of an injury.

#### Potential Unmet Need for Behavioral Health Care Services

- The analyses suggest that potentially several thousand District residents have unmet need for mental health care services for severe mental illness, and potentially 60% of adults and 72% of adolescents enrolled in Medicaid managed care who have depression have unmet need for depression services.
- Gaps in surveillance surveys made it impossible to estimate levels of potential unmet need among children with severe mental health conditions.
- Enrollees in the D.C. Healthcare Alliance (public program that provides access to health care to eligible District residents) and uninsured residents have significant mental health needs, with at least 12,000 adults and adolescents potentially having depression alone. Utilization among these individuals is not captured systematically, and, therefore, the level of unmet need cannot be readily estimated.

#### Utilization of Public Behavioral Health Care Services

- 60% of children and 54% of adults enrolled in the mental health rehabilitation services (MHRS) program have over 10 visits per year to a core service agency (CSA) treatment facility (a provider that contracts with DMH to provide MHRS).
- Approximately 16% of children and 15% of adults enrolled in MHRS have contact with the MHRS system only one (1) or two (2) times per year. For individuals undergoing active treatment for severe mental illness, such utilization rates are likely to be inadequate.

- 45% of children and 41% of adults enrolled in MHRS have gaps in care that exceed 6 months during a 12-month period, and 19% of children and 18% of adults have gaps of 10 months or longer.
- 11% of children and 17% of adult Medicaid managed care enrollees with mental health disorders who had at least some mental health services use had no outpatient visits over the course of 1 year but had one (1) or more inpatient admissions or visits to an emergency department (ED) during the same period.
- 30-day readmission rates for Medicaid managed care enrollees after a mental health hospitalization were 20% for children and 16% for adults.
- A substantial fraction of children with disabling mental health disorders receiving services through HSCSN had no mental health specialty visits, including nearly three-fourths of children with an emotional disturbance, two-thirds of children with adjustment disorders, more than half of children with a depressive disorder, and one-third of children with an episodic mood disorder.
- Approximately 10% of children with episodic mood disorders and 9% of children with emotional disturbance received care exclusively through the ED. Children with episodic mood disorders were far more likely to have multiple inpatient stays and repeated ED use compared to other HSCSN enrollees.
- The rate of ED use associated with schizophrenia is considerably higher in Wards 7 and 8 compared with all other parts of the District; rates are as much as twice the District-wide rate for most age groups.
- The rate of ED use associated with all mental health conditions among residents of Wards 7 and 8 is much higher than the District average.

Focus Groups and Stakeholder Interviews: Interviews were conducted with a wide range of individuals and organizations to provide insight into the behavioral health safety net system in the District of Columbia. The interviewees included: government employees from behavioral health agencies, providers of mental health and substance abuse services, primary care providers, insurance company executives, representatives of hospitals, local nonprofit organizations, and researchers and experts on the delivery of behavioral health care.

Participants highlighted several major challenges to the optimal provision of behavioral health services in the District. Two (2) recurring themes were gaps in care and difficulties in coordination of care for particular populations and particular services. Other themes revolved around challenges related to housing, financing, information technology, and quality measurement.

## Priority Areas

The RAND study identified five (5) priorities for the District that include:

- Work to reduce unmet need for public mental health care.
- Track and coordinate care for individuals in the public system with mental health diagnoses.
- Improve the availability and accessibility of substance abuse treatment services.
- Increase the coordination of care for individuals with comorbid mental health and substance abuse conditions.
- Fundamentally upgrade the data infrastructure of the public behavioral health care system to allow for improved monitoring of service utilization, quality of care, and patient outcomes.

## **DISTRICT OF COLUMBIA HEALTH ISSUES**

The District of Columbia Community Health Needs Assessment, Volume 1 (revised 3/15/13), is a comprehensive analysis of a series of indicators and outcomes that describe the overall health status of District residents. A summary of the highlights is presented below.

### **Key Indicators**

- Life expectancy for the average District resident has climbed to a historic high of 77.5 years in 2010, a 10-year gain from the life expectancy in the early 1990s.
- The number of deaths to District residents has dropped by 11.7% from 2006 to 2010; however, disparities persist between gender, race, and ward of residence.
- The District achieved its Healthy People 2010 objective of reducing infant mortality rate (IMR) to no more than 8 infant deaths per 1,000 live births; however the District IMR was 31% higher than the national rate.
- District resident seniors are projected to grow by 17.4% in 2030. As the population continues to live longer and the estimated life expectancy in the District continues to rise, the need for health care among the elderly will likewise increase.

### **Leading Causes of Death**

- Heart disease and cancer are the two (2) leading causes of death among District residents, regardless of sex and race, and they accounted for 50% of deaths in the District in the last 5 years.
- Among 10-24 year olds, homicide/assault is the leading cause of death (55%) followed by accidents (13%).

- Despite a 43.2% drop in the HIV age-adjusted mortality rate in the last 5 years, the District rate for deaths due to HIV was 8.2 times higher than the national rate in 2010.
- The leading causes of death for adults 65 and older were heart disease, cancer, cerebrovascular disease, chronic lower respiratory disease, and Alzheimer's disease.

### **Diseases and Disorders**

- Significant decreases were seen in incidence and mortality rates for colorectal, breast, and prostate cancer.
- With nearly 3% of its population diagnosed and reported with HIV, the District has a severe and generalized epidemic and District residents between 40-49 years of age and black men have the highest rates of HIV.
- One in 100 youth in the District is HIV positive.
- Lifetime and current asthma prevalence for children in the District were higher than the national medians. Children under 5 years accounted for the largest percentage (20%) of emergency visits due to asthma from 2008 to 2010.
- Chronic diseases have caused most of the deaths among the elderly in the District.

### **Ward Level**

- Deaths due to Accidents, Diabetes, and Septicemia increased dramatically in Ward 8 from 2006 to 2010.
- Ward 8 residents have the highest obesity rates, and are least likely to exercise or consume the recommended serving of fruits and vegetables.
- District residents in 10 zip-codes accounted for 83% of total District resident hospital discharges. They belong to Wards 1, 4, 5, and 8.
- Prevalence and mortality associated with diabetes are highest in District Wards 4, 5, 7, and 8, where rates are higher than the city-wide rate.
- While 50% of youth live in Wards 7 and 8, less than 10% of the District's grocery stores are located there.

### **Access to Care**

- Emergency visits and ambulatory services have increased steadily while patient days declined in the District.
- Pregnancy-related and Heart Disease are the two (2) leading causes of hospitalization for DC residents.
- Although there are sufficient numbers of providers serving the general population in "Medically Underserved" designation areas in the District, there is still a shortage of providers serving the low-income and/or homeless populations in these areas.

- The District of Columbia implemented early expansion of Medicaid eligibility under the Affordable Care Act that has led to insurance coverage for 93% of adults and 96% of children living in the District – the second highest insurance rate in the nation after Massachusetts.

### **Health Behaviors and Risk Factors**

- The District provides greater access to healthy food options compared to nationally, except in school settings.
- Currently, there are no state laws addressing childhood obesity in the District.
- District residents have a healthier body mass index (BMI) compared to the rest of country.
- The prevalence of heavy drinking for District adults is 6% compared to 5.1% nationally.
- Self-reporting of attempted suicide by District students has consistently been double the national average of 6.3%.
- Gay, lesbian, and bisexual District residents were more likely to report positive perceived health status, healthy weight, physical activity, lower blood pressure, and HIV testing. They were also more likely to report smoking, heavy or binge drinking, and engaging in risky behavior.
- In 2007, an estimated 100 non-fatal traffic injuries in the District involved an underage driver that had been drinking.

### **Racial Disparities**

- Non-Hispanic black infants account for a disproportionate percentage of all infant deaths.
- Hispanic females were expected to live the longest in the District (88.9 years), followed closely by Hispanic males (88.4 years).
- Hispanics newly diagnosed with HIV were more likely to be younger than other racial groups.
- Blacks have the highest obesity rates, and are least likely to exercise or consume the recommended serving of fruits and vegetables.
- The crude death rate due to diabetes for Blacks/African Americans was 7 times the rate for Whites in 2010.
- Blacks/African Americans were over 3 times more likely to die from cerebrovascular diseases compared to their White counterparts.

Table 1 Step 3,4: -Priority Area and Annual Performance Indicators

Priority #: 1

Priority Area: 1- Creation of Department of Behavioral Health

Priority Type: SAP, SAT, MHP, MHS

Population SMI, SED

(s):

Goal of the priority area:

Merger of the Department of Mental Health, the State Mental Health Authority, with the Addiction, Prevention and Recovery Administration, the Single State Agency for Substance Abuse, to provide better integrated care for individuals with co-occurring disorders.

Strategies to attain the goal:

Effective October 1, 2013, the Department of Mental Health will merge with the Addiction Prevention and Recovery Administration in the Department of Health to integrate treatment and services for residents with mental health and substance use disorders. Mayor Vincent C. Gray formed the new Department of Behavioral Health (DBH) to improve the health and well-being of residents who receive mental health and substance use treatment and supports. It is estimated that annually about 22,000 adults and children receive mental health treatment while about 12,000 residents receive substance use disorder treatment.

FY 2013 was the initial planning phase for establishing the DBH. The activities included: 1) creating a Planning Committee, developing a work plan, adopting Guiding Principles and the Charter, establishing work groups and reporting requirements, and identifying data requirements; 2) conducting work group meetings including developing work plans and schedule of deliverables, and monthly report to the Planning Committee; 3) developing a strategy for communication and engagement of partners and the general public; 4) addressing infrastructure issues such as contracts and procurement, billing and claims, certification and accountability; and rules and policy; 5) launching the new Department on October 1, 2013 with consumer/client services continuing and uninterrupted with same mental health or substance use disorder provided; 6) on an ongoing basis continue evaluation of services and identification of gaps, provide training on assessment and treatment of co-occurring disorders, and address a host of other issues; and 7) competitively acquire consultant services to facilitate the development of the DBH. During the FY 2013 fourth quarter a consultant, The Technical Assistance Collaborative (TAC), was brought onboard to provide technical assistance for the development and implementation of the DBH.

During FY 2014- FY 2015, the new Department plans to begin the process to better integrate clinical services and develop an infrastructure within the mental health and substance use disorder programs to better support integrated service delivery. Residents who only seek mental health treatment or only substance use treatment will continue to be served by the new Department.



Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: System capabilities and challenges in providing integrated mental health and substance use disorder care

Baseline Measurement: Assessment of pre-merger systems' capacities, capabilities and challenges

First-year target/outcome measurement: Identify post-merger service system best suited to provide integrated care; develop transitional plan

Second-year target/outcome measurement: Ongoing implementation of transitional plan and operational integrated care system

Data Source:

Claims and service data bases of both systems (Mental Health services: Community-based: eCura, Anasazi and LOCUS/CALOCUS; Inpatient: Avatar, PYXIS, WorX, TDSynergy; FileNet; and for Substance Abuse services DATA WITTS); iCAMS, a single integrated care management/claims system scheduled to be implemented June 2014; provider and consumer surveys; fidelity assessments; community service reviews; audits and Provider Scorecards.

Description of Data:

Utilization data, gap analysis, and enrollment data; client and provider perception of services; assessment of consumers' levels of care and functioning; assessment of provider quality of care and business practices; Uniform Reporting System Tables (URS) and National Outcome Measures (NOMS).

Data issues/caveats that affect outcome measures::

Currently systems are not compatible but full implementation of iCAMS in June 2014 will address that issue for data systems that are not replaced by iCAMS.

Priority #: 2

Priority Area: 2- Health Home Planning Initiative

Priority Type: MHS

Population (s): SMI

Goal of the priority area:

Consistent with the proposed DC Medicaid Health Home SPA that will be submitted to CMS for approval, the mental health Core Services Agencies (CSAs) as well as some specialty providers of Assertive Community Treatment (ACT) will become Health Home providers.

Strategies to attain the goal:

The District Department of Health Care Finance (DHCF) and the Department of Health (DOH) partnered with the Department of Mental Health (DMH) to design health homes tailored to the needs of chronically ill Medicaid beneficiaries who, through better care management and coordination, would most likely experience improved health outcomes and reductions in emergency room (ER) visits and avoidable hospital admissions. Through the analysis of DC Medicaid claims and encounter data, mental health conditions were found to be the primary diagnosis for most individuals who frequently use inpatient hospital and ER services, particularly among individuals with bipolar disorder or schizophrenia. Co-occurring physical health conditions, such as diabetes and heart disease, were also prevalent in those with SMI. Initially, Medicaid beneficiaries with a SMI are eligible for enrollment in a DC Medicaid Health Home to receive Health Home services.

Providers certified by DMH as CSAs are eligible to be Health Home providers in the DC Medicaid program. DMH is continuing to define Health Home provider certification requirements; however, the District plans to require that each Health Home employ staff that will ensure that a consumer's care is integrated, specifically: a Health Home Director, Team Leader, a Nurse Care Manager, Primary Care Liaison and a Care Coordinator. Health Homes will receive a bundled payment for providing Health Home services with the expectation that care coordination services provided are consistent with consumers' needs.

Health Management Associates has been hired to assist with this process. In 2013, District government leadership will seek federal approval from CMS, via a SPA, to establish Health Homes beginning in 2014.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Adult Body Mass Index (BMI) Assessment
Baseline Measurement:	Percentage of Health Home enrollees 18-74 years of age who had an outpatient visit and who had their BMI documented the year prior to the Health Home initiative implementation.
First-year target/outcome measurement:	Same as above documented within the first year of the Health Home initiative implementation.
Second-year target/outcome measurement:	Same as above documented within the second year of the Health Home intervention implementation.
Data Source:	

The data source for this measure has not been determined, however, multiple data sources are being explored.

Description of Data:

Numerator Description- Body mass index documented during the measurement year or the year prior to the measurement year  
Denominator Description- Members 18-74 of age who had an outpatient visit

Data issues/caveats that affect outcome measures::

To be determined.

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Indicator #: 2

Indicator: Ambulatory Care-Sensitive Condition Admission

Baseline Measurement: Age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission to the hospital, per 20,000 population under age 75 years, the year prior to the implementation of the Health Home initiative.

First-year target/outcome measurement: Same as above within the first year of the Health Home initiative implementation.

Second-year target/outcome measurement: Same as above within the second year of the Health Home initiative implementation.

Data Source:

The data source for this measure has not been determined, however, multiple data sources are being explored.

Description of Data:

Numerator Description- Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years  
Denominator Description- Total mid-year population under age 75

Data issues/caveats that affect outcome measures::

Voluntary hospitalizations and hospitalizations where the primary cause of care was for physical health reasons are not currently tracked for the targeted Health Home population. Therefore, it will be difficult to calculate a baseline rate for this measure.

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Indicator #: 3

Indicator: Care Transition Record Transmitted to Health Care Professional  
OMB No. 0930-0168 Approved: 05/21/2013 Expires: 05/31/2016

Baseline Measurement: Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge, within the year prior to the Health Home initiative implementation.

First-year target/outcome measurement: Same as above within the first year of the Health Home initiative implementation.

Second-year target/outcome measurement: Same as above within the second year of the Health Home initiative implementation.

Data Source:

The data source for this measure has not been determined yet; however, multiple data sources are being explored.

Description of Data:

Numerator Description- Patients for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.

Denominator Description- All patients, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self-care or any other site of care.

Data issues/caveats that affect outcome measures::

Data for the baseline measurement may be collected from the Integrated Care Division for Health Home enrollees that were admitted to a hospital involuntary for mental health reasons. However, the caveat cited for Indicator #2 applies.

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Indicator #: 4

Indicator: Follow-Up After Hospitalization for Mental Illness

Baseline Measurement: A year before the Health Home initiative implementation, percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge.

First-year target/outcome measurement: Same as above within the first year of the Health Home initiative implementation.

Second-year target/outcome measurement: Same as above within the second year of the Health Home initiative implementation.

Data Source:

The data source for this measure has not been determined, however, multiple data sources are being explored.

Description of Data:

Numerator Description- An outpatient visit, intensive outpatient encounter, or partial hospitalization (refer to Table FUH-C in the original measure documentation for codes to identify visits) with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.

Denominator Description- Members 6 years of age and older discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis on or between January 1 and December of the measurement year.

Data issues/caveats that affect outcome measures::

Same as reported for Indicator #3.

Indicator #:

5

Indicator:

Plan- All Cause Readmission

Baseline Measurement:

For members 18 years of age and older, the number of acute inpatient stays during the year prior to the Health Home initiative implementation that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.

First-year target/outcome measurement:

Same as above during the first year of the Health Home initiative implementation.

Second-year target/outcome measurement:

Same as above during the second year of the Health Home initiative implementation.

Data Source:

The data source for this measure has not been determined, however, multiple data sources are being explored.

Description of Data:

Numerator Description- Count the number of Index Hospital Stays with a readmission within 30 days for each age, gender, and total combination

Denominator Description- Count the number of Index Hospital Stays for each age, gender, and total combination

Data issues/caveats that affect outcome measures::

Same as reported for Indicator #3.

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Indicator #: 6

Indicator: Screening for Clinical Depression and Follow-up Plan

Baseline Measurement: Percentage of patients aged 18 years and older screened for clinical depression using a standardized tool AND follow-up documented, within a year prior to Health Home initiative implementation.

First-year target/outcome measurement: Same as above within the first year of Health Home initiative implementation.

Second-year target/outcome measurement: Same as above within the second year of Health Home initiative implementation.

Data Source:

The data source for this measure has not been determined, however, multiple data sources are being explored.

Description of Data:

Numerator Description- Total number of patients from the denominator who have follow-up documentation  
Denominator Description- All patients 18 years and older screened for clinical depression using a standardized tool

Data issues/caveats that affect outcome measures::

To be determined.

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Indicator #: 7

Indicator: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Baseline Measurement: Year before Health Home initiative, % of adolescents & adults with new AOD receiving initiation & engagement services

First-year target/outcome measurement: Same as above within the year after the Health Home initiative implementation.

Second-year target/outcome measurement: Same as above within the second year after the Health Home initiative implementation

Data Source:

The data source for this measure has not been determined, however, multiple data sources are being explored.

Description of Data:

Initiation of AOD Dependence Treatment: Health Home enrollees with initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of diagnosis. And Engagement of AOD Treatment: Initiation of AOD treatment and two (2) or more inpatient admissions, outpatient visits, intensive outpatient encounters, or partial hospitalizations with any AOD diagnosis within 30 days after the date of the Initiation encounter (inclusive). Multiple engagement visits may occur on the same day, but they must be with different providers in order to be counted.

Denominator Description- Health Home enrollees 13 years of age and older as of December 31 of the measurement year with a new episode of AOD during the intake period, reported in two age stratifications (13-17 years, 18+ years) and a total rate. The total rate is the sum of the two (2) numerators divided by the sum of the two (2) denominators.

Data issues/caveats that affect outcome measures::

The addiction data system (DATA) may not be able to provide the data needed for the baseline measure.

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Indicator #: 8

Indicator: Controlling High Blood Pressure

Baseline Measurement: Year before Health Home initiative, % of patients 18–85 with HTN & BP adequately controlled (<140/90)

First-year target/outcome measurement: Same as above within the year post the Health Home initiative implementation.

Second-year target/outcome measurement: Same as above within the second year post the Health Home initiative implementation.

Data Source:

The data source for this measure has not been determined, however, multiple data sources are being explored.

Description of Data:

Numerator Description- The number of patients in the denominator whose most recent, representative BP is adequately controlled during the measurement year. For a member's BP to be controlled, both the systolic and diastolic BP must be <140/90mm Hg.

Denominator Description- Patients 18-85 with hypertension. A patient is considered hypertensive if there is at least one outpatient encounter with a diagnosis of HTN during the first six months of the measurement year.

Data issues/caveats that affect outcome measures::

To be determined.

Priority #: 3

Priority Area: Transition to a Behavioral Health Planning and Advisory Council

Priority Type: SAP, SAT, MHP, MHS

Population SMI, SED

(s):

Goal of the priority area:

Transition into a Behavioral Health Planning and Advisory Council by merging the current mental health councils, expanding the membership to include substance use disorder services, Department representation and the Recovery Advisory Committee.

Strategies to attain the goal:

The need to develop a District of Columbia Behavioral Health Planning and Advisory Council is derived from: 1) the District's mandate to create a Department of Behavioral Health, and 2) the federal mandate to create a Behavioral Health Advisory Council. In January 2013, the Department and the District of Columbia State Mental Health Planning Council (DC SMHPC) jointly submitted an application to participate in the State Planning Council National Learning Community Technical Assistance Project to assist with the transition to a Behavioral Health Planning and Advisory Council. While the application was not 1 of the 8 that was selected, in April 2013 the Department and the DC SMHPC requested technical assistance through the general services available to state planning and advisory councils to pursue the transition to a Behavioral Health Planning and Advisory Council. The request was approved.

Some of the initial planning activities have included: 1) participating in national webinars including The Evolving Role of Mental Health Planning and Advisory Councils in Behavioral Health Reform (January 2013) and Assessing Your Behavioral Health IQ: The Road to Planning Council Integration (April 2013); 2) creating a Behavioral Health Planning and Advisory Council Advisory Committee (May 2013); 3) participating



in a conference call with the consultant to discuss the technical assistance objectives and plan the on-site technical assistance consultation (June 2013); 4) participating in the on-site technical assistance consultation meeting (July 2013); and 5) participating in the August 2013 post on-site technical assistance meeting, which included a review and discussion of the draft By-Laws.

### Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Implementation and operation of a District of Columbia Behavioral Health Planning and Advisory Council

Baseline Measurement: Expand the Advisory Committee for the Behavioral Health Planning and Advisory Council; determine the Behavioral Health Planning and Advisory Council's authority, mission, membership, activities, values, strengths, and challenges; finalize by-laws; consult with existing Behavioral Health Planning and Advisory Councils; and continue the technical assistance consultation from Advocates for Human Potential, Inc.

First-year target/outcome measurement: Develop Draft District of Columbia Behavioral Health Planning and Advisory Council Transition Plan.

Second-year target/outcome measurement: Obtain feedback from the Department Director, Senior Deputy Director, other appropriate senior and program staff. Revise and finalize the District of Columbia Behavioral Health Planning and Advisory Council Transition Plan and begin implementation.

#### Data Source:

Department existing data reports and tailored reports for the District of Columbia Behavioral Health Planning and Advisory Council; reports developed by federal, District and private agencies; and national studies that address behavioral health issues.

#### Description of Data:

Utilization data, gap analysis, and enrollment data; client and provider perception of services; assessment of consumers' levels of care and functioning; assessment of provider quality of care and business practices; Uniform Reporting System Tables (URS) and National Outcome Measures (NOMS).

#### Data issues/caveats that affect outcome measures:

The District of Columbia Behavioral Health Planning and Advisory Council will discuss these data issues with the Department.

Footnotes:

The three (3) planning initiatives are entered in the table section.

Table 2 State Agency Planned Expenditures

Planning Period - From 07/01/2013 to 06/30/2015

Activity (See instructions for using Row 1.)	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other
1. Substance Abuse Prevention and Treatment*							
a. Pregnant Women and Women with Dependent Children*							
b. All Other							
2. Substance Abuse Primary Prevention							
3. Tuberculosis Services							
4. HIV Early Intervention Services							
5. State Hospital			\$ 2,828,477	\$ 3,556,301	\$	\$ 74,648,941	\$ 2,775,281
6. Other 24 Hour Care		\$	\$ 6,112,905	\$ 300,000	\$	\$	\$
7. Ambulatory/Community Non -24 Hour Care		\$	\$ 60,294,300	\$	\$	\$ 7,411,490	\$
8. Mental Health Primary Prevention		\$	\$	\$	\$	\$ 211,850	\$
9. Mental Health Evidenced- based Prevention and Treatment (5% of total award)		\$	\$ 184,252	\$	\$	\$ 772,479	\$
10. Administration (Excluding Program and Provider Level)		\$ 40,053	\$ 3,164,201	\$	\$	\$ 98,876,185	\$
11. Total	\$	\$ 40,053	\$ 72,584,135	\$ 3,856,301	\$	\$ 181,920,945	\$ 2,775,281

\* Prevention other than primary prevention

Footnotes:

### III: Use of Block Grant Dollars for Block Grant Activities

Table 3 State Agency Planned Block Grant Expenditures by Service

Planning Period - From 07/01/2013 to SFY 06/30/2015

Service	Unduplicated Individuals	Units	Expenditures
Healthcare Home/Physical Health			\$67,924
Specialized Outpatient Medical Services			\$
Acute Primary Care			\$
General Health Screens, Tests and Immunizations			\$
Comprehensive Care Management			\$
Care coordination and Health Promotion			\$67,924
Comprehensive Transitional Care			\$
Individual and Family Support			\$
Referral to Community Services Dissemination			\$
Prevention (Including Promotion)			\$66,956
Screening, Brief Intervention and Referral to Treatment			\$10,000

Brief Motivational Interviews			\$15,000
Screening and Brief Intervention for Tobacco Cessation			\$15,000
Parent Training			\$26,956
Facilitated Referrals			\$
Relapse Prevention/Wellness Recovery Support			\$
Warm Line			\$
Substance Abuse (Primary Prevention)			\$15,000
Classroom and/or small group sessions (Education)			\$
Media campaigns (Information Dissemination)			\$
Systematic Planning/Coalition and Community Team Building(Community Based Process)			\$
Parenting and family management (Education)			\$
Education programs for youth groups (Education)			\$
Community Service Activities (Alternatives)			\$
Student Assistance Programs (Problem Identification and Referral)			\$15,000
Employee Assistance programs (Problem Identification and Referral)			\$

Community Team Building (Community Based Process)			\$
Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental)			\$
Engagement Services			\$20,000
Assessment			\$
Specialized Evaluations (Psychological and Neurological)			\$
Service Planning (including crisis planning)			\$
Consumer/Family Education			\$20,000
Outreach			\$
Outpatient Services			\$10,038
Evidenced-based Therapies			\$
Group Therapy			\$10,038
Family Therapy			\$
Multi-family Therapy			\$
Consultation to Caregivers			\$
Medication Services			\$

Medication Management			\$
Pharmacotherapy (including MAT)			\$
Laboratory services			\$
Community Support (Rehabilitative)			\$410,740
Parent/Caregiver Support			\$10,000
Skill Building (social, daily living, cognitive)			\$
Case Management			\$
Behavior Management			\$
Supported Employment			\$90,740
Permanent Supported Housing			\$310,000
Recovery Housing			\$
Therapeutic Mentoring			\$
Traditional Healing Services			\$
Recovery Supports			\$42,320
Peer Support			\$42,320
Recovery Support Coaching			\$

Recovery Support Center Services			\$
Supports for Self-directed Care			\$
Other Supports (Habilitative)			\$29,000
Personal Care			\$
Homemaker			\$
Respite			\$
Supported Education			\$
Transportation			\$
Assisted Living Services			\$
Recreational Services			\$29,000
Trained Behavioral Health Interpreters			\$
Interactive Communication Technology Devices			\$
Intensive Support Services			\$
Substance Abuse Intensive Outpatient (IOP)			\$
Partial Hospital			\$



Assertive Community Treatment				\$
Intensive Home-based Services				\$
Multi-systemic Therapy				\$
Intensive Case Management				\$
Out-of-Home Residential Services				\$
Children's Mental Health Residential Services				\$
Crisis Residential/Stabilization				\$
Clinically Managed 24 Hour Care (SA)				\$
Clinically Managed Medium Intensity Care (SA)				\$
Adult Mental Health Residential				\$
Youth Substance Abuse Residential Services				\$
Therapeutic Foster Care				\$
Acute Intensive Services				\$
Mobile Crisis				\$
Peer-based Crisis Services				\$

Urgent Care				\$
23-hour Observation Bed				\$
Medically Monitored Intensive Inpatient (SA)				\$
24/7 Crisis Hotline Services				\$
Other (please list)				\$

**Footnotes:**

The information in Table 3 State Agency Planned Block Grant Expenditures By Service is an estimate. The allocation of the FY 2014-FY 2015 Mental Health Block Grant funds has not yet been determined. Historically, the Department's practice is to: 1) work with the District's Mental Health Planning and Advisory Council to develop the project areas of interest; and 2) work with the District's Office of Partnership and Grants Services to issue a notice of funding availability (NOFA) to solicit applications for Block Grant funding for behavioral health services and supports. Responses to the NOFA are then evaluated by the Planning Council who make recommendations to the Director for the final allocation of the funds. The plan is to issue the NOFA for the FY 2014-FY 2015 Mental Health Block Grant projects by the end of October 2013.

The information reported in Table 3 includes estimated type of services and the projected costs. This estimate is based on the FY 2013-FY 2014 allocation of Block Grant funds, which was determined in accordance with the process described above.

Table 6b MHBG Non-Direct Service Activities Planned Expenditures

Planning Period - From 07/01/2013 to 06/30/2014

Service	Block Grant
MHA Technical Assistance Activities	\$ <input type="text"/>
MHA Planning Council Activities	\$ <input type="text" value="25,000"/>
MHA Administration	\$ <input type="text" value="40,063"/>
MHA Data Collection/Reporting	\$ <input type="text" value="40,000"/>
Enrollment and Provider Business Practices (3 percent of total award)	\$ <input type="text" value="24,032"/>
MHA Activities Other Than Those Above	\$ <input type="text" value="10,000"/>
Total Non-Direct Services	\$139095
Comments on Data: <input type="text"/>	

Footnotes:

The Department does not have plans at this time to use Mental Health Block Grant funds for Mental Health Authority Technical Assistance Activities. The Department will seek follow-up and/or new technical assistance (TA) opportunities through the SAMHSA sub-contractors that provided valuable TA during FY 2013. This included TA consultation through the National Association of State Mental Health Program Directors (NASMHPD) related to: 1) older adult issues, needs, and community transitions; 2) integrated treatment for dual disorders (mental health and substance use disorders); and 3) day services programs. Other TA services were provided by Advocates for Human Potential, Inc. (AHP) related to transitioning to a Behavioral Health Planning and Advisory Council.

## IV: Narrative Plan

### C. Coverage M/SUD Services

#### Narrative Question:

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Beginning in 2014, Block Grant dollars should be used to pay for (1) people who are uninsured and (2) services that are not covered by insurance and Medicaid. Presumably, there will be similar concerns at the state-level that state dollars are being used for people and/or services not otherwise covered. States (or the Federal Marketplace) are currently making plans to implement the benchmark plan chosen for QHPs and their expanded Medicaid programs (if they choose to do so). States should begin to develop strategies that will monitor the implementation of the Affordable Care Act in their states. States should begin to identify whether people have better access to mental and substance use disorder services. In particular, states will need to determine if QHPs and Medicaid are offering mental health and substance abuse services and whether services are offered consistent with the provisions of MHPAEA.

Please answer the following questions:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs on January 1, 2014?
2. Do you have a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
3. Who in your state is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe their monitoring process.
4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations of MHPAEA?
5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?

#### Footnotes:

The planning for the new Department of Behavioral Health will address issues related to whether people have better access to mental health and substance use disorder services. Also, in Planning Step 1, Behavioral Health Populations and Services, under SAMHSA Strategic Initiative #5 Health Reform, there is a discussion about health reform implementation, health information exchange, the Health Benefit Exchange Authority, and health homes planning.

## IV: Narrative Plan

### D. Health Insurance Marketplaces

#### Narrative Question:

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Health Insurance Marketplaces (Marketplaces) will be responsible for performing a variety of critical functions to ensure access to desperately needed behavioral health services. Outreach and education regarding enrollment in QHPs or expanded Medicaid will be critical. SMHAs and SSAs should understand their state's new eligibility determination and enrollment system, as well as how insurers (commercial, Medicaid, and Medicare plans) will be making decisions regarding their provider networks. States should consider developing benchmarks regarding the expected number of individuals in their publicly-funded behavioral health system that should be insured by the end of FY 2015. In addition, states should set similar benchmarks for the number of providers who will be participating in insurers' networks that are currently not billing third party insurance.

QHPs must maintain a network of providers that is sufficient in the number and types of providers, including providers that specialize in mental health and substance abuse, to assure that all services will be accessible without unreasonable delay. Mental health and substance abuse providers were specifically highlighted in the rule to encourage QHP issuers to provide sufficient access to a broad range of mental health and substance abuse services, particularly in low-income and underserved communities.

Please answer the following questions:

1. How will the state evaluate the impact that its outreach, eligibility determination, enrollment, and re-enrollment systems will have on eligible individuals with behavioral health conditions?
2. How will the state work with its partners to ensure that the Navigator program is responsive to the unique needs of individuals with behavioral health conditions and the challenges to getting and keeping the individuals enrolled?
3. How will the state ensure that providers are screening for eligibility, assisting with enrollment, and billing Medicaid, CHIP, QHPs, or other insurance prior to drawing down Block Grant dollars for individuals and/or services?
4. How will the state ensure that there is adequate community behavioral health provider participation in the networks of the QHPs, and how will the state assist its providers in enrolling in the networks?
5. Please provide an estimate of the number of individuals served under the MHBG and SABG who are uninsured in CY 2013. Please provide the assumptions and methodology used to develop the estimate.
6. Please provide an estimate of the number of individuals served under the MHBG and SABG who will remain uninsured in CY 2014 and CY 2015. Please provide the assumptions and methodology used to develop the estimate.
7. For the providers identified in Table 8 -Statewide Entity Inventory of the FY 2013 MHBG and SABG Reporting Section, please provide an estimate of the number of these providers that are currently enrolled in your state's Medicaid program. Please provide the assumptions and methodology used to develop the estimate.
8. Please provide an estimate of the number of providers estimated in Question 7 that will be enrolled in Medicaid or participating in a QHP. Provide this estimate for FY 2014 and a separate estimate for FY 2015, including the assumptions and methodology used to develop the estimate.

#### Footnotes:

The planning for the new Department of Behavioral Health will consider benchmarks that address the expected number of individuals in the publicly-funded behavioral health system that should be insured by the end of FY 2015.

## IV: Narrative Plan

### E. Program Integrity

#### Narrative Question:

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The Affordable Care Act directs the Secretary of HHS to define EHBs. Non-grandfathered plans in the individual and small group markets both inside and outside of the Marketplaces, Medicaid benchmark and benchmark-equivalent plans, and basic health programs must cover these EHBs beginning in 2014. On December 16, 2011, HHS released a bulletin indicating the Secretary's intent to propose that EHBs be defined by benchmarks selected by each state. The selected benchmark plan would serve as a reference plan, reflecting both the scope of services and any limits offered by a "typical employer plan" in that state as required by the Affordable Care Act.

SMHAs and SSAs should now be focused on two main areas related to EHBs: monitoring what is covered and aligning Block Grant and state funds to compensate for what is not covered. There are various activities that will ensure that mental and substance use disorder services are covered. These include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including EHBs as per the state benchmark; (2) ensuring that individuals are aware of the covered mental health and substance abuse benefits; (3) ensuring that consumers of substance abuse and mental health services have full confidence in the confidentiality of their medical information; and (4) monitoring utilization of behavioral health benefits in light of utilization review, medical necessity, etc.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the SABG and MHBG. State systems for procurement, contract management, financial reporting, and audit vary significantly. SAMHSA expects states to implement policies and procedures that are designed to ensure that Block Grant funds are used in accordance with the four priority categories identified above. Consequently, states may have to reevaluate their current management and oversight strategies to accommodate the new priorities. They may also be required to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment. States should describe their efforts to ensure that Block Grant funds are expended efficiently and effectively in accordance with program goals. In particular, states should address how they will accomplish the following:

1. Does the state have a program integrity plan regarding the SABG and MHBG?
2. Does the state have a specific staff person that is responsible for the state agency's program integrity activities?
3. What program integrity activities does the state specifically have for monitoring the appropriate use of Block Grant funds? Please indicate if the state utilizes any of the following monitoring and oversight practices:
  - a. Budget review;
  - b. Claims/payment adjudication;
  - c. Expenditure report analysis;
  - d. Compliance reviews;
  - e. Encounter/utilization/performance analysis; and
  - f. Audits.
4. How does the state ensure that the payment methodologies used to disburse funds are reasonable and appropriate for the type and quantity of services delivered?
5. How does the state assist providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
6. How will the state ensure that Block Grant funds and state dollars are used to pay for individuals who are uninsured and services that are not covered by private insurance and/or Medicaid?

SAMHSA will review this information to assess the progress that states have made in addressing program integrity issues and determine if additional guidance and/or technical assistance is appropriate.

#### Footnotes:

The planning for the new Department of Behavioral Health will consider issues related to Program Integrity and follow the SAMHSA guidance that includes: 1) appropriately direct complaints and appeals requests to ensure that QHPs and Medicaid programs are including EHBs as per the District benchmark; 2) ensure that individuals are aware of the covered mental health and substance abuse benefits; 3) ensure that consumers of substance abuse and mental health services have full confidence in the confidentiality of their medical information; and 4) monitor utilization of behavioral health benefits in light of utilization review, medical necessity, etc.

## IV: Narrative Plan

### F. Use of Evidence in Purchasing Decisions

#### Narrative Question:

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SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers decisions regarding mental health and substance abuse services. SAMHSA is requesting that states respond to the following questions:

- 1) Does your state have specific staff that are responsible for tracking and disseminating information regarding evidence-based or promising practices?
- 2) Did you use information regarding evidence-based or promising practices in your purchasing or policy decisions?
  - a) What information did you use?
  - b) What information was most useful?
- 3) How have you used information regarding evidence-based practices?
  - a) Educating State Medicaid agencies and other purchasers regarding this information?
  - b) Making decisions about what you buy with funds that are under your control?

#### Footnotes:

Historically, the use of evidence-based and/or promising practices has been incorporated in various aspects of clinical and support services. The planning for the new Department of Behavioral Health will incorporate these practices in purchasing or policy decisions.

## IV: Narrative Plan

### G. Quality

#### Narrative Question:

Up to 25 data elements, including those listed in the table below, will be available through the Behavioral Health Barometer which SAMHSA will prepare annually to share with states for purposes of informing the planning process. The intention of the Barometer is to provide information to states to improve their planning process, not for evaluative purposes. Using this information, states will select specific priority areas and develop milestones and plans for addressing each of their priority areas. States will receive feedback on an annual basis in terms of national, regional, and state performance and will be expected to provide information on the additional measures they have identified outside of the core measures and state barometer. Reports on progress will serve to highlight the impact of the Block Grant-funded services and thus allow SAMHSA to collaborate with the states and other HHS Operating Divisions in providing technical assistance to improve behavioral health and related outcomes.

	Prevention	Substance Abuse Treatment	Mental Health Services
Health	Youth and Adult Heavy Alcohol Use - Past 30 Day	Reduction/No Change in substance use past 30 days	Level of Functioning
Home	Parental Disapproval Of Drug Use	Stability in Housing	Stability in Housing
Community	Environmental Risks/Exposure to prevention Messages and/or Friends Disapproval	Involvement in Self-Help	Improvement/Increase in quality/number of supportive relationships among SMI population
Purpose	Pro-Social Connections Community Connections	Percent in TX employed, in school, etc - TEDS	Clients w/ SMI or SED who are employed, or in school

- 1) What additional measures will your state focus on in developing your State BG Plan (up to three)?
- 2) Please provide information on any additional measures identified outside of the core measures and state barometer.
- 3) What are your states specific priority areas to address the issues identified by the data?
- 4) What are the milestones and plans for addressing each of your priority areas?

#### Footnotes:

The District's mental health and substance use disorder systems, which have historically operated in two separate departments, are merging on October 1, 2013 to become the Department of Behavioral Health. The planning process began in FY 2013 and will continue in FY 2014. As the planning and implementation process moves forward, the Department will incorporate some of the quality measures identified in the Behavioral Health Barometer as well as other sources.



## IV: Narrative Plan

### H. Trauma

#### Narrative Question:

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In order to better meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed care approach consistent with SAMHSA's trauma-informed care definition and principles. This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate so that these services and programs can be more supportive and avoid being traumatized again.

Please answer the following questions:

1. Does your state have any policies directing providers to screen clients for a personal history of trauma?
2. Does the state have policies designed to connect individuals with trauma histories to trauma-focused therapy?
3. Does your state have any policies that promote the provision of trauma-informed care?
4. What types of evidence-based trauma-specific interventions does your state offer across the life-span?
5. What types of trainings do you provide to increase capacity of providers to deliver trauma-specific interventions?

#### Footnotes:

The District's Behavioral Health Assessment and Plan, Planning Step 1 section on Behavioral Health Populations and Services is organized by the statutory reporting criteria and SAMHSA Eight (8) Initiatives. The second initiative addresses Trauma and Justice. This section includes: 1) a description of training and technical assistance related to child and adolescent evidence-based trauma focused models; 2) adult and child Block Grant funded projects related to trauma issues; 3) suicide initiatives; and 4) disaster mental health initiatives.

## IV: Narrative Plan

### I. Justice

#### Narrative Question:

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The SABG and MHBG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance abuse disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: drug courts and mental health courts. In addition to these behavioral health problem-solving courts, some jurisdictions operate courts specifically for DWI/DUI, veterans, families, and reentry, as well as courts for gambling, domestic violence, truancy, and other subject-specific areas.<sup>42,43</sup> Rottman described the therapeutic value of problem-solving courts: Specialized courts provide a forum in which the adversarial process can be relaxed and problem solving and treatment processes emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs. Youths in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient utilization of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; and therefore, risk factors remain unaddressed.<sup>44</sup>

A true diversion program takes youth who would ordinarily be processed within the juvenile justice system and places them instead into an alternative program. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with mental and/or substance use disorders from correctional settings. States should also examine specific barriers such as lack of identification needed for enrollment; loss of eligibility resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention

Please answer the following questions:

1. Does your state have plans to enroll individuals involved in the criminal and juvenile justice systems in Medicaid as a part of coverage expansions?
2. What screening and services are provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?
3. Are your SMHA and SSA coordinating with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities, and the reentry process for those individuals?
4. Do efforts around enrollment and care coordination address specific issues faced by individuals involved in the criminal and juvenile justice systems?
5. What cross-trainings do you provide for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

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42 The American Prospect: In the history of American mental hospitals and prisons, The Rehabilitation of the Asylum. David Rottman, 2000.

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

44 Journal of Research in Crime and Delinquency: Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice. Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNeil, Dale E., and Renée L. Binder. OJJDP Model Programs Guide.

#### Footnotes:

The District's Behavioral Health Assessment and Plan, Planning Step 1 section on Behavioral Health Populations and Services is organized by the statutory reporting criteria and SAMHSA Eight (8) Initiatives. The second initiative addresses Trauma and Justice. This section includes a description of court and criminal justice system initiatives. It includes adult and juvenile diversion programs, prison re-entry, competency restoration, jail services, and Crisis Intervention Officer training.

## IV: Narrative Plan

### J. Parity Education

#### Narrative Question:

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SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action states can develop communication plans to provide and address key issues. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position.

Please answer the following questions:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness about parity?
2. How will or can states coordinate across public and private sector entities to increase awareness and understanding about benefits (e.g., service benefits, cost benefits, etc.?)
3. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that are directly impacted by parity?

#### Footnotes:

The planning for the new Department of Behavioral Health will address proactive steps to improve consumer knowledge about parity.

## IV: Narrative Plan

### K. Primary and Behavioral Health Care Integration Activities

#### Narrative Question:

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

Please answer the following questions:

1. Describe your involvement in the various coordinated care initiatives that your state is pursuing?
2. Are there other coordinated care initiatives being developed or implemented in addition to opportunities afforded under the Affordable Care Act?
3. Are you working with your state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHC), other primary care practices and the publicly funded behavioral health providers?
4. Describe how your behavioral health facilities are moving towards addressing nicotine dependence on par with other substance use disorders.
5. Describe how your agency/system regularly screens, assesses, and addresses smoking amongst your clients. Include tools and supports (e.g. regular screening with a carbon monoxide (CO) monitor) that support your efforts to address smoking.
6. Describe how your behavioral health providers are screening and referring for:
  - a. heart disease,
  - b. hypertension,
  - c. high cholesterol, and/or
  - d. diabetes.

#### Footnotes:

The District's Behavioral Health Assessment and Plan, Planning Step 1 section on Behavioral Health Populations and Services is organized by the statutory reporting criteria and SAMHSA Eight (8) Initiatives. The fourth initiative, Recovery Support, has a section on health and mental health. It includes medical and dental services, primary care physician linkage, integration of primary health in behavioral health and other settings, as well as related Block Grant funded projects.

## IV: Narrative Plan

### L. Health Disparities

#### Narrative Question:

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In the Block Grant application, states are routinely asked to define the population they intend to serve (e.g., adults with SMI at risk for chronic health conditions, young adults engaged in underage drinking, populations living with or at risk for contracting HIV/AIDS). 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, Latino adults with SMI may be at heightened risk for metabolic disorder due to lack of appropriate in-language primary care services, 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, and African American women may be at greater risk for contracting HIV/AIDS due to lack of access to education on risky sexual behaviors in urban low-income communities.

While these factors might not be pervasive among the general population served by the Block Grant, they may be predominant among subpopulations or groups vulnerable to disparities. To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is being served or not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. In order for states to address the potentially disparate impact of their Block Grant funded efforts, they will be asked to address access, use, and outcomes for subpopulations, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection, and sexual orientation (i.e., lesbian, gay, bisexual).

In the space below please answer the following questions:

1. How will you track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBTQ, and age?
2. How will you identify, address and track the language needs of disparity-vulnerable subpopulations?
3. How will you develop plans to address and eventually reduce disparities in access, service use, and outcomes for the above disparity-vulnerable subpopulations?
4. How will you use Block Grant funds to measure, track and respond to these disparities?

#### Footnotes:

The District of Columbia Community Health Needs Assessment, Volume 1 (revised 3/15/13), is a comprehensive analysis of a series of indicators and outcomes that describe the overall health status of District residents. It highlights a number of health disparities. The planning for the new Department of Behavioral Health will consider how these disparities adversely impact individuals with mental health and/or substance use disorders.

## IV: Narrative Plan

### M. Recovery

#### Narrative Question:

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SAMHSA encourages states to take proactive steps to implement recovery support services. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports, 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.

### Indicators/Measures

Please answer yes or no to the following questions:

1. Has the state has developed or adopted (or is the state in the process of developing and/or adopting) a definition of recovery and set of recovery values and/or principles that have been vetted with key stakeholders including people in recovery?
2. Has the state documented evidence of hiring people in recovery in leadership roles (e.g., in the state Office of Consumer Affairs) within the state behavioral health system?
3. Does the state's plan include strategies that involve the use of person-centered planning and self-direction and participant-directed care?
4. Does the state's plan indicate that a variety of recovery supports and services that meets the holistic needs of those seeking or in recovery are (or will be) available and accessible? Recovery supports and services include a mix of services outlined in The Good and Modern Continuum of Care Service Definitions, including peer support, recovery support coaching, recovery support center services, supports for self-directed care, peer navigators, and other recovery supports and services (e.g., warm lines, recovery housing, consumer/family education, supported employment, supported employments, peer-based crisis services, and respite care).
5. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?
6. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services?
7. Does the state have an accreditation program, certification program, or standards for peer-run services?
8. Describe your state's exemplary activities or initiatives related to recovery support services that go beyond what is required by the Block Grant application and that advance the state-of-the-art in recovery-oriented practice, services, and systems. Examples include: efforts to conduct empirical research on recovery supports/services, identification and dissemination of best practices in recovery supports/services, other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system.

### Involvement of Individuals and Families

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

1. How are individuals in recovery and family members utilized in the planning, delivery, and evaluation of behavioral health services?
2. Does the state sponsor meetings or other opportunities that specifically identify individuals' and family members' issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?
3. How are individuals and family members presented with opportunities to proactively engage the behavioral health service delivery system; participate in treatment and recovery planning, shared decision making; and direct their ongoing care and support?
4. How does the state support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

### Housing

1. What are your state's plans to address housing needs of persons served so that they are not served in settings more restrictive than necessary?
2. What are your state's plans to address housing needs of persons served so that they are more appropriately incorporated into a

supportive community?

**Footnotes:**

The District's Behavioral Health Assessment and Plan, Planning Step 1 section on Behavioral Health Populations and Services is organized by the statutory reporting criteria and SAMHSA Eight (8) Initiatives.. The fourth initiative, Recovery Support, has sections on home, purpose and community. It describes Block Grant funded and other projects related to housing, education, peer advocacy, youth and adult training, and employment opportunities.

## IV: Narrative Plan

### N. Evidence Based Prevention and Treatment Approaches for the MHBG (5 percent)

#### Narrative Question:

States are being asked to utilize at least five percent of their MHBG funds to award competitive grants to implement the most effective evidence-based prevention and treatment approaches focusing on promotion, prevention and early intervention. States that receive two percent or more of the total FY 2014 state allotment will be required to implement a competitive sub award process. States should describe how they intend to implement the competitive grants and/or sub award process.

#### Footnotes:

Historically, the mental health system has embraced using a number of evidence-based treatment approaches across our consumer populations, especially children and youth. The planning for the new Department of Behavioral Health will assess the need to expand these approaches across mental health and substance use disorder programs and services. It will consider the use of MHBG funds in the future to support these initiatives.



## IV: Narrative Plan

### O. Children and Adolescents Behavioral Health Services

#### Narrative Question:

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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 over 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states. In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidence-based treatment for youth with substance use disorders.

SAMHSA expects that states will build on this well-documented, effective system of care approach to serving children and youth with behavioral health needs. Given the multi-system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. The array of services and supports in the system of care approach includes non-residential services, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification.

Please answer the following questions:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with mental and substance use disorders?
2. What guidelines have and/or will the state establish for individualized care planning for children/youth with mental, substance use and co-occurring disorders?
3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?
4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?
5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?

#### Footnotes:

The District's Behavioral Health Assessment and Plan, Planning Step 1 section on Behavioral Health Populations and Services is organized by the statutory reporting criteria and SAMHSA Eight (8) Initiatives. Criterion 3 is Children's Services. It describes system of care planning initiatives; early childhood prevention and intervention projects; wraparound initiative; establishing a primary family-run organization; residential treatment center reinvestment program; choice providers; child and youth mobile crisis services; and juvenile diversion program.

## IV: Narrative Plan

### P. Consultation with Tribes

Narrative Question:

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SAMHSA is required by the 2009 Memorandum on Tribal Consultation 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.

Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinions between 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.

For the context of the Block Grants 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. SAMHSA is requesting that states provide a description of how they consulted with tribes in their state, which should indicate how concerns of the tribes were addressed in the State Block Grant plan(s). States shall not require any tribe to waive its sovereign immunity in order to receive funds or in order 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. For states that are currently working with tribes, a description of these activities must be provided in the area below. States seeking technical assistance for conducting tribal consultation may contact the SAMHSA project officer prior to or during the Block Grant planning cycle.

**Footnotes:**

Not applicable for the District of Columbia

## IV: Narrative Plan

### Q. Data and Information Technology

Narrative Question:

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In the FY 2012/2013 Block Grant application, SAMHSA asked each state to:

- Describe its plan, process, and resources needed and timeline for developing the capacity to provide unique client-level data;
- List and briefly describe all unique information technology systems maintained and/or utilized by the state agency;
- Provide information regarding its current efforts to assist providers with developing and using EHRs;
- Identify the barriers that the state would encounter when moving to an encounter/claims based approach to payment; and
- Identify the specific technical assistance needs the state may have regarding data and information technology.

Please provide an update of your progress since that time.

**Footnotes:**

The District's Behavioral Health Assessment and Plan, Planning Step 1 section on Behavioral Health Populations and Services is organized by the statutory reporting criteria and SAMHSA Eight (8) Initiatives. The seventh initiative is Data Outcomes and Quality. It describes the Provider Scorecard, Applied Research and Evaluation Unit, the Data Infrastructure Grant, Reporting Work Group, and the implementation of the integrated applications care management system (iCAMS).

## IV: Narrative Plan

### R. Quality Improvement Plan

#### Narrative Question:

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In the FY 2012/2013 Block Grant application, 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, that will describe the health of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, continue reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements and garner and use stakeholder input, including individuals in recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints and grievances. In an attachment, states must submit a CQI plan for FY 2014/2015.

#### Footnotes:

While the Department does not currently have a formal Quality Improvement Plan, there are several documented Quality Improvement functions taking place in our system. First, within the Office of Accountability there is a centralized quality improvement process. This process includes oversight for provider certification, claims audits, quality reviews, publishing the Provider Scorecard, conducting investigations, facility licensure, and facilitating both external and internal Quality Improvement committees. The Organizational Development Division's Community Services Review Unit oversees the adult and child reviews. Also, the Office of Programs and Policy provides ongoing technical assistance to providers through the Systems of Care Unit and Adult Services. Provider Relations provides support to enhance the success and effectiveness of the Department's provider network development.

## IV: Narrative Plan

### S. Suicide Prevention

Narrative Question:

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In the FY 2012/2013 Block Grant application, SAMHSA asked states to:

- Provide the most recent copy of your state's suicide prevention plan; or
- Describe when your state will create or update your plan.

States shall include a new plan as an attachment to the Block Grant Application(s) to provide a progress update since that time. Please follow the format outlined in the new SAMHSA document [Guidance for State Suicide Prevention Leadership and Plans](#) available on the SAMHSA website at [here](#).

**Footnotes:**

The most recent Suicide Prevention Plan is attached.



## D.C. Suicide Prevention Plan

<b>Goal 1: Promote awareness that suicide is a serious public health problem and that many suicides are preventable</b>			
<b>Objectives</b>	<b>Activities</b>	<b>Outcomes Expected</b>	<b>Products/Outcomes as of October 2011</b>
<ul style="list-style-type: none"> <li>• Create culturally competent social marketing campaign on risk factors for suicide and depression</li> </ul>	<ul style="list-style-type: none"> <li>• Create a series of multilingual (Spanish, English, Aramaic etc.) posters, brochures to be distributed to schools, recreation centers, collaborative centers, boys/girls' clubs, barber shops, shopping centers, churches, hospitals, detention centers, pediatrician's offices, health fairs, emergency rooms, workshop sites.</li> <li>• Distribute information about suicide prevention through an advertising campaign utilizing billboards, radio ads, television in Spanish and English</li> </ul>	<ul style="list-style-type: none"> <li>• By 2010, 10% of residents of D.C. will have been exposed to some suicide prevention materials</li> <li>• By 2011, 25% of residents of D.C. will have been exposed to suicide prevention materials</li> <li>• By 2015, all residents of D.C. will have been exposed to some suicide prevention materials</li> <li>• Increased # parents will consent for screening.</li> <li>• Increased # groups will request materials.</li> </ul>	<ul style="list-style-type: none"> <li>• Social Marketing Campaign created: I Am The Difference (posters depict youth of difference ethnicities)</li> <li>• Materials distributed widely</li> <li>• Chat and Chews in community planned for Fall</li> <li>• Radio Ads ran end of Aug thru September on WKYS</li> <li>• Radio to run again Thanksgiving thru Christmas</li> <li>• 750,000 people in DC – at least 10% reached via radio, materials</li> <li>•</li> </ul>
<ul style="list-style-type: none"> <li>• Provide information about suicide prevention and awareness to established groups</li> </ul>	<ul style="list-style-type: none"> <li>• Present DC suicide plan and information on suicide prevention to local working groups such as interfaith boards, Mayor's Reconnecting Disconnected Youth Board, School Health Work Group, relevant Boards and Commissions</li> <li>• Collaborate with local mental health associations to reach DC residents (NAMI DC, Mental Health America DC, Mental Health Association of DC)</li> </ul>	<ul style="list-style-type: none"> <li>• Present to established groups by 2010</li> <li>• Present yearly to update groups and expand efforts</li> </ul>	<ul style="list-style-type: none"> <li>• Have worked with some groups – Children and Youth Directors, Children's Hospital planned in Oct, School nurses planned in Oct,</li> <li>• NAMI and Mental Health America attended our conference</li> </ul>
<ul style="list-style-type: none"> <li>• Collaborate with local conferences and forums and provide awareness and education about suicide prevention and intervention</li> </ul>	<ul style="list-style-type: none"> <li>• Present at local conferences or meetings</li> <li>• Seek out conferences that incorporate faith community as well as Latino, GLBT, school officials.</li> </ul>	<ul style="list-style-type: none"> <li>• Present at local events each year</li> </ul>	<ul style="list-style-type: none"> <li>• Held DC Youth Suicide Prevention conference</li> <li>• Two minigrant partners reaching out to faith community</li> </ul>
<ul style="list-style-type: none"> <li>• Collaborate and partner with other community health programs such as community outreach workers on substance abuse, HIV</li> </ul>	<ul style="list-style-type: none"> <li>• Present jointly at local forums</li> <li>• Train community outreach workers in signs and symptoms of suicide as well as risk factors</li> </ul>	<ul style="list-style-type: none"> <li>• Present at least three local forums or trainings each year</li> </ul>	<ul style="list-style-type: none"> <li>• DOH has a QPR Trainer</li> </ul>
<b>Goal 2: Develop broad based support for suicide prevention</b>			

*Last updated 10/2011*

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1

• Objectives	• Activities	• Outcomes	• Outcomes/Products as of October 2011
<ul style="list-style-type: none"> <li>Establish task force to address youth suicide and to initiate goals of this plan.</li> </ul>	<ul style="list-style-type: none"> <li>Expand the STOP Suicide Advisory Board to include representatives from other agencies including: Mayor's Executive Group, DMH, DOH, DJJ, Chancellor's Office, MPD, DOES, DCPS, residential programs, Universities, primary care, suicide organizations such as AAS and SPAN, community providers, parents, youth.</li> </ul>	<ul style="list-style-type: none"> <li>Task force will be created and meet at least quarterly</li> </ul>	<ul style="list-style-type: none"> <li>Coalition meets bimonthly – well supported public/private</li> </ul>
<ul style="list-style-type: none"> <li>Increase the number of professional, volunteer, faith community, and other groups that integrate suicide prevention activities into their ongoing activities and adopt policies to prevent suicide</li> </ul>	<ul style="list-style-type: none"> <li>Develop community/neighborhood partnerships</li> <li>Identify organizations who can outreach to parents, youth</li> <li>Reach out to church groups (Health Ministries)</li> </ul>	<ul style="list-style-type: none"> <li># of groups who request materials, trainings</li> <li># groups who incorporate suicide prevention activities into their organizations</li> </ul>	<ul style="list-style-type: none"> <li>Nine migrant partners</li> <li>At least 50 different agencies receiving materials</li> <li>58 trainings completed</li> <li>Policy change at CFSA for foster care parents</li> </ul>
<b>Goal 3: Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse and suicide prevention services</b>			
• Objectives	• Activities	• Outcomes	• Outcomes/Products as of October 2011
<ul style="list-style-type: none"> <li>Address belief systems of residents and consumers in D.C. to reduce stigma associated with receiving mental health and substance abuse services</li> </ul>	<ul style="list-style-type: none"> <li>Develop outreach materials and social marketing campaign that is culturally competent</li> <li>Create suicide prevention/health and wellness materials for distribution in physicians' offices, schools</li> <li>Materials will be available in multiple languages</li> <li>Emphasize neurobiological basis of many mental disorders and promote effective medicines and therapies</li> </ul>	<ul style="list-style-type: none"> <li>50% of DC youth referred for therapy by screening program will stay in treatment for at least two appointments</li> <li>Materials will be distributed during all well visits.</li> <li>There will be an increase in the percent of parental consents received for screening and education in suicide.</li> </ul>	<ul style="list-style-type: none"> <li>84% youth referred were linked within three months and went to at least one appointment</li> <li>Materials to be given to school nurses in Oct 2011</li> <li>Materials to be disseminated to pediatricians</li> <li>Of 60% of returned consent forms – 58% parents approved</li> </ul>
<ul style="list-style-type: none"> <li>Provide education for families of youth involved in the mental health system for suicide, substance abuse or other mental health issues</li> <li>Work with Medicaid Managed Care Organizations to increase identification of covered services for the Medicaid population</li> </ul>	<ul style="list-style-type: none"> <li>Materials and support groups will be available for families</li> <li>Work through the local Income Maintenance Administration to develop an MOU to increase oversight of interventions on behalf of the Medicaid population</li> </ul>	<ul style="list-style-type: none"> <li>At least 2 new support groups will be established in different regions of the city through churches, hospitals, community based organizations or mental health agencies</li> </ul>	<ul style="list-style-type: none"> <li></li> </ul>

Last updated 10/2011

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<ul style="list-style-type: none"> <li>• Increase the number of suicidal youth with underlying mental health disorders who receive appropriate mental health treatment</li> </ul>	<ul style="list-style-type: none"> <li>• Identify youth through screening and education and link to treatment</li> </ul>	<ul style="list-style-type: none"> <li>• 33% of schools will provide screening by 2013</li> <li>• Schools will sustain screening year to year</li> <li>• Increased # of parents who provide consent for screening and treatment.</li> <li>• Increased # of youth referred for mental health services for depression and suicide.</li> <li>• Improved satisfaction with treatment services.</li> <li>• Referred youth will attend more appointments.</li> </ul>	<ul style="list-style-type: none"> <li>•</li> </ul>
<ul style="list-style-type: none"> <li>• Imbue cultural competence in all prevention strategies</li> </ul>	<ul style="list-style-type: none"> <li>• Identify differences in the ways unique communities in DC respond to suicide prevention and mental health promotion</li> </ul>	<ul style="list-style-type: none"> <li>• All suicide prevention programming will be culturally competent</li> </ul>	<ul style="list-style-type: none"> <li>•</li> </ul>
<ul style="list-style-type: none"> <li>• Promote resilience</li> </ul>	<ul style="list-style-type: none"> <li>• Incorporate wellness programs into DCPS health curriculum</li> <li>• Help promote use of youth external supports, inner-strengths, and interpersonal and problem-solving skills</li> </ul>	<ul style="list-style-type: none"> <li>• All schools will conduct health and wellness prevention programs as part of Health classes by 2011</li> <li>• Families of youth with mental health needs will receive support</li> </ul>	<ul style="list-style-type: none"> <li>•</li> </ul>
<b>Goal 4: Identify, develop, implement and evaluate youth suicide prevention programs</b>			
<ul style="list-style-type: none"> <li>• <b>Objectives</b></li> </ul>	<ul style="list-style-type: none"> <li>• <b>Activities</b></li> </ul>	<ul style="list-style-type: none"> <li>• <b>Outcomes</b></li> </ul>	<ul style="list-style-type: none"> <li>•</li> </ul>
<ul style="list-style-type: none"> <li>• Develop technical support activities to build the capacity across the District to implement and evaluate suicide prevention programs</li> </ul>	<ul style="list-style-type: none"> <li>• Establish collaborations with local stakeholders to share in training, education, and evaluation</li> </ul>	<ul style="list-style-type: none"> <li>• Key positions and coalition will be established</li> </ul>	<ul style="list-style-type: none"> <li>•</li> </ul>
<ul style="list-style-type: none"> <li>• Create policy changes to increase suicide prevention programming and education</li> </ul>	<ul style="list-style-type: none"> <li>• Work with DCPS to incorporate suicide prevention into health curriculum</li> <li>• Establish a policy that makes suicide prevention training mandatory for all school personnel</li> <li>• Make suicide prevention training available to police, recreation staff and other frontline workers</li> </ul>	<ul style="list-style-type: none"> <li>• Suicide prevention will be taught in all health classes for middle and high school youth</li> <li>• All school personnel will receive at least 2 hours annually in suicide prevention</li> <li>• Auxiliary personnel and frontline workers will receive training at least one time annually.</li> <li>• Screening will be incorporated into primary care settings.</li> </ul>	<ul style="list-style-type: none"> <li>•</li> </ul>

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<ul style="list-style-type: none"> <li>• Develop public/private partnerships with local organizations who work with youth at risk for related risk factors for suicide.</li> </ul>	<ul style="list-style-type: none"> <li>• Develop partnership with National Campaign to Prevent Teen Pregnancy, Metro Teen AIDS, Latin American Youth Center</li> </ul>	<ul style="list-style-type: none"> <li>• # organizations who partner</li> <li>• Provide training and/or screening annually.</li> <li>• There will be an increase in help seeking behaviors by youth affiliated with these organizations.</li> </ul>	<ul style="list-style-type: none"> <li>•</li> </ul>
<ul style="list-style-type: none"> <li>• Identify youth at risk for suicide, suicidal behavior, and related risk factors</li> </ul>	<ul style="list-style-type: none"> <li>• Conduct universal screening of depression and suicide in middle and high schools.</li> <li>• Conduct screening through local organizations such as Health ministries</li> <li>• Conduct suicide screening for youth in juvenile detention centers</li> <li>• Conduct suicide screening for youth in CFSA</li> <li>• Conduct suicide screening for youth enrolled in substance abuse treatment through APRA</li> </ul>	<ul style="list-style-type: none"> <li>• Increased # of youth screened for depression and suicide annually.</li> <li>• # of settings conducting screening</li> <li>• # people trained to screen</li> <li>• # screenings held</li> <li>• At least 500 youth screened per year</li> </ul>	<ul style="list-style-type: none"> <li>•</li> </ul>
<ul style="list-style-type: none"> <li>• Train youth in signs and symptoms suicide and how to talk to friends at risk</li> </ul>	<ul style="list-style-type: none"> <li>• Conduct education based prevention program in schools, community, churches</li> <li>• Train staff of organizations with youth workers such as teen pregnancy, HIV prevention in signs of suicide and how to incorporate into their prevention programming</li> </ul>	<ul style="list-style-type: none"> <li>• There will be an increase in help seeking behaviors by youth for mental health services.</li> <li>• # youth who receive training</li> <li>• # sites conducting training</li> </ul>	<ul style="list-style-type: none"> <li>•</li> </ul>
<ul style="list-style-type: none"> <li>• Train medical providers to conduct suicide assessments</li> </ul>	<ul style="list-style-type: none"> <li>• Provide training to pediatricians, managed care organizations, school nurses, ER staff on suicide warning signs and risk factors</li> </ul>	<ul style="list-style-type: none"> <li>• All youth will be asked about thoughts of suicide and depression during well visits</li> <li>• # youth identified through screenings in primary care settings.</li> </ul>	<ul style="list-style-type: none"> <li>•</li> </ul>
<ul style="list-style-type: none"> <li>• Ensure availability of suicide hotlines</li> </ul>	<ul style="list-style-type: none"> <li>• Encourage Department of Mental Health Access Helpline to become a certified crisis line through AAS</li> </ul>	<ul style="list-style-type: none"> <li>• DMH will be a certified crisis hotline for 1800/273-TALK by 2009</li> </ul>	<ul style="list-style-type: none"> <li>•</li> </ul>
<b>Goal 5: Promote efforts to reduce access to lethal means and methods of self-harm</b>			

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<ul style="list-style-type: none"> <li>• <b>Objectives</b></li> <li>• Reduce deaths by passive suicidal means</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Activities</b></li> <li>• Develop partnerships with organizations to reduce risk factors for passive suicidal behavior such as through violence, HIV exposure, substance abuse</li> <li>• Incorporate training on risk factors related to suicide such as exposure to violence, substance abuse when working with youth, families, schools, and community partners</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Outcomes</b></li> <li>• Increased # youth and families will recognize risk factors related to suicide behaviors</li> <li>• At least 500 youth annually participate in these activities</li> </ul>	<ul style="list-style-type: none"> <li>•</li> </ul>
<b>Goal 6: Implement training for recognition of at-risk behavior and delivery of effective treatment</b>			
<ul style="list-style-type: none"> <li>• <b>Objectives</b></li> <li>• Identify individuals to be trained as “Certified QPR Trainers”</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Activities</b></li> <li>• Establish group of individuals to be trained from diverse agencies within DC – including DCPS, DOH, DMH, DJJ, DOES, MPD, DCPS, CFSA, DYRS, organizations that serve charter schools, church representatives, parents, school nurses, neighborhood/community groups</li> <li>• Identify staff in programs who work with high risk youth to receive training through programs such as Metro TeenAIDS, Campaign to Prevent Teen Pregnancy, GLBT programs, Latino community</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Outcomes</b></li> <li>• 50 individuals will be trained as certified QPR trainers</li> <li>• Pre/Post-tests by trainees will show increase in knowledge and skills acquisition</li> <li>• Within 5 years, 75% of staff at each of these agencies will have received QPR training.</li> <li>• 1000 people annually will receive QPR gatekeeper training</li> </ul>	<ul style="list-style-type: none"> <li>•</li> </ul>
<ul style="list-style-type: none"> <li>• Train medical professionals in signs and symptoms of suicide and depression</li> </ul>	<ul style="list-style-type: none"> <li>• Train pediatricians in signs and symptoms of suicide</li> <li>• Train hospital emergency room workers in signs and symptoms of suicide</li> <li>• Train mobile outreach groups (dental, pediatrics, maternal/child) in signs and symptoms of suicide</li> </ul>	<ul style="list-style-type: none"> <li>• Train at least 100 individuals yearly involved in well visits</li> </ul>	<ul style="list-style-type: none"> <li>•</li> </ul>
<b>Goal 7: Develop and promote effective clinical and professional practices</b>			
<ul style="list-style-type: none"> <li>• <b>Objectives</b></li> <li>• Enhance the abilities of providers to provide culturally competent, evidence-based management of youth in crisis</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Activities</b></li> <li>• Provide training to DMH, CFSA, DJJ, CSAs and private providers, physicians, nurses</li> <li>• Provide training to all providers of mental health services in the management youth in a suicidal crisis</li> <li>• All training will be based on culturally competent principles</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Outcomes</b></li> <li>• At least 500 individuals will receive training per year</li> </ul>	<ul style="list-style-type: none"> <li>•</li> </ul>
<ul style="list-style-type: none"> <li>• Establish group of individuals who have received training in suicide prevention and identification in schools</li> </ul>	<ul style="list-style-type: none"> <li>• Encourage schools to apply for school-based accreditation through AAS</li> </ul>	<ul style="list-style-type: none"> <li>• At least 5 schools per year will receive accreditation in suicide prevention</li> </ul>	<ul style="list-style-type: none"> <li>•</li> </ul>

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<ul style="list-style-type: none"> <li>Promote therapeutic support for victims of violence and sexual abuse as risk factor for suicidal behavior</li> </ul>	<ul style="list-style-type: none"> <li>Identify youth who are victims of violence or sexual abuse</li> <li>Promote linkage between violence and suicide</li> <li>Youth with histories of violence or sexual abuse will be identified and providers working with these youth will incorporate screening for suicide and depression</li> </ul>	<ul style="list-style-type: none"> <li>10% more youth yearly will be identified to mental health providers or receive prevention programming from community based organizations with histories of exposure to violence or sexual abuse</li> </ul>	<ul style="list-style-type: none"> <li></li> </ul>
<b>Goal 8: Improve access to and community linkages with mental health and substance abuse services</b>			
<ul style="list-style-type: none"> <li><b>Objectives</b></li> </ul>	<ul style="list-style-type: none"> <li><b>Activities</b></li> </ul>	<ul style="list-style-type: none"> <li><b>Outcomes</b></li> </ul>	<ul style="list-style-type: none"> <li></li> </ul>
<ul style="list-style-type: none"> <li>Ensure timely and accurate compliance with referrals of all youth referred to local mental health providers.</li> </ul>	<ul style="list-style-type: none"> <li>Create database and reporting mechanisms for data regarding screening, referral, and compliance with recommendations</li> <li>Monitor and track length of time from referral to first appointment</li> </ul>	<ul style="list-style-type: none"> <li>50% of youth will be linked to services within one month of screen</li> <li>75% of youth will be linked to service within six months of screen</li> </ul>	<ul style="list-style-type: none"> <li></li> </ul>
<ul style="list-style-type: none"> <li>Determine length of treatment</li> </ul>	<ul style="list-style-type: none"> <li>Assess whether youth stays in treatment for at least two appointments</li> </ul>	<ul style="list-style-type: none"> <li>Collaborate with treatment providers to obtain follow-up data on at least 50% of youth referred for treatment</li> </ul>	<ul style="list-style-type: none"> <li></li> </ul>
<ul style="list-style-type: none"> <li>Ensure satisfaction of services rendered</li> </ul>	<ul style="list-style-type: none"> <li>Conduct parent satisfaction surveys.</li> </ul>	<ul style="list-style-type: none"> <li>50% of parents with youth referred for treatment will complete Satisfaction Survey</li> </ul>	<ul style="list-style-type: none"> <li></li> </ul>
<ul style="list-style-type: none"> <li>Compile and update a guide to DC suicide prevention resources and services</li> </ul>	<ul style="list-style-type: none"> <li>Update resource list to include local, state, and national organizations with a focus on suicide awareness, prevention, intervention, and aftercare.</li> <li>Distribute list widely.</li> </ul>	<ul style="list-style-type: none"> <li>Guide will be available at schools, mental health centers, local organizations, pediatricians by 2012</li> </ul>	<ul style="list-style-type: none"> <li></li> </ul>
<b>Goal 9: Improve reporting and portrayals of suicidal behavior, mental illness, and substance abuse in the entertainment and news media</b>			
<ul style="list-style-type: none"> <li><b>Objectives</b></li> </ul>	<ul style="list-style-type: none"> <li><b>Activities</b></li> </ul>	<ul style="list-style-type: none"> <li><b>Outcomes</b></li> </ul>	<ul style="list-style-type: none"> <li></li> </ul>
<ul style="list-style-type: none"> <li>Increase the number of local television programs and news reports that observe recommended guidelines in the depiction of suicide and mental illness</li> </ul>	<ul style="list-style-type: none"> <li>Provide guidelines from AAS to local media outlets</li> </ul>	<ul style="list-style-type: none"> <li>Local news agencies will make changes to their reporting</li> </ul>	<ul style="list-style-type: none"> <li></li> </ul>

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<b>Goal 10: Promote and support research on suicide and suicide prevention</b>			
<b>• Objectives</b>	<b>• Activities</b>	<b>• Outcomes</b>	<b>•</b>
<ul style="list-style-type: none"> <li>Promote youth suicide prevention research</li> </ul>	<ul style="list-style-type: none"> <li>Develop partnerships with universities to collect, analyze, and disseminate data on youth suicide prevention and training</li> </ul>	<ul style="list-style-type: none"> <li>Data and activities of the DC Suicide Prevention Coalition will be analyzed annually and distributed</li> </ul>	<ul style="list-style-type: none"> <li></li> </ul>
<ul style="list-style-type: none"> <li>Evaluate prevention programs</li> </ul>	<ul style="list-style-type: none"> <li>Gather data on universal suicide prevention programs on numbers of youth identified with suicidality, depression, substance abuse</li> <li>Gather data on numbers of youth linked effectively to treatment for mental health services following screening</li> <li>Gather data on numbers of youth identified as suicidal as a result of gatekeeper training</li> <li>Gather data on numbers of youth identified through classroom-based peer prevention programs</li> </ul>	<ul style="list-style-type: none"> <li>Data and activities of the DC Suicide Prevention Coalition will be analyzed annually and distributed</li> <li>Data will be presented at national and local conferences</li> </ul>	<ul style="list-style-type: none"> <li></li> </ul>
<b>Goal 11: Improve and expand surveillance systems</b>			
<b>• Objectives</b>	<b>• Activities</b>	<b>• Outcomes</b>	<b>•</b>
<ul style="list-style-type: none"> <li>Synthesize suicide data for the District</li> </ul>	<ul style="list-style-type: none"> <li>Obtain data from all relevant stakeholders (hospitals, Child Fatality Review Committee, police, schools, crisis response teams, Access Helpline) with regard to youth suicide (completions, attempts, hotline calls) in the District</li> <li>Determine STIPDA representative for District</li> <li>Encourage DC to establish National Violent Death Reporting System</li> </ul>	<ul style="list-style-type: none"> <li>Stakeholders will provide data to central repository</li> <li>DC will contribute to NVDRS</li> </ul>	<ul style="list-style-type: none"> <li></li> </ul>
<ul style="list-style-type: none"> <li>Increase the number of hospitals and local service providers that code for external cause of injuries</li> </ul>	<ul style="list-style-type: none"> <li>Encourage hospitals to code for suicidal behaviors</li> <li>Encourage police to report on transporting suicide victim</li> </ul>	<ul style="list-style-type: none"> <li>Hospitals will use codes for external causes of injury</li> </ul>	<ul style="list-style-type: none"> <li></li> </ul>
<ul style="list-style-type: none"> <li>Produce an annual report on youth suicide</li> </ul>	<ul style="list-style-type: none"> <li>Present findings to District leaders (Mayor, City Council) and recommend changes</li> </ul>	<ul style="list-style-type: none"> <li>Annual report will be distributed yearly</li> </ul>	<ul style="list-style-type: none"> <li></li> </ul>

*Last updated 10/2011*

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## IV: Narrative Plan

### T. Use of Technology

Narrative Question:

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In the FY 2012/2013 Block Grant application, SAMHSA asked states to describe:

- What strategies the state has deployed to support recovery in ways that leverage ICT;
- What specific application of ICTs the State BG Plans to promote over the next two years;
- What incentives the state is planning to put in place to encourage their use;
- What support system the State BG Plans to provide to encourage their use;
- Whether there are barriers to implementing these strategies and how the State BG Plans to address them;
- How the State BG Plans to work with organizations such as FQHCs, hospitals, community-based organizations, and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine;
- How the state will use ICTs for collecting data for program evaluation at both the client and provider levels; and
- What measures and data collection the state will promote to evaluate use and effectiveness of such ICTs.

States must provide an update of any progress since that time.

**Footnotes:**

The planning for the new Department of Behavioral Health will consider how to support recovery of individuals with mental health and substance use disorders by using ICTs and develop an appropriate strategy.

## IV: Narrative Plan

### U. Technical Assistance Needs

Narrative Question:

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States shall describe the data and technical assistance needs identified during the process of developing this plan that will facilitate the implementation of the proposed plan. The technical assistance needs identified may include the needs of the state, providers, other systems, persons receiving services, persons in recovery, or their families. Technical assistance includes, but is not limited to, assistance with assessing needs; capacity building at the state, community and provider level; planning; implementation of programs, policies, practices, services, and/or activities; evaluation of programs, policies, practices, services, and/or activities; cultural competence and sensitivity including how to consult with tribes; and sustainability, especially in the area of sustaining positive outcomes. The state should indicate what efforts have been or are being undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.

1. What areas of technical assistance is the state currently receiving?
2. What are the sources of technical assistance?
3. What technical assistance is most needed by state staff?
4. What technical assistance is most needed by behavioral health providers?

Footnotes:

The Department has identified seven (7) priority needs that include:

1. Sustaining programs for housing for transitional-aged youth (Department);
2. Workforce development: recruiting and retaining psychiatrists (Department and providers);
3. Modifications to mental health rehabilitation services to incentivize providers (Department);
4. Affordable Care Act- Mental Health/Behavioral Health issues (Department and providers);
5. Behavioral/primary care integration- specifically HIT/HIE data sharing issues (Department and providers);
6. Grant writing for consumers/family members/small community-based organizations and others (Department, providers and community); and
7. Grant administration (Department).

## IV: Narrative Plan

### V. Support of State Partners

#### Narrative Question:

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The success of a state's MHBG and SABG 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. States should identify these partners in the space below and describe how the partners will support them in implementing the priorities identified in the planning process. In addition, the state should provide a letter of support indicating agreement with the description of their role and collaboration with the SSA and/or SMHA, including the state education authority(ies), the State Medicaid Agency, entity(ies) responsible for health insurance and health information marketplaces (if applicable), adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency. SAMHSA will provide technical assistance and support for SMHAs and SSAs in their efforts to obtain this collaboration. These letters should provide specific activities that the partner will undertake to assist the SMHA or SSA with implanting its plan.<sup>45</sup> This could include, but is not limited to:

- The State Medicaid Agency 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 the expanded Medicaid population.
- The state justice system authorities that will work with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with mental and substance use disorders who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment.
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective actors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements.
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system. Specific service issues, such as the appropriate use of psychotropic medication, can also be addressed for children and youth involved in child welfare.
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities.

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<sup>45</sup> SAMHSA will inform the federal agencies that are responsible for other health, social services, and education

#### Footnotes:

The District's Behavioral Health Assessment and Plan, Planning Step 1 has a section on Behavioral Health Partners. It describes the Department of Health Care Finance and the Department of Health. This section also references other partners that have a District-wide and/or agency cluster oversight role, and sister agencies. The specific initiatives that the Department has established with the Behavioral Health Partners is discussed throughout the section on Behavioral Health Populations and Services.



## IV: Narrative Plan

### W. State Behavioral Health Advisory Council

#### Narrative Question:

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Each state is required to establish and maintain a state Behavioral Health Advisory Council (Council) for services for individuals with a mental disorder. While many states have established a similar Council for individuals with a substance use disorders, that is not required. SAMHSA encourages states to expand their required Council's comprehensive approach by designing and use the same Council to review issues and services for persons with, or at risk of, substance abuse and substance use disorders. In addition to the duties specified under the MHBG statute, a primary duty of this newly formed Council will be to advise, consult with, and make recommendations to SMHAs and SSAs regarding their activities. The Council must participate in the development of the MHBG state plan and is encouraged to participate in monitoring, reviewing, and evaluating the adequacy of services for individuals with substance abuse and mental disorders within the state. SAMHSA's expectation is that the State will provide adequate guidance to the Council to perform their review consistent with the expertise of the members on the Council. States are strongly encouraged to include American Indians and/or Alaska Natives in the Council; however, their inclusion does not suffice as tribal consultation. In the space below describe how the state's Council was actively involved in the plan. Provide supporting documentation regarding this involvement (e.g., meeting minutes, letters of support, etc.)

Additionally, please complete the following forms regarding the membership of your state's Council. The first form is a list of the Council members for the state and second form is a description of each member of the Council.

There are strict state Council membership guidelines. States must demonstrate (1) that the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council and (2) that no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services. States must consider the following questions:

- What planning mechanism does the state use to plan and implement substance abuse services?
- How do these efforts coordinate with the SMHA and its advisory body for substance abuse prevention and treatment services?
- Was the Council actively involved in developing the State BG Plan? If so, please describe how it was involved.
- Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into the work of the Council?
- Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
- Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders.

#### Footnotes:

The District of Columbia currently has a State Mental Health Planning and Advisory Council (DC SMHPC) that is transitioning to become a Behavioral Health Planning and Advisory Council (BHPAC). There are two (2) driving forces for creating a BHPAC: 1) on October 1, 2013 the District's mental health and substance use disorder systems, historically in separate departments, will merge to become the Department of Behavioral Health; and 2) the SAMHSA FY 2014-FY 2015 Mental Health Block Application states that "Each state is required to establish and maintain a state Behavioral Health Advisory Council for services for individuals with a mental disorder."

During FY 2013, the Department and the DC SMHPC submitted an application to participate in the State Planning Council National Learning Community Technical Assistance (TA) Project to assist with the transition process. While this application was not selected, an April 2013 application was approved for TA through the general services available to state planning and advisory councils to pursue the transition to a BHPAC. The transition planning process will continue during FY 2014 and will focus on creating a single council by combining the two (2) existing mental health councils; obtaining participation by substance use disorder services staff and stakeholders as well as others; developing roles and responsibilities; and creating a transition plan.

The current description of the membership is based on the District's State Mental Health Planning and Advisory Council.

## IV: Narrative Plan

### Behavioral Health Advisory Council Members

Start Year:   
 End Year:

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Lorry Bonds	State Employees	Housing	1133 North Capitol Street, N.E., Suite 242 Washington, D.C., DC 20002 PH: 202-535-2737 FAX: 202-535-1102	lbonds@dchousing.org
Merita Carter	State Employees	Education	825 N. Capitol Street, NE, Suite 8116 Washington, D.C., DC 20002 PH: 202-442-5640 FAX: 202-442-5602	merita.carter@k12.dc.us
Ricardo Galbis	Providers	Andromeda Transcultural Mental Health Center	1843 S Street, NW Washington, D.C., DC 20009 PH: 202-291-4707 FAX: 202-723-4560	Galbisb@aol.com
Claudia Schlosberg	State Employees	Medicaid	899 North Capitol Street, NE, Sixth Floor Washington, D.C., DC 20002 PH: 202-442-9107 FAX: 202-442-8114	Claudia.schlosberg@dc.gov
Nader Marzban	State Employees	Criminal Justice	1923 Vermont Avenue, NW, Suite 101 Washington, D.C., DC 20001 PH: 202-671-2069	nadr.marzban@dc.gov
Peggy Massey	State Employees	Social Services	64 New York Avenue, NE, 6th Floor Washington, D.C., DC 20002 PH: 202-671-4346 FAX: 202-279-8742	peggy.massey@dc.gov
Edmund Neboh	State Employees	Vocational Rehabilitation	810 First Street, NE, 10th Floor Washington, D.C., DC 20002 PH: 202-442-8633 FAX: 202-442-8742	edmund.neboh@dc.gov
Juanita Reaves	State Employees	Mental Health	64 New York Avenue, NE, 2nd Floor Washington, D.C., DC 20002 PH: 202-671-4080 FAX: 202-673-7053	juanita.reaves@dc.gov
			323 Quackenbos	

Senora Simpson	Family Members of Individuals in Recovery (to include family members of adults with SMI)		Street, NE Washington, D.C., DC 20011 PH: 202-529-2134	ssimps2100@aol.com
Effie Smith	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		461 H Street, NW , Suite 919 Washington, D.C., DC 20001 PH: 202-408-1817	esmith@can-dc.org
Lynne Smith	Family Members of Individuals in Recovery (to include family members of adults with SMI)		921 French Street, NW Washington, D.C., DC 20001 PH: 202-412-3999	lynne.smith@dc.gov
Burton Wheeler	Family Members of Individuals in Recovery (to include family members of adults with SMI)		3800 25th Street, NE Washington, D.C., DC 20018 PH: 202-468-5607 FAX: 301-499-4388	burton.globalbiz@gmail.com
Samuel Awosika	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		4201 Fort Dupont Terrace, SE Washington, D.C., DC 20020 PH: 202-299-5157 FAX: 202-561-6974	samuel.awosika@dc.gov
Bertha Holliday	Others (Not State employees or providers)		1719 First Street, NW Washington, D.C., DC 20001 PH: 202-265-8308	bhollidaypsy@gmail.com
Sharon White	State Employees	District of Columbia Department of Mental Health	64 New York Avenue, NE, 3rd Floor Washington, D.C., DC 20002 PH: 202-673-4372	sharonm.white@dc.gov

**Footnotes:**

The Behavioral Health Planning Council members reported here are the current members on the roster of the District Mental Health Planning and Advisory Council. This Council is in the process of transitioning to a Behavioral Health Planning Council. This membership will change once the Transition Plan is developed, approved, and implemented.

## IV: Narrative Plan

### Behavioral Health Council Composition by Member Type

Start Year:

End Year:

Type of Membership	Number	Percentage
Total Membership	19	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	2	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	3	
Parents of children with SED*	0	
Vacancies (Individuals and Family Members)	<input type="text" value="4"/>	
Others (Not State employees or providers)	1	
<b>Total Individuals in Recovery, Family Members &amp; Others</b>	<b>10</b>	<b>52.63%</b>
State Employees	8	
Providers	1	
Federally Recognized Tribe Representatives	0	
Vacancies	<input type="text" value="0"/>	
<b>Total State Employees &amp; Providers</b>	<b>9</b>	<b>47.37%</b>
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text" value="0"/>	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text" value="0"/>	
<b>Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations</b>	<b>0</b>	
Persons in recovery from or providing treatment for or advocating for substance abuse services	<input type="text" value="0"/>	

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

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

Planning Council members reviewed the Draft FY 2014-FY 2015 Mental Health Block Grant Application. There were no recommendations to modify the application. Members of this body also serve on the Advisory Committee for the transition to a Behavioral Health Planning and Advisory Council. This initiative began in FY 2013 and will continue in FY 2014.

The Planning Council will also participate in the development of the FY 2014- FY 2015 Request for Projects including: 1) identifying initiatives and/or services for developing projects that will be included in the notice of funding availability (NOFA); 2) reviewing all project proposals; and 3) making recommendations to the Director regarding the projects and funding amounts for his final approval.

#### Footnotes:

Because the District is in the process of planning the transition from a mental health planning council to a Behavioral Health Planning and Advisory Council, we cannot address additional member representation at this time. The District will strive to be compliant with the statutory requirements for Planning Council membership, as well as encourage other member representatives and categories of membership in the new Behavioral Health Planning and Advisory Council.

## IV: Narrative Plan

### X. Enrollment and Provider Business Practices, Including Billing Systems

#### Narrative Question:

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Each state is asked to set-aside three percent each of their SABG and MHBG allocations to support mental and substance use service providers in improving their capacity to bill public and private insurance and to support enrollment into health insurance for eligible individuals served in the public mental and substance use disorder service system. The state should indicate how it intends to utilize the three percent to impact enrollment and business practices taking into account the identified needs, including:

- Outreach and enrollment support for individuals in need of behavioral health services.
- Business plan redesign responsive to the changing market under the Affordable Care Act and MHPAEA.
- Development, redesign and/or implementation of practice management and accounts receivable systems that address billing, collection, risk management and compliance.
- Third-party contract negotiation.
- Coordination of benefits among multiple funding sources.
- Adoption of health information technology that meets meaningful use standards.

#### Footnotes:

The planned FY 2014 expenditures include the three percent (3%) set-aside of the MHBG allocation to support mental health providers improve their capacity to bill public and private insurance and to support enrollment into health insurance for eligible individuals served in the public mental health service system. The development of the strategy to realize this goal is pending.

## IV: Narrative Plan

### Y. Comment on the State BG Plan

#### Narrative Question:

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Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. 300x-51) requires that, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the State BG 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 the Secretary of HHS.

#### Footnotes:

It is the Department's practice to post the Mental Health Block Grant Application on its website. The District of Columbia FY 2014- FY 2015 Mental Health Block Grant Application will remain on the website allowing ongoing comment and feedback. Comments may be received from consumers, family members, advocates, providers, and other public and private agencies, including District, Federal, state, and national entities.

# I: State Information

## State Information

### Plan Year

Start Year:

2014

End Year:

2015

### State DUNS Number

Number

14384031

Expiration Date

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

Agency Name

District of Columbia Department of Behavioral Health

Organizational Unit

Office of Strategic Planning, Policy & Evaluation

Mailing Address

64 New York Avenue, N.E., Third Floor

City

Washington, D.C.

Zip Code

20002

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

First Name

Juanita Y.

Last Name

Reaves

Agency Name

District of Columbia Department of Behavioral Health

Mailing Address

64 New York Avenue, N.E., Second Floor

City

Washington, D.C.

Zip Code

20002

Telephone

202-671-4080

Fax

202-673-7053

Email Address

juanita.reaves@dc.gov

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

From

To

### IV. Date Submitted



NOTE: this field will be automatically populated when the application is submitted.

Submission Date

Revision Date

**V. Contact Person Responsible for Application Submission**

First Name

Last Name

Telephone

Fax

Email Address

**Footnotes:**

## I: State Information

### Assurance - Non-Construction Programs

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

**PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.**

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

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


1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

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Name:   
Title:   
Organization:

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Signature: 

Date: 8/22/13

**Footnotes:**

# I: State Information

## Certifications

### 1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

- a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
- d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

### 2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 45 CFR Part 76 by:

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

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management  
Office of Grants Management  
Office of the Assistant Secretary for Management and Budget

### 3. Certifications Regarding Lobbying

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

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

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

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

### 4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA)

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

### 5. Certification Regarding Environmental Tobacco Smoke

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

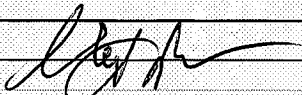
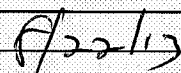
Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

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

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

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

Name	Stephen T. Baron
Title	Director
Organization	D.C. Department of Behavioral Health

Signature:  Date: 

#### Footnotes:

## I: State Information

### Chief Executive Officer's Funding Agreements (Form 3) - Fiscal Year 2014

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

#### Title XIX, Part B, Subpart I of the Public Health Service Act

Section	Title	Chapter
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6

#### Title XIX, Part B, Subpart III of the Public Health Service Act

Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

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

Name of Chief Executive Officer (CEO) or Designee

Stephen T. Baron

Title

Director, D.C. Department of Behavioral Health

Signature of CEO or Designee<sup>1</sup>:



Date:

8/29/13

<sup>1</sup> If the agreement is signed by an authorized designee, a copy of the designation must be attached.

**Footnotes:**

**GOVERNMENT OF THE DISTRICT OF COLUMBIA**

**ADMINISTRATIVE ISSUANCE SYSTEM**

Mayor's Order 2011-193  
December 9, 2011

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

**ORIGINATING AGENCY:** Office of the Mayor

By virtue of the authority vested in me as Mayor of the District of Columbia by sections 422(6) and (11) of the District of Columbia Home Rule Act, approved December 24, 1973, 87 Stat. 790, Pub. L. 93-198, D.C. Official Code § 1-204.22(6) and (11) (2011 Supp.), it is hereby


**ORDERED** that:

- FIRST DELEGATION OF AUTHORITY:** The Mayor hereby delegates to the Director of the Department of Health, or in his absence the Chief Operating Officer of the Department of Health, and the Senior Deputy Director, or designee, for the Addiction Prevention and Recovery Administration, authority to sign funding agreements and certifications, provide assurances of compliance to the Secretary of the U.S. Department of Health and Human Services, and to perform similar acts relevant to the administration of the Substance Abuse Prevention and Treatment (SAPT) Block Grant until such time as this delegation of authority is rescinded.
- SECOND DELEGATION OF AUTHORITY:** The Mayor hereby delegates to the Director of the Department of Mental Health, or designee, authority to sign funding agreements with the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration for grants to be administered by the Department of Mental Health.
- RESCISSIONS:** Mayor's Order 2007-67, dated March 16, 2007, is rescinded. The Mayor's letter to Barbara Orlando regarding a delegation of authority to Stephen T. Baron, dated March 4, 2011, is rescinded.



4. **EFFECTIVE DATE:** This Order shall be effective *nunc pro tunc* to January 3, 2011.

  
\_\_\_\_\_  
VINCENT C. GRAY  
MAYOR

ATTEST:   
\_\_\_\_\_  
CYNTHIA BROCK-SMITH  
SECRETARY OF THE DISTRICT OF COLUMBIA

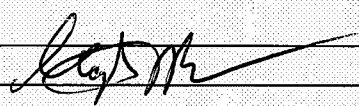
## I: State Information

### Disclosure of Lobbying Activities

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

[Standard Form LLL \(click here\)](#)

Name	Stephen T. Baron
Title	Director
Organization	D.C. Department of Behavioral Health

Signature: 

Date: 1/27/13

#### Footnotes:

Not Applicable