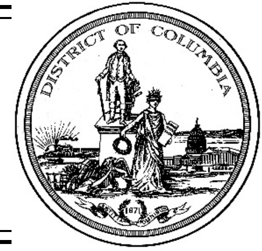
COUNCIL OF THE DISTRICT OF COLUMBIA
COMMITTEE ON HEALTH AND HUMAN SERVICES
CHAIRWOMAN YVETTE M. ALEXANDER
COUNCILMEMBER, WARD 7



Department of Behavioral Health
Oversight Questions

1. Please provide a current organizational chart for DBH. Please provide information to the activity level. In addition, please identify the number of full time equivalents (FTEs) at each organizational level and the employee responsible for the management of each program and activity. If applicable, please provide a narrative explanation of any organizational changes made during FY15 and to date in FY16.

2. Please provide the following budget information for DBH, including the amount budgeted and actually spent for FY15 and to date in FY16. In addition, please describe any variance between the amount budgeted and actually spent for FY15 and to date in FY16:
    a. At the agency level, please provide information broken out by source of funds and by Comptroller Source Group and Comptroller Object;
    b. At the program level, please provide the information broken out by source of funds and by Comptroller Source Group and Comptroller Object; and,
    c. At the activity level, please provide the information broken out by source of funds and by Comptroller Source Group.

3. Please provide a complete accounting of all intra-district transfers received by or transferred from DBH during FY15 and to date in FY16. For each, please provide a narrative description as to the purpose of the transfer and which programs, activities, and services within DBH the transfer affected.

4. Please provide a complete accounting of all reprogrammings received by or transferred from DBH in FY15 and to date in FY16. For each, please provide a narrative description as to the purpose of the transfer and which programs, activities, and services within DBH the reprogramming affected.

5. Please provide a complete accounting of all of DBH's Special Purpose Revenue Funds for FY15 and to date in FY16. Please include the following:
    a. Revenue source and code;

b. Source of the revenue for each special purpose revenue fund (*i.e. license fee, civil fine*);
c. Total amount of funds generated by each source or program in FY15 and to date in FY16;
d. DBH activity that the revenue in each special purpose revenue source fund supports; and,
e. The FY15 and to date FY16 expenditure of funds, including purpose of expenditure.

6. Please provide a complete accounting of all federal stimulus funds received, used, or carried over for FY15 and FY16.

7. Please provide copies of any investigations, reviews or program/fiscal audits completed on programs and activities within DBH during FY15 and to date in FY16. This includes any reports of the DC Auditor, the Office of the Inspector General, or the Office of Accountability. In addition, please provide a narrative explanation of steps taken to address any issues raised by the program/fiscal audits. Please include the following:

8. Please complete the attached Program and Activity Detail Worksheet for each program and activity within DBH.

9. Did DBH meet the objectives set forth in the performance plan for FY15? Please provide a narrative description of what actions DBH undertook to meet the key performance indicators. For any performance indicators that were not met, if any, please provide a narrative description for why they were not met and any remedial actions taken. In addition, please provide a narrative description of the performance objectives for FY16 and what actions DBH has undertaken to meet them to date.

10. Do you anticipate any FY16 spending pressures or has the CFO identified any spending pressures? If so, please provide a detailed narrative of the spending pressure, including any steps that are being taken to minimize the impact on the FY16 budget.

11. What legislative objectives, if any, does DBH have for FY16?

12. Please provide DBH's capital budgets for FY15 and FY16, including amount budgeted and actual dollars spent. In addition, please provide an update on all capital projects undertaken in FY15 and FY16. In your response, please include information regarding the iCAMS project.

13. Did any of the capital projects undertaken in FY15 or FY16 have an impact on the operating budget of DBH? If so, please provide an accounting of such impact.

14. Please provide DBH's fixed cost budget and actual dollars spent for FY14, FY15 and to date in FY16. Include the source of funding and the percentage of these costs assigned to each DBH administration. Please provide the percentage change between the DBH's fixed costs budget for these years and a narrative explanation for any changes.

15. Please provide a current list of all properties supported by DBH's budget. Please indicate whether the property is owned by the District or leased and which DBH program utilizes the space. If the property is leased, please provide the lease term. For all properties, please provide an accounting of annual costs (i.e., rent, security, janitor services).

16. Please provide a narrative description of what impact, if any, that the Department of General Services has had on DBH's fixed cost budget in FY15 and to date in FY16, including an accounting of costs or savings.

17. Please provide a list of any properties vacated by DBH during FY15 and to date in FY16. Please provide an explanation for why the property was vacated and an accounting of any associated costs or savings.

18. Please provide a list of all FY15 and to date in FY16 full-time equivalent (FTE) positions for DBH, broken out by program and activity. In addition, for each position, please note whether the position is filled (and, if filled, the name of the employee) or whether it is vacant.

19. Please provide a list of all FTE positions detailed to DBH, broken down by program and activity for FY15 and to date in FY16. In addition, please provide which agency the detailee originated from and how long they were detailed to DBH.

20. Please provide a list of all FTE positions detailed from DBH to another agency in FY15 and to date in FY16. In addition, please provide which agency the employee was detailed to and for how long.

21. How many vacancies were posted during FY15? To date in FY16? Which positions? In addition, please note how long the position was vacant, whether or not the position has

been filled, where the vacancies were posted (i.e., press release, internet, newspaper, etc.), and please provide the position description.

22. How many employee performance evaluations were completed in FY15? To date in FY16? What is the process for establishing employee goals, responsibilities, and objectives? What steps were taken to ensure that all DBH employees are meeting individual job requirements? What remedial actions were taken for employees that failed to meet employee goals, responsibilities, and objectives?

23. Please provide the Committee with the following:
    a. A list of all employees who receive cell phones, personal digital assistants, or similar communication devices;
    b. The number of landlines provided by DBH;
    c. A list of travel expenses for FY15 and to date FY16, arranged by employee; and,
    d. A list of employees who earn $100,000 or more in FY15 or to date in FY16, including their names, position, salary, grade, step, position description, and agency within DBH.

24. Please provide the Committee with a list of all employees who received an administrative premium, bonus, hiring incentive, retroactive pay, separation pay, special awards pay, or severance pay in FY15 and to date in FY16. In addition, please provide the employee's name and the amount of the compensation, the type of compensation the employee received, and if the employee was a FTE.

25. What steps is DBH taking to ensure that the monitoring reports of both grants and subgrants are being completed in accordance with the Grants Sourcebook?

26. Please provide the following information for all grants awarded to DBH during FY15 and to date in FY16, broken down by DBH program and activity:
    a. Grant Number/Title;
    b. Approved Budget Authority;
    c. Funding source;
    d. Expenditures (including encumbrances and pre-encumbrances);
    e. Purpose of the grant;
    f. Grant deliverables;
    g. Grant outcomes, including grantee performance;
    h. Any corrective actions taken or technical assistance provided;
    i. DBH program and activity supported by the grant; and,
    j. DBH employee responsible for grant deliverables.

27. Please provide a complete accounting of all grant lapses including a detailed statement as to why the lapse occurred and any corrective action taken by DBH. Please provide accounting of any grant carryover from FY14 to FY15 or FY15 to FY16 and a detailed explanation as to why it occurred.

28. Please provide the following information for all grants/subgrants awarded by DBH during FY15 and to date on FY16, broken down by DBH program and activity:
    a. Grant Number/Title;
    b. Approved Budget Authority;
    c. Funding source;
    d. Expenditures (including encumbrances and pre-encumbrances);
    e. Purpose of the grant;
    f. Grant deliverables;
    g. Grant outcomes, including grantee performance;
    h. Any corrective actions taken or technical assistance provided;
    i. DBH program and activity supported by the grant; and,
    j. DBH employee responsible for grant deliverables.

29. Please provide the following information for all contracts awarded by DBH during FY15 and to date in FY16, broken out by DBH program and activity:
    a. Contract number;
    b. Approved Budget Authority;
    c. Funding source;
    d. Whether it was competitively bid or sole sourced;
    e. Expenditures (including encumbrances and pre-encumbrances);
    f. Purpose of the contract;
    g. Name of the vendor;
    h. Contract deliverables;
    i. Contract outcomes;
    j. Any corrective action taken or technical assistance provided;
    k. DBH employee/s responsible for overseeing the contract; and,
    l. Oversight/Monitoring plan for the contract.

30. Please provide the following information for all contract modifications made by DBH during FY15 and to date in FY16, broken out by DBH program and activity:
    a. Name of the vendor;
    b. Purpose and reason of the contract modification;
    c. DBH employee/s responsible for overseeing the contract;
    d. Modification cost, including the budgeted amount and the amount actually spent; and,
    e. Funding source.

31. Please provide the following information for all Human Care Agreements (HCA) and task orders issued during FY15 and to date in FY16, broken out by DBH program and activity:
    a. Vendor name;
    b. Services provided;
    c. Funding source;
    d. HCA amount;
    e. Task order amount;
    f. Actual expenditures;
    g. Status of performance; and,
    h. DBH employee responsible for monitoring the HCA and task order.

32. Does your Agency use purchase orders and purchase cards to acquire supplies or services? If so:
    a. What safeguards has your agency put in place to prevent waste, fraud, and abuse of purchase cards and purchase orders;
    b. How many purchase orders were received, completed, for how much, and to whom in FY15 and to date in FY16;
    c. How many purchase cards were issued, to whom, and for how much in FY15 and to date in FY16;
    d. What is the maximum amount that can be spent with a purchase card;
    e. What limitations are placed on the items that can be purchased with a purchase card; and,
    f. What has been purchased using these methods in FY15 or to date in FY16?

33. Please provide an update on the "Now is the Time" Transitional Age Youth Grant. Please describe the project. Which organizations participated in the grant in FY15? To date in FY16? How many individuals were served in FY15 and to date in FY16? How has this program improved access to mental health and substance use disorders?

34. Please provide a list and narrative description of any DBH partnerships with District agencies, if any, in FY15 and to date in FY16 to address employment for DBH consumers. In addition, please provide the number of individuals served, the types of employment placements available, and the employee/s responsible for coordinating the partnership.
    a. Please provide an update on the MOU with the Department of Human Services Economic Security Administration to provide Supported Employment services to individuals with serious mental illness who receive Temporary Assistance for Needy Families (TANF). How many individuals participated in this program in FY15? To date in FY16?

35. Please provide a description of all housing programs administered by DBH. For each, please provide the following information:
    a. Name of the program and services provided;
    b. Number of individuals served in FY15 and to date in FY16;
    c. Capacity of the program;
    d. Performance measures and associated outcomes for each program;
    e. The name and title of the DBH employee responsible for administering the program;
    f. The average wait time for a consumer to access housing through the program;
    g. The number of individuals on waiting lists for the program; and,
    h. Of those individuals on the wait list, whether any are homeless or in other housing programs.

36. Please provide an update on DBH's work with the Department of Housing and Community Development (DHCD) for the 300 units that have been set aside for individuals with mental illness.

37. Please provide a list and narrative description of any DBH partnerships with District agencies in FY15 and to date in FY16 to address homelessness for DBH consumers. In addition, please provide the number of individuals served, the types of housing placements available, and the employee/s responsible for coordinating the partnership.

38. Please provide an update on the following forensic programs, including the number of individuals served in FY15 and to date in FY16, along with a description of the services provided:
    a. Pre-booking diversion – DC Linkage Plus;
    b. Post-booking diversion – Options Program;
    c. Outpatient Competency Restoration Program;
    d. Frequent Users of Enhanced Services;
    e. N Street Village Recovery; and,
    f. Any other jail diversion or forensic activities undertaken during FY15 and to date in FY16. Please indicate any partnerships with other District agencies or programs.

39. Please provide an update on the work of the Court Urgent Care Center (CUCC). Please include:
    a. The services provided;
    b. Eligibility requirements to receive services;
    c. The number of individuals served in FY15 and to date in FY16 and the referral source for individuals (i.e., DBH Jail Liaison, Pre-Trial Services Agency, D.C. Misdemeanor and Traffic Court, etc.); and,
    d. Any costs associated with the program.

40. Please provide a description and an update on the Behavioral Court Diversion program including:
    a. A description of which youth are eligible to participate in the program;
    b. The process or protocol for selecting or referring youth to the program;
    c. The number of youth who participated in FY15 and to date in FY 16, the type of status offense they were alleged to have committed, the referral source (i.e., judge, probation officer, prosecutor, etc.) and the outcomes for youth in the program;
    d. The recidivism rate of the youth participants and an explanation of how recidivism rates are measured;
    e. Any costs associated with the program; and,
    f. The program's capacity and any expansion plan or barriers to expansion.

41. Please provide a description of the program and activities within the Children and Youth Services Division, including the FY15 and FY16, to date, performance measures and outcomes.

42. Please provide an update on the Agency's early childhood mental health projects, including any studies or reports.
    a. For the Parent Child Infant Early Childhood Program include a description of the services provided, the type of clinicians employed, their capacity and the number of children served in FY15 and to date in FY16.
    b. For the Early Childhood Mental Health Consultation Project, list the child care centers that are participating, the services they have received and provide any progress/outcome measures available.
    c. For the Behavioral Health Access Project, list the number of individual patients who participate in the Project, the number of pediatric primary care providers who have been using the Project, and any efforts made by DBH to engage other pediatric primary care providers in using the Project.

43. Please provide an update on the Department's work with the DC Collaborative for Mental Health in Pediatric Primary Care.

44. Please provide an update on the work of the children mobile crisis teams. What services are provided? How many individuals were served in FY15? To date in FY16? Please be sure to specifically speak to the work of the Children and Adolescent Mobile Psychiatric Service (ChAMPS), as well as any related services.
    a. What is the process in determining what calls are deployable and non-deployable?
    b. What is the response time for deployable calls? Please include the longest and shortest response times that occurred in FY15 and FY16 to date.

   c. How many mobile crisis teams are there? How are calls triaged to ensure that a team is available upon request?
   d. Please explain the nature of the training DCPS staff participated in as well as the number of staff who were trained.

45. Please provide an update on the work of the Psychotropic Monitoring Group (PMG) and their collaboration with the District of Columbia Drug Utilization Review Board in developing a protocol for identifying children above age five (5) prescribed four (4) or more psychotropic medications.
    a. Has the report of findings complied and analyzed by the PMG been completed? If so, please provide the results of that report and any other reports by the group written in FY14, FY15, and FY16 to date.
    b. Please provide an update on how many cases this group has review and the outcomes.

46. How many days, on average, does it take to connect children who have been screened as needing mental health services to a core service agency? What is being done to ensure timely access to care?
    a. To the extent possible, please break down days based on type of care (e.g. medication management, CBI, community support, etc.).

47. How many days, on average, does it take for a child who has been referred to a core service agency to actually start receiving care? What is being done to ensure timely access to care? To the extent possible, please break down days based on type of care (*e.g.* medication management, CBI). Please provide a comparison between FY14, FY15 and to date in FY16.

48. During FY15, what percentage of children discharged from a hospital were seen within the community within seven days?

49. Please explain the work the Department is doing with Child and Family Services Agency to better serve the mental health needs of foster children in the District. How long does it take for a child who has been identified as needing mental health services before they are connected to those services? During FY15, what percentage of children were screened within 30 days of entering or re-entering care? Has there been a decrease in time to linkage to first services from FY 14 and FY15? If available, please provide any documentation that shows that children are receiving more timely services. What efforts have been made to improve more timely services?

50. Please explain the work the Department has been doing with the Child and Family Services Agency on trauma-informed care.

51. Please explain the work the Department is doing with CFSA to better serve the mental health needs of foster children in Maryland.

52. Please explain the work Choice Providers are doing with CFSA's Review Evaluate and Direct (RED) Team and Family Team Meetings (FTM) to connect children and families to mental health services.

53. Please explain the work the Department has been doing to treat children/youth exposed to violence in their communities or at home.

54. Please explain the work the Department is doing to serve DC youth who have been identified as commercially sexually exploited. Are there any evidence-based practices that DBH plans to employ to provide options for this population? Does DBH have beds available for this population when they do not have housing options?

55. Please explain the work the Department has been doing with the DC Mental Health Access in Pediatrics program in FY15 and FY16 to date to assist pediatricians in managing moderate mental health concerns.

56. Please explain the work the Department is doing with the Department of Health Care Finance to improve care coordination.

57. Please provide an update on the Department's efforts to increase trainings for peer specialists.

58. Please provide an update on the Department's home visiting program. How many individuals were served by this program in FY15 and FY16 to date? Are there any plans to expand this program?

59. Please provide an update on the Wayne Place Project. How many youth were served in FY15 and FY16 to date?

60. Please explain the work the Department is doing to work with other District agencies to address the K2/synthetic drugs epidemic.

61. Please provide an update on the collaboration between DBH, DYRS, DHS, CFSA, OSSE, DCPS, and DC Public Charter Schools to implement CAFAS and PECFAS. In your response, please provide an update on the plan to develop the data warehouse that will allow for CAFAS/PECFAS results to be shared with all of a specific child/youth's providers.

62. The *South Capitol Street Memorial Amendment Act of 2012* required a variety of reports and programs. Please provide an update on each of the following:
    a. The creation of a Behavioral Health Ombudsman Program.
    b. A comprehensive plan with a strategy for expanding early childhood and school based behavioral health programs and services to all schools by SY2016-2017.
    c. The creation of a behavioral health resource guide for parents and guardians.
    d. The creation of a behavioral health resource guide for youth.

63. Please provide an update on the Department's School Based Mental Health Program including a list of all schools that participate and how many FTEs serve each school.

64. Please describe what mental health services, other than those offered by the Department of Behavioral Health, that are currently in DC Public and DC Charter schools. Please provide this information for each school and grade.

65. Please provide a comprehensive plan for mental health services in schools in the District.

66. Please provide an update on the online behavioral health training program for all child development facilities and public schools that was launched in the first quart of FY15.

How many teachers and other personnel completed the online training in FY15 and FY16 to date?

67. Please describe what substance abuse services are offered to children and youth and the process for obtaining these services. Are there any plans for FY16 to expand the types of services offered to children and youth? How many children and youth have received services through the Adolescent Community Reinforcement Approach (A-CRA) in FY15 and FY16 to date?

68. Please provide a list of children's mental health services which are currently being funded with local dollars - not Medicaid dollars. For each service, please explain the possibility of it being covered by Medicaid and if this option is being explored with the Department of Health Care Finance or whether this is a service which will always remain locally-funded.

69. Please provide an update on the School Mental Health Program (SMHP). Specifically, please include:
    a. A list of participating schools and please indicate whether a school is a "tier 1" or "tier 2" school;
    b. The number of students who met with a clinician;
    c. The number of students who were referred to care;
    d. The outcomes of all care linkages;
    e. The most common diagnosis;
    f. The referral source (i.e. walk-in, teacher);
    g. The number of students participating in prevention programs;
    h. Whether the current programs are meeting the existing need for services, and if not, what is being done to meet the total need;
    i. What prevention programs and services were offered through the SMHP in FY15 and FY16 to date;
    j. Any plans to expand the program and barriers to expansion and,
    k. How many FTEs serve each school.

70. What kinds of primary prevention SMHP activities were undertaken in FY15 and to date in FY16? What kinds of secondary prevention SMHP program activities were undertaken in FY15 and to date in FY16? What kinds of clinical services did the SMHP program provide during FY15 and to date in FY16? Was there any increased utilization in specific programs and services? Please provide a narrative explanation of each along with a breakdown of the number of students served.

71. Please provide the results of the midyear and last year's end of the year surveys that were distributed to school administrators to measure the satisfaction of services provided

by SMHP clinicians. In your response, please indicate any actions taken to address concerns raised in the FY14 surveys regarding the need to have additional or full-time SMHP clinicians in schools.

72. Please provide an update on the implementation of ICAMS for SMHP and how this has improved the integration of care.

73. Please provide an update on the High Fidelity Wraparound Program. How many individuals were served in FY15 and to date in FY16?
    a. How many individuals were served in FY15?
    b. How many children were diverted from PRFT placements? Please provide a breakdown for the school and community-based programs.
    c. What community-based organizations provide the case management for the wrap program? How many children did each serve?
    d. Please provide any outcome evaluations or reports of the program from the past two years.

74. Please provide an update on DBH's work with OSSE to provide intense wraparound services to students. Which schools have been targeted? What services are provided? How many students at each school were served in FY15 and to date in FY16?

75. Please provide the list of services available as part of the Mental Health Rehabilitation Services (MHRS) system. Specifically, please provide a description of each service and indicate whether or not it is available as part of the Medicaid MHRS program, the non-MHRS program, or both. In addition, please provide the FY15 and current reimbursement rates for each service.
    a. Please provide any reports or studies used to determine the impact of a decrease in day services rates on community providers.

76. For MHRS Medicaid payments, please identify the average length of time between:
    a. Date of service and date the claim was received;
    b. Date the claim was received and date the claim was adjudicated;
    c. Date the claim was adjudicated and date the claim is warranted for payment; and,
    d. Date the claim is warranted for payment and date of the actual payment.

77. For MHRS local-only claim payments, please identify the average length of time between:
    a. Date of service and date the claim was received;
    b. Date the claim was received and date the claim was adjudicated;
    c. Date the claim was adjudicated and date the claim is warranted for payment; and,
    d. Date the claim is warranted for payment and date of the actual payment.

78. Please provide the monthly MHRS utilization data for FY15 and to date in FY16. Specifically, please include the following:
    a. A breakdown of Medicaid MHRS vs. non-Medicaid MHRS;
    b. For Medicaid MHRS, please provide a breakdown by managed care vs. fee-for-service (and include a breakdown by specific managed care organization);
    c. For non-Medicaid MHRS enrollees, please indicate whether the individual had coverage via the DC Healthcare Alliance or was uninsured; and,
    d. For non-Medicaid MHRS enrollees, please provide a breakdown by income.

79. Please provide the name of all certified MHRS providers. For each provider, please provide the following information for FY14, FY15 and to date in FY16:
    a. Whether or not the provider utilizes the Medicaid MHRS program, the locally-funded MHRS program, or both;
    b. The amount of their Human Care Agreements (HCA);
    c. The amount of their purchase orders;
    d. Actual expenditures under the purchase order;
    e. Any modifications that were made to a HCA or purchase order, including an explanation for the modification;
    f. Number of individuals served per purchase order. Please provide a breakdown by Medicaid vs. non-Medicaid enrollees;
    g. Service utilization per purchase order; and,
    h. Any complaints, investigations, or audits of the provider by DBH and the results of any such investigation or audit.

80. Please provide the following information for MHRS providers for FY14, FY15, and to date in FY16:
    a. Rate of claims denial, broken out by provider;
    b. Average length of time between when claims are submitted by providers and when they are determined to be “clean” by DBH;
    c. Average length of time between when a “clean” locally-funded claim is submitted to DBH and when it is adjudicated;
    d. Average length of time between when a “clean” locally-funded claim is adjudicated by DBH and when it is paid;
    e. Rate of “clean” Medicaid claims transmitted by DBH to DHCF within 5 working days of receipt;
    f. Average length of time between when a “clean” Medicaid claim is submitted to DHCF and when it is adjudicated;
    g. Rate of claims paid within 30 days of being warranted, broken out by provider; and,
    h. Average length of time, broken out by Medicaid and non-Medicaid claims, between when a claim is first submitted and when payment is received.

81. Please provide a list of all programs funded by DBH. Please include:
    a. Whether the programs are evidence based; and,
    b. The evaluation methods used to determine the impact of the programs.

82. Please provide an updated list of all Evidence-Based Practices and for each EBP please note:
    a. The name of each provider who offers it;
    b. Each provider's capacity;
    c. Each provider's current enrollment;
    d. Whether the EBP is Medicaid-reimbursable and if so, under what code or rate;
    e. Any quality assessment or outcome measures that have been put in place to assess the program.

83. Please provide an updated list of all Evidence-Based Practices that are considered trauma-informed and for each EBP please note:
    a. The name of each provider who offers it;
    b. Each provider's capacity;
    c. Each provider's current enrollment;
    d. Whether the EBP is Medicaid-reimbursable and if so, under what code or rate;
    e. Any quality assessment or outcome measure that have been put into place to assess the program.

84. Please provide an update on the Department's efforts to work with DHCF to allow behavioral health providers to bill for collateral contacts.

85. How many children (0-20) received a service through MHRS during FY15? How does this compare to the number who received a service in FY14?

86. Please provide the following information regarding the Comprehensive Psychiatric Emergency Program (CPEP):
    a. What is the total number of CPEP admissions during FY15 and to date in FY16? Please provide a breakdown by month and note whether or not the individual was brought to CPEP by the police department or other known source (e.g. case worker).
    b. What is the average length of stay for a patient at CPEP?
    c. The number of individuals served at CPEP linked to substance abuse services during FY15? To date in FY16?

87. What activities did DBH undertake in FY15 and FY16 to date to serve individuals with co-occurring mental health and substance abuse issues? What activities to date in FY15? In your response, please provide an update on the streamlined application and certification process for both mental health and substance abuse providers.

88. Please provide an update on The 12 Cities Minority AIDS Initiative. How many individuals were served under this initiative in FY15 and FY16 to date?

89. Please provide a list and narrative description any DBH partnerships with District agencies in FY15 and to date in FY16 to address co-occurring mental health and substance abuse issues for DBH consumers. In addition, please provide the number of individuals served, the types of services, programs or activities available, and the employee/s responsible for coordinating the partnership.

90. What activities did DBH undertake in FY15 to serve veterans? What activities to date in FY16? Please provide a list and narrative description of any DBH partnerships with District agencies in FY15 and to date in FY16 to serve the mental health needs of veterans. In addition, please provide the number of individuals served, the types of services, programs or activities available, and the employee/s responsible for coordinating the partnership.

91. What activities did DBH undertake in FY15 to serve the elderly? What activities to date in FY16? Please provide a list and narrative description of any DBH partnerships with District agencies in FY15 and to date in FY16 to serve the mental health needs of the elderly. In addition, please provide the number of individuals served, the types of services, programs or activities available, and the employee/s responsible for coordinating the partnership.

92. Please provide an update on the Illness Management and Recovery Pilot program for elderly individuals with mental illness designed to assist them in developing self-management and recovery skills. How many individuals have been enrolled in this program in FY15 and FY16 to date?

93. What activities did DBH undertake in FY15 to serve the low income populations in the District? What activities to date in FY16? Please provide a list and narrative description any DBH partnerships with District agencies in FY15 and to date in FY16 to serve the mental health needs of low income District residents. In addition, please provide the number of individuals served, the types of services, programs or activities available, and the employee/s responsible for coordinating the partnership.

94. What activities did DBH undertake in FY15 to serve LGBTQ individuals in the District? What activities to date in FY16? Please provide a list and narrative description of any DBH partnerships with District agencies in FY15 and to date in FY16 to serve the mental health needs of LGBTQ individuals. In addition, please provide the number of individuals served, the types of services, programs or activities available, and the employee/s responsible for coordinating the partnership.

95. Please provide the following information with respect to St. Elizabeths. Please provide a breakdown by civil and forensic programs.
    a. Monthly census at St. Elizabeths for FY15 and to date in FY16;
    b. Number of admissions, by month, for FY15 and to date in FY16;
    c. Number of discharges, by month, for FY15 and to date in FY16; and,
    d. Average length of stay.

    e.

96. How many individuals are currently receiving hospital discharge support in order to move back into the community? What are some of the barriers to discharge and what steps have been taken to address these barriers?

97. Have you completed FY15 Provider Scorecards? If so, please attach. If not, please explain why Provider Scorecards were not completed.

98. Please attach the FY15 Community Services Review results of children/youth. Please explain when the targeted review of adults will be conducted. In addition, please describe the review process for substance use disorder services.

99. Please provide an update on any other new evaluations DBH is utilizing to determine whether mental health interventions have had good outcomes for children/youth.

100. Please provide an update on the work of DBH's Integrated Care Division in discharge planning efforts at St. Elizabeths. Elaborate on any new projects that were undertaken in FY15 and to date in FY16?

101. Please provide an update on the New Directions Program which focuses on community re-integration efforts for long-term St. Elizabeths patients. How many individuals were served by this program in FY15 and to date in FY16?

102. Please provide an update on the number of Community Residential Facilities certified or operated by DBH. In your response, please indicate the number of CRFs in each Ward.

103. Please provide an update on all of the goals and activities described in Appendix A of the Department of Mental Health's Strategic Housing Plan for 2012-2017, clearly identifying which actions have been completed, and on what timeframe.

104. Please describe the adequacy of DBH's existing supportive housing capacity to meet the needs of adults with severe and persistent mental illness.

105. Please identify the unduplicated number of clients served by each provider organization certified by APRA for drug treatment for FY2015 and FY16 to date.

Q1. Please provide a current organizational chart for DBH. Please provide information to the activity level. In addition, please identify the number of full time equivalents (FTEs) at each organizational level and the employee responsible for the management of each program and activity. If applicable, please provide a narrative explanation of any organizational changes made during FY15 and to date in FY16.

DBH Response
See Attachment. FY 15 Organizational Chart

Q2. Please provide the following budget information for DBH, including the amount budgeted and actually spent for FY 15 and to date in FY16. In addition, please describe any variance between the amount budgeted and actually spend for FY15 and to date in FY 16.

a. *At the agency level, please provide information broken out by source of funds and by Comptroller Source Group and Comptroller Object;*
b. *At the program level, please provide the information broken out by source of funds and by Comptroller Source Group and Comptroller,; and*
c. *At the activity level, please provide the information broken out by source of funds and by Comptroller Source Group.*

DBH Response:

The FY 15 appropriated budget was $279,709,799 and the actual spending totaled $271,723,197 with a variance of $7,609,477. The variance was due to:

- 4,561,572 in funds set aside for the development of housing for reserved for individuals with mental illnesses
- 1,500,000 in savings in fixed costs, and
- 1,547,905 in unanticipated underspending in supplies, professional services, and contractual services

The FY 16 spending through December 31, 2015 is $131,036,619 compared to the appropriated budget of $281,590,357. DBH is on track to spend within the appropriated budget.

See Attachment. Budget to Actual at Agency, Program and Activity Level

Q3. Please provide a complete accounting of all intra-district transfers received by or transferred from DBH during FY15 and to date in FY16. For each, please provide a narrative description as to the purpose of the transfer and which programs, activities, and services within DBH the transfer affected.

DBH Response
See Attachment. Intra-Districts

Q4. Please provide a complete accounting of all reprogrammings received by or transferred from DBH in FY15 and to date in FY16. For each, please provide a narrative description as to the purpose of the transfer and which programs, activities, and services within DBH the reprogramming affected.

DBH Response: See Attachment. Reprogrammings

Q5. Please provide a complete accounting of all of DBH's Special Purpose Revenue Funds for FY15 and to date in FY16. Please include the following:

a. *Revenue source and code;*
b. *Source of the revenue for each special purpose revenue fund (i.e. license fee, civil fine);*
c. *Total amount of funds generated by each source or program in FY15 and to date in FY16;*
d. *DBH activity that the revenue in each special purpose revenue source fund supports; and,*
e. *The FY15 and to date FY16 expenditure of funds, including purpose of expenditure.*

DBH Response

See Attachment. Special Purpose Revenue

Q6. Please provide a complete accounting of all federal stimulus funds received, used, or carried over for FY15 and FY16.

DBH Response
DBH did not receive any stimulus funds in FY 15 or FY 16.

Q7. Please provide copies of any investigations, reviews or program/fiscal audits completed on programs and activities within DBH during FY15 and to date in FY16. This includes any reports of the DC Auditor, the Office of the Inspector General, or the Office of Accountability. In addition, please provide a narrative explanation of steps taken to address any issues raised by the program/fiscal audits. Please include the following:

DBH Response

No investigations, reports or reviews were conducted by the DC Auditor or the Office of the Inspector General in FY 15 and to date in FY 16. In FY 15, the University Legal Services conducted an investigation into the death of Saint Elizabeths Hospital patient G Riley in May 2014. See Attachment 1 of 2. ULS Report. DBH provided a response. See Attachment 2 of 2.

DBH Response

The Office of Accountability (OA) conducts audits of paid claims for each fiscal year for every provider. The auditing process generally crosses fiscal years. In FY15, the following audits and audit activities were conducted:

FY14:
Annual audits of 33 mental health rehabilitation services certified providers
Reviews of 26 substance use disorder certified providers
Letters were sent to providers to recover funds paid for services that could not be substantiated during the claims audit. The total value of the recoupment is $304,727 of which $281,700 is Medicaid funding and 23,000 is local funds.

FY15:
Focused audits of 17 mental health rehabilitation services certified providers
Focused audits of substance use disorder certified providers for FY 13

FY16 to date:
Annual audits of certified mental health rehabilitation services and substance use disorder certified providers completed by September 30, 2016
Rolling audits of substance use disorder certified providers to monitor compliance with new Chapter 63 regulations to be completed by April 2016
Rolling audits of mental health rehabilitation services certified Health home roll out audit review to be completed by June 2016.

QUALITY REVIEWS
OA is conducting Quality Reviews at 32 Core Service Agencies and Specialty providers with site visits scheduled to be completed by March, 2016. The Quality Review results will be incorporated into the FY15 Provider Scorecard.

Q8. Please complete the attached Program and Activity Detail Worksheet for each program and activity within DBH.

DBH Response:

See Attachment 1 of 6. Agency Management
Attachment 2 of 6. Authority
Attachment 3 of 6. Saint Elizabeths
Attachment 4 of 6. Behavioral Health Supports
Attachment 5 of 6. APRA
Attachment 6 of 6. Financing

Q9. Did DBH meet the objectives set forth in the performance plan for FY15? Please provide a narrative description of what actions DBH undertook to meet the key performance indicators. For any performance indicators that were not met, if any, please provide a narrative description why they were not met and any remedial actions taken. In addition, please provide a narrative description of the performance objectives for FY16 and what actions DBH has undertaken to meet them to date.

DBH Response:

The DBH FY15 Performance Plan includes 20 Performance Objectives. The overall status of the Objectives is: 1) fully achieved =10, 2) partially achieved =10.
The DBH FY15 Performance Plan includes 26 Key Performance Indicators (KPIs). The overall status of the KPIs includes the following: 1) fully achieved =12, 2) partially achieved =10, 3) not achieved= 4.

See Attachment 1 of 3. FY15 Performance Objectives
See Attachment 2 of 3. FY15 KPI status.
See Attachment 3 of 3. FY16 Performance Objectives

Q10. Do you anticipate any FY16 spending pressures or has the CFO identified any spending pressures? If so, please provide a detailed narrative of the spending pressure, including any steps that are being taken to minimize the impact on the FY16 budget.

DBH Response:

DBH is closely monitoring spending and does not anticipate any FY 16 spending pressures.

Q11. What legislative objectives, if any, does DBH have for FY16?

DBH Response: DBH is working with the Deputy Mayor for Health and Human Services and the Office of Policy and Legislative Affairs to develop legislative objectives.

Q12: Please provide DBH's Capital budgets for FY 15, and FY 16, including amount budgeted and actual dollars spent. In addition please provide an update on all capital projects undertaken in FY15 and FY16. In your response, please include information regarding the ICAMS project.

DBH Response:

In FY 2015 and FY2016 DBH did not receive funding for any new projects. All projects listed on the attachment are ongoing.

The iCAMS project has expended 95% of its $3.5 million budget and the remaining 5% is obligated. The first phase of the iCAMS project to migrate certified mental health rehabilitation services providers to iCAMS was completed on February 8, 2015. Currently, implementation continues with the transition of contracted substance use disorders services providers to iCAMS upon certification under the new Chapter 63 regulations. The new Chapter 63 regulations strengthen the quality of care and allow substance use disorders providers to bill for Medicaid reimbursement. DBH is phasing in the transition of substance use disorder services providers to iCAMS over six months. To date, six of an anticipated 24 providers have been transitioned to iCAMS. On February 1, 2016, another eight providers will transition to iCAMS with all providers operating on iCAMS by June 1, 2016.

Q13: Did any of the capital projects undertaken in FY 15 or FY 16 have an impact on the operating budget of DBH? If so, please provide an accounting of such impact.

DBH Response:

There were no capital projects undertaken in FY 15 or in FY 16 to date that have had an impact on the DBH operating budget.

Q14. Please provide DBH's fixed cost budget and actual dollars spent for FY14, FY15 and to date in FY16. Include the source of funding and the percentage of these costs assigned to each DBH administration. Please provide the percentage change between the DBH's fixed costs budget for these years and a narrative explanation for any changes.

DBH Response:

See Attachment. Fixed Costs

Q15. Please provide a current list of all properties supported by DBH's budget. Please indicate whether the property is owned by the District or leased and which DBH program utilizes the space. If the property is leased, please provide the lease term. For all properties, please provide an accounting of annual costs (i.e., rent, security, janitor services).

DBH Response:

See Attachment 1 of 1. DBH Properties

Q16: Please provide a narrative description of what impact, if any, that the Department of General Services has had on DBH's fixed cost budget in FY 15 and to date in FY 16, including an accounting of costs or savings.

DBH Response:

DBH and DGS staff met to discuss the projections for DBH fixed cost expenses prior to the finalization of the FY16 budget. DGS explained the process used to project the fixed cost budget. DBH will see a savings of $500,000 in electricity costs.

Q17: Please provide a list of any properties vacated by DBH during FY15 and to date in FY16. Please provide an explanation for why the property was vacated and an accounting of any associated costs or savings.

DBH Response:

DBH consolidated space by moving the Addiction Prevention Recovery Administration offices from 1900 First Street NE to the DBH headquarters at 64 New York Avenue NE in July 2015 on the expiration of the lease. The consolidation enhanced integration of operations and service coordination. There are no cost savings as funds previously allotted for the program's rental costs are now being used to fund the new space.

Q18. Please provide a list of all FY15 and to date in FY16 full-time equivalent (FTE) positions for DBH, broken out by program and activity. In addition, for each position, please note whether the position is filled (and, if filled, the name of the employee) or whether it is vacant.

DBH Response
See Attachment. List of FTEs

Q19. Please provide a list of all FTE positions detailed to DBH, broken down by program and activity for FY15 and to date in FY16. In addition, please provide which agency the detailee originated from and how long they were detailed to DBH.

DBH Response:

No FTEs are detailed to DBH.

Q20. Please provide a list of all FTE positions detailed from DBH to another agency in FY15 and to date in FY16. In addition, please provide which agency the employee was detailed to and for how long.

DBH Response

No FTES are detailed from DBH to another agency.

Q21. How many vacancies were posted during FY15? To date in FY16? Which positions? In addition, please note how long the position was vacant, whether or not the position has been filled, where the vacancies were posted (i.e., press release, internet, newspaper, etc.), and please provide the position description.

DBH Response
See Attachment 1 of 2. Vacancy Postings. FY 15
See Attachment 2 of 2. Vacancy Postings. FY 16

Q22. How many employee performance evaluations were completed in FY15? To date in FY16? What is the process for establishing employee goals, responsibilities, and objectives? What steps were taken to ensure that all DBH employees are meeting individual job requirements? What remedial actions were taken for employees that failed to meet employee goals, responsibilities, and objectives?

DBH Response:

For the FY15 performance appraisal period (October 1, 2014 through September 30, 2015), 1,124 employee performance evaluations were completed which represents 90 per cent of the DBH workforce.

The establishment of employee goals, responsibilities and objectives is a collaborative process between managers and employees which is part of the employee's annual performance plan. They engage in goal setting conversations using SMART techniques to establish performance goals that are specific, measurable, attainable, relevant, and time-sensitive. The SMART philosophy is an effective way to establish employee performance goals and create a path for their achievement. The overall goals of the Agency cascade down and are incorporated into individual employee goals and objectives. Supervisors are required to continuously monitor and assess employees' performance and provide appropriate feedback to ensure that employees are meeting individual job requirements. During FY15, five on-site performance management training sessions were presented to DBH management/supervisory staff. This interactive learning course provided participants with a comprehensive understanding of the process by which employee performance expectations and objectives are identified, measured and evaluated to meet the DC Government goals. To date in FY16, 1,148 performance plans have been completed, which represents 91 percent of the DBH workforce.

Ensuring that employees are meeting the goals, responsibilities and objectives of their positions is critical to the continued success of DBH. As such, remedial actions for employees' development and growth include: ongoing assessment of employee performance, providing constructive feedback, and determining relevant training opportunities to improve job deficiencies. Additionally, an individual may be placed on a performance improvement plan (PIP) if the minimum requirements of the position are not met. Trained personnel within the Office of Human Resources are available to provide guidance and direction to both the affected employees and managers throughout the performance management process.

Q23. Please provide the Committee with the following:

a. A list of all employees who receive cell phones, personal digital assistants, or similar communication devices;
b. The number of landlines provided by DBH;
c. A list of travel expenses for FY15 and to date FY16, arranged by employee; and,
d. A list of employees who earn $100,000 or more in FY15 or to date in FY16, including their names, position, salary, grade, step, position description, and agency within DBH.

DBH Response:

a. A list of all employees who receive cell phones, personal digital assistants, or similar communication devices;

See Attachment1 of 3. DBH Communication Devices

b. The number of landlines provided by DBH;

DBH has 1262 landlines

c. A list of travel expenses for FY14 and to date FY15, arranged by employee; and,

See Attachment 2 of 3. Travel Report

d. A list of employees who earn $100,000 or more in FY14 or to date in FY15, including their names, position, salary, grade, step, position description, and agency within DBH.

See Attachment 3 of 3. List of Employees

Q24. Please provide the Committee with a list of all employees who received an administrative premium, bonus, hiring incentive, retroactive pay, separation pay, special awards pay, or severance pay in FY15 and to date in FY16. In addition, please provide the employee's name and the amount of the compensation, the type of compensation the employee received, and if the employee was a FTE.

DBH Response

See Attachment. List of Employees

Q25. What steps is DBH taking to ensure that the monitoring reports of both grants and subgrants are being completed in accordance with the Grants Sourcebook?

DBH Response

The Grants Coordinator serves as the central point-of-contact for all matters related to grants to be coordinated and streamlined within the DBH and ensures compliance with monitoring reports for grants and sub-grants. Assessment tools for programmatic and fiscal monitoring have been created. Using a collaborative effort between the grants coordinator, the project director (programmatic) and fiscal services team, a monitoring schedule is established. Grantees and sub-grantees are assessed based on risk and prioritization.

Every effort is made to conduct both programmatic and fiscal monitoring in a coordinated, but independent, manner to reduce burden on the organization. If needed, the grant, program and fiscal services team will oversee any corrective action concerns identified in the grantee/subgrantee monitoring report to ensure compliance with grant requirements and the Grants Sourcebook.

Q26. Please provide the following information for all grants awarded to DBH during FY15 and to date in FY16, broken down by DBH program and activity:

a. *Grant Number/Title;*
b. *Approved Budget Authority;*
c. *Funding source;*
d. *Expenditures (including encumbrances and pre-encumbrances);*
e. *Purpose of the grant;*
f. *Grant deliverables;*
g. *Grant outcomes, including grantee performance;*
h. *Any corrective actions taken or technical assistance provided;*
i. *DBH program and activity supported by the grant; and,*
j. *DBH employee responsible for grant deliverables.*

DBH Response

Please see Attachment . DBH Grants

Q27. Please provide a complete accounting of all grant lapses including a detailed statement as to why the lapse occurred and any corrective action taken by DBH. Please provide accounting of any grant carryover from FY14 to FY15 or FY15 to FY16 and a detailed explanation as to why it occurred.

DBH Response:
Please see Attachment 1 of 2: FY 14 Grant Lapse Report
Attachment 2 of 2: FY 15 Grant Lapse Report

Q28. Please provide the following information for all grants/subgrants awarded by DBH during FY15 and to date on FY16, broken down by DBH program and activity:

a. *Grant Number/Title;*
b. *Approved Budget Authority;*
c. *Funding source;*
d. *Expenditures (including encumbrances and pre-encumbrances);*
e. *Purpose of the grant;*
f. *Grant deliverables;*
g. *Grant outcomes, including grantee performance;*
h. *Any corrective actions taken or technical assistance provided;*
i. *DBH program and activity supported by the grant; and,*
j. *DBH employee responsible for grant deliverables.*

DBH Response: Please see Attachment 1 of 2 Grants and Subgrants (FY 15)
Attachment 2 of 2 Grants and Subgrants (FY 16)

Q29. Please provide the following information for all contracts awarded by DBH during FY14 and to date in FY15, broken out by DBH program and activity:

- a. *Contract number;*
- b. *Approved Budget Authority;*
- c. *Funding source;*
- d. *Whether it was competitively bid or sole sourced;*
- e. *Expenditures (including encumbrances and pre-encumbrances);*
- f. *Purpose of the contract;*
- g. *Name of the vendor;*
- h. *Contract deliverables;*
- i. *Contract outcomes;*
- j. *Any corrective action taken or technical assistance provided;*
- k. *DBH employee/s responsible for overseeing the contract; and,*
- l. *Oversight/Monitoring plan for the contract.*

DBH Response:

See Attachment 1 of 2. Contracts. FY 15
Attachment 2 of 2. Contracts. FY 16

Q30. Please provide the following information for all contract modifications made by DBH during FY14 and to date in FY15, broken out by DBH program and activity:

a. *Name of the vendor;*
b. *Purpose and reason of the contract modification;*
c. *DBH employee/s responsible for overseeing the contract;*
d. *Modification cost, including the budgeted amount and the amount actually spent; and,*
e. *Funding source.*

DBH Response:

See Attachment 1 of 2. Contract Modifications. FY 15
Attachment 2 of 2. Contract Modifications. FY 16

Q31. Please provide the following information for all Human Care Agreements (HCA) and task orders issued during FY14 and to date in FY15, broken out by DBH program and activity:

- *a. Vendor name;*
- *b. Services provided;*
- *c. Funding source;*
- *d. HCA amount;*
- *e. Task order amount;*
- *f. Actual expenditures;*
- *g. Status of performance; and,*
- *h. DBH employee responsible for monitoring the HCA and task order.*

DBH Response:

See Attachment 1 of 2. HCAs. FY 15

Attachment 2 of 2. HCAs. FY 16

Q32: Does your Agency use purchase orders and purchase cards to acquire supplies or services? If so:

a. What safeguards has your agency put in place to prevent waste, fraud, and abuse of purchase cards and purchase orders;
b. How many purchase orders were received, completed, for how much, and to whom in FY15 and to date in FY16;
c. How many purchase cards were issued, to whom, and for how much in FY15 and to date in FY16;
d. What is the maximum amount that can be spent with a purchase card;
e. What limitations are placed on the items that can be purchased with a purchase card; and,
f. What has been purchased using these methods in FY15 or to date in FY16?

DBH Response:

a. What safeguards has your agency put in place to prevent waste, fraud, and abuse of purchase cards and purchase orders;

The purchase card program is for small purchases. Oversight of the purchase card program occurs at five levels: cardholder profile, merchandise commodity codes, by reviewer (purchaser) by approver, and finally by an Agency Review Committee. As defined by the Office of Contracting and Procurement, defined merchandise/commodity codes restrict each card. Each cardholder's profile determines whether the card can be used for the purchase of goods or can be used for travel. Expenditures for travel require an approved District Travel Request Form before a purchase card can be used to cover costs.

The cardholder is required to review each of their transactions on a monthly basis through an on-line management system to ensure accuracy. If an erroneous transaction is found, it can be disputed.. Once each transaction is reviewed, it is forwarded in the system to the cardholder's supervisor for approval. The cardholder's approver must approve each transaction before the transaction can be closed on a monthly statement. If transactions remain open, a report is sent to the Agency Review Committee. The Agency Review Committee is composed of five Agency staff (four DBH and one OCFO assigned) who review all transactions on a monthly basis. The purchase card management system auto generates reports for the Committee's review. Included in the reports are account transaction detail reports and a report that identifies any unusual card activity. The Unusual Activity Report specifically is designed to identify the potential splitting of transactions that might circumvent the procurement process.

The Review Committee must attest that the reports have been reviewed and that any necessary follow up regarding the review/approval of cards has taken place and that no unusual activity has occurred. The attestation (sign-in sheet) is sent to the Office of Contracts and Procurement Services (CPS) which oversees the purchase card program.

The DBH enforces a number of safeguards to ensure accountability in the procurement process. These safeguards apply to the administration of the PASS system, procurement procedures, and the clear definition of COTR responsibilities. First, the PASS system for the agency is managed by a single point of contact. This ensures that people entered into the approval flow are at the appropriate approval level. The structure also ensures that staff that enter requisitions do not perform the receiving function for the same items. Through the Office of Contract and Procurement Services

DBH strictly enforces laws associated with full and open competition, as well as those prohibiting split purchase orders.

CPS also conducts vendor name checks in multiple databases to verify that there are no adverse matches regardless of dollar amount. DBH also employs the three-way match for the submission of invoices. This requires that a purchase order, contract pricing sheet and a vendor invoice are formatted in the same way so that any invoicing irregularities are immediately identified.

Finally, DBH issues a Contract Officer Technical representative (COTR) Appointment Memorandum with each contract. This memo defines the delegated authority of the COTR with respect to the monitoring of the commodity provided, the reconciliation of invoices, and the requirement to ensure that funding is available to support the contract. DBH also provides annual mandatory COTR training that includes Ethics and Integrity in Procurement.

b. How many purchase orders were received, completed, for how much, and to whom in FY15 and to date in FY16;

Please see Attachment 1 of 3. DBH Purchase Order Report FY15
Attachment 2 of 3. DBH Purchase Order Report FY16

c. How many purchase cards were issued, to whom, and for how much in FY15 and to date in FY16;

d. What is the maximum amount that can be spent with a purchase card;

DBH currently has issued 37 purchase cards. Purchase cards are issued to employees who are responsible for purchasing goods or services or who must travel as part of their job responsibilities. A manager must approve the issuance and funds must be obligated to pay for projected expenditures for the year. Purchase cards are not re-issued each fiscal year but funds must be set aside each fiscal year to pay for purchases. Each area/division with a purchase card is responsible for funding the card limit for the fiscal year. Each purchase card has a transaction limit of $5,000.00 a day.

Please see Attachment 3 of 3. Cardholder Hierarchy for list of cardholders and card limits

e. What limitations are placed on the items that can be purchased with a purchase card; and,

f. What has been purchased using these methods in FY15 or to date in FY16?

As defined by the Office of Contracting and Procurement, defined merchandise/commodity codes restrict each card. For example, cards that not approved for travel expenditures are restricted from the purchase of gasoline, car rental, hotel rooms and flights. Cards are restricted from the purchase of food, alcohol and tobacco.

The total amount spent through purchase cards by DBH in FY 15 was $959,882 and to date in FY 16 is $146,863. Each purchase card has a daily transaction limit of $5,000.00. Purchase cards differ by cycle (30 day periods) limit based on the amount the card has been funded for the fiscal year.

Q33. Please provide an update on the "Now is the Time" Transitional Age Youth Grant. Please describe the project. Which organizations participated in the grant in FY15? To date in FY16? How many individuals were served in FY15 and to date in FY16? How has this program improved access to mental health and substance use disorders?

DBH Response

The "Now is the Time" Healthy Transitions Grant is designed to develop a behavioral health system of care that improves the life trajectories for youth and young adults ages 16-25 with, or at risk, of serious mental health conditions. The purpose of this program is to improve access to mental health and substance use disorders treatment and provide support services through deliberate care coordination and planning. The populations of focus for this effort are youth and young adults residing in Wards 7 and 8.

The grant will enable DBH to organize its Evidence-Based and informed practices and recovery supports to better address the needs of youth and young adults and support their transition to adulthood. Specific services are listed below. DBH will evaluate the impact of these services and identify what is working and what additional services are needed.

1. Transitions to Independence Process (TIP)—an evidence-supported model proven effective with youth and young adults
2. Assertive Community Treatment (TACT) 24-hour mental health services and supports tailored to meet the needs of transition age youth
3. Adolescent Community Reinforcement Approach (A-CRA) which provides age-specific substance use disorders services
4. Supported Employment that provides job training or assists the youth in entering continuing education programs
5. Supportive Housing for 12-18 months that includes life skills development
6. Health Homes which will provide intensive care coordination with primary care for youth 18-25
7. Peer-to-Peer support by young people with prior experience within the system of care to act as mentors and help others make positive life decisions and learn how to successfully advocate for themselves.

DBH plans to contract with three certified community based providers to deliver transition age youth-specific services and supports through trained transition specialists.

In May 2015, DBH held a provider informational webinar targeting both child and adult providers to assess interest and existing capacity to provide these services. As a result of this webinar, DBH launched an initiative to train new providers in the Transition to Independence Process. Three new providers (Green Door, Family Wellness Center and the new Wayne Place Apartment community staff team) and a total of 38 staff participated in the TIP training. A second TIP training was held in November and a total of 36 staff participated. As a result of this effort, the TIP provider network has expanded from six to nine sites. DBH anticipates that an additional provider will be added in FY16.

Because of the investment in building community capacity, DBH now has a substantial pool of youth and young adult providers who are trained to provide transition age specific services and support.   The next step is to release within the next few months a Request For Proposal (RFP) to contract with community based providers for these services.

In FY 15, DBH in partnership with the Child and Family Services Agency (CFSA) opened Wayne Place located in Ward 8 to support care coordination and Evidence Based Practices and recovery supports for transition age youth. At any given time, Wayne Place will be home to 40 young people.

Q34: Please provide a list and narrative description of any DBH partnerships with District agencies, if any, in FY15 and to date in FY16 to address employment for DBH consumers. In addition, please provide the number of individuals served, the types of employment placements available, and the employee/s responsible for coordinating the partnership.

a. Please provide an update on the MOU with the Department of Human Services Economic Security Administration to provide Supported Employment services to individuals with serious mental illness who receive Temporary Assistance for Needy Families (TANF). How many individuals participated in this program in FY15? To date in FY16?

DBH Response:

DBH and Rehabilitation Services Administration (RSA) continue a collaborative effort where DBH certified Supported Employment providers maintain a Human Care Agreement with RSA to provide Evidence-Based Supported Employment services. In FY15 a DBH Supported Employment provider agency successfully piloted an outcome based funding system to provide job development, placement and retention milestone payments for these services. To date in FY16, all DBH certified Supported Employment providers are using the milestone payment system to pay for job development, placement and retention services for all eligible referred consumers. RSA has currently allocated $735,000 in purchase orders to DBH certified Supported Employment providers for these services. Providers are able to request additional funding if needed.

DBH is an active partner in the “Employment First Initiative” that is led by the DC Department of Disability Services. This Initiative is anchored on the belief that all individuals including individuals with significant disabilities are capable of full participation in integrated paid competitive employment. DBH Evidenced Based Supported Employment fits perfectly in line with Employment First principles and practices. In FY16 DBH has two provider agencies piloting Customized Employment strategies. With the application of these new strategies, the current Evidenced-Based Supported Service Program will be enhance and anticipate consumers with multiple barriers to employment will obtain and maintain employment.

The DBH Supported Employment program served 1,290 consumers in FY15.

Competitive employment opportunities were located for individuals enrolled in the program. In FY15 and to date in FY16, the ten (10) Supported Employment programs helped individuals obtain the following types of employment placements:

- Senior Patent Paralegal
- Utility Clerk
- Fleet Mechanic
- Lead Cook
- Dietary Aide
- Custodian
- Substitute Teacher
- Driver
- Shelter Aide
- Produce Clerk
- Caregiver
- Demolition Worker
- Child Care Aide
- Library Tech
- Peer Support Worker
- Crisis Counselor
- Residential Counselor
- Dishwasher
- Cashier
- Crossing Guard
- Pressman
- Food Runner
- Bagger
- Inventory Manager
- Store Associate
- Aesthetician
- Optical Technician
- Office Cleaner

- Supervisor
- Painter
- Event Set Up
- Janitor
- Stock Clerk
- Senior Patent Paralegal
- Line Associate
- Customer Service Support
- Garbage Collector
- Hospitality Trainer
- Deli Clerk
- Security Guard

The following is a sample list of the private and public sector agencies that have hired individuals in the program:

- Dunlap & Weaver Law Offices
- Nova Properties
- Metro
- Sodexho
- Sunrise Senior Living
- Safety First Child Care
- Goel Construction
- Aramark
- Harris Teeter
- Kennedy Center
- Catholic Charities
- US Geological Service
- Express Paper
- Capella Hotel
- Macys
- Hearts & Homes Youth
- Rent A Center
- Gordon Biersch
- Nationals Stadium
- Pepco
- Walmart
- Metro Access
- Massage Envy
- Marshalls
- Coalition For The Homeless
- Jade Fitness
- Ross
- Logan Hardware
- IHOP
- US MED Innovations
- Roti
- Dip & Sons Transportation
- National Woman's Law Center
- US Marines
- House of Ruth
- CSG Construction
- House of Ruth
- CSG Construction
- Nordstrom
- Salvation Army
- 7 Eleven
- Café Dupont
- Carolina Kitchen
- TJMaxx
- The Cheesecake Factory
- USA Furniture
- Giant Food
- The Spirit of Washington
- Dunlap & Weaver Law Offices
- Uber
- TC Williams High School
- Hilton Hotel
- Embassy Suites Hotel
- UDC
- Panera Bread
- Dollar Tree
- Oak Creek Grove
- T&G
- Brueggers Bagels
- Wilsons Leathers
- Beefsteak Restaurant

District Government Agencies

- Department of Transportation
- DC Library of Congress
- District of Columbia Government

Federal Agencies

- Food & Drug Administration
- Department of Interior
- Government Services Administration

Q35. Please provide a description of all housing programs administered by DBH. For each, please provide the following information:

a. Name of the program and services provided;
b. Number of individuals served in FY15 and to date in FY16;
c. Capacity of the program;
d. Performance measures and associated outcomes for each program;
e. The name and title of the DBH employee responsible for administering the program;
f. The average wait time for a consumer to access housing through the program;
g. The number of individuals on waiting lists for the program; and,
h. Of those individuals on the wait list, whether any are homeless or in other housing programs.

DBH Response:

A. Name of the program and services provided

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

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

Community Residential Facilities (CRFs)

- **Intensive Rehabilitative Residence (IRR)**

An intensive level of care for individuals enrolled in the DBH behavioral health system that have medical issues that put them at risk of for needing nursing home care if they do not receive physical health care nursing supports along with the appropriate mental health rehabilitation services.

- **Supportive Rehabilitative Residence (SRR)**

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

residents take their medications as prescribed; provision of 1:1 support to manage behaviors or perform functional living skills; transportation to doctor's appointments; assistance with money management; and participation in treatment planning, implementation, and follow-up.

- **Supportive Residence (SR)**

SR CRFs provide on-site supervision when residents are in the facility; medication monitoring; maintenance of a medication log to ensure that medication is taken as prescribed; assistance with activities of daily living; arrangement of transportation; monitoring behaviors to ensure consumer safety; and participation in treatment planning and follow-up. DBH licenses these homes. In May 2014, the ICRF operators were provided contracts (through September 2014) to receive funding to support operations and services for DBH residences. In FY14-4Q, ICRF operators were provided the opportunity to submit proposals in response to a Request for Proposal (RFP) for ICRF services (to be known as Supportive Residence (SR) services). In FY15-1Q, twenty-seven (27) SR CRF Operators were awarded contracts to receive a per diem for SR services provided to each DBH consumer in the residence

DC Local Rent Supplement Program

The Local Rent Supplement Program, in effect since 2007, is designed to increase the number of permanent affordable housing units and provide housing assistance to extremely low-income households, including individuals who are homeless or need supportive services, such as elderly individuals or those with disabilities. The LRSP follows the rules and regulations of the federal housing choice voucher program, is administered by the D.C. Housing Authority, and is supported through local funds.

Federal Voucher Programs

DBH consumers participate in several federally-funded housing programs as described below:

Shelter Plus Care

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

Housing Choice Voucher Program (HCVP)

The Housing Choice Voucher Program (HCVP) (formerly 'Section 8'), the federal low income assistance program, is administered through the D.C. Housing Authority (DCHA). Through a Memorandum of Agreement (MOA) with DCHA, DBH has a set-aside of HCVP vouchers for individuals with serious mental illness.

Mainstream Housing For People With Disabilities

The HUD Mainstream Program, which provides federal vouchers for individuals with disabilities, is administered through DCHA. Since 1999, mental health consumers have been eligible to participate in this program, and fifty (50) vouchers were set aside for DBH consumers.

Partnerships for Affordable Housing
The Partnerships for Affordable Housing program, administered by DCHA, is a project-based voucher program providing housing for low-income disabled or elderly families.

B. Number of Individuals Served in FY15 and to date FY16

In FY15, a total of 2,820 people received housing compared to total of 2,574 in FY16, through December 31, 2015.

C. Capacity of the Program

Housing Program Capacity and Utilization

Program	FY15 Capacity*	Consumers Served FY15	FY16 Capacity*	Consumers Served FY16 (through 12/31/15
Home First	1,105	926	945	914
Supported Independent Living (SIL)	405	386	405	405
Local Rent Subsidy (LRSP)	60	60	60	60
Federal Vouchers	586	569	586	586
Intensive Residence (IR) Community Residential Facilities (CRFs)	0	0	8	0
Supportive Rehabilitative Residence (SRR) Community Residential Facilities (CRFs)	208	218	208	208
Supportive Residence (SR) Community Residential Facilities (CRFs)	456	463	452	393
Total	**2,820**	**2,622**	**2,664**	**2,574**

*Capacity is the aggregate of:

a. Consumers who are active in the Home First Program.
b. Individuals awarded a Home First Program subsidy and who were still searching for housing.

D. Performance Measures and Associated Outcomes for each Program

DBH established three performance measures for its Home First Subsidy Program:
1. Housing Tenure/Stability
2. Program Occupancy
3. Housing Participant Access to Housing Services and Supports

Outcomes on DBH Housing Performance Measures for Home First Subsidy Recipients

Quality Domain	Performance Measure	Outcome
Housing Tenure/Stability	75% of consumers will maintain community tenure in independent housing for 12 months or longer	88% of consumers maintained community tenure
Housing Occupancy	DBH will maintain an 80% or greater occupancy rate within its subsidized housing program	100% occupancy rate
Availability of Housing Services/Supports	80% of consumers in housing will enroll with a CSA to receive mental health services and supports	96% of consumers are enrolled with a CSA

E. The name and title of the DBH employee responsible for administering the program

Estelle (Jackie) Richardson, Residential Services Director, is directly responsible for administering the residential services described above.

F. The average wait time for a consumer to access housing through the program

The average wait time varies according to the housing program. For the Home First Program, the average wait time from date of application to move-in date for consumers awarded a voucher in FY15 was thirty months. For all other DBH housing options, the average wait time from date of application to placement is four weeks.

*G. The **number of individuals on waiting lists for the program***

As of December 31, 2015, there were 4,268 consumers on the DBH Housing Waiting List. This list is reviewed annually to ensure that the individuals listed are still actively searching for housing. Individuals who have left the District or have found housing through other agencies or with other resources are removed from the list.

H. Of those individuals on the wait list, whether any are homeless or in other housing programs

DBH uses the Department of Housing and Urban Development (HUD) definition of "homeless"[i]. In FY15, DBH received 1,044 Housing Waiting List (HWL) applications. Applicants self-report their living situation on their HWL application, with living situations including residing in shelter; living on the streets; living temporarily with family/friends; recently released from jail/prison; in transitional housing; or recently discharged from treatment facilities.

Twenty-five percent or 1,067 of the consumers on the HWL reported that they are homeless; living on the streets; staying 'place-to-place', or living in shelters at the time of application submission. The living situation for all other consumers on the HWL ranges from transitional housing to residing with family/friends.

Persons who have been on the HWL the longest are given priority. Some individuals may have obtained housing after requesting assistance from DBH, therefore when vouchers are available, DBH works with the community providers to obtain updated information on the living situation of those consumers on the HWL. Vouchers are prioritized for individuals who are homeless; individuals who are being discharged from Saint Elizabeth's Hospital; individuals in more restrictive housing settings whose level of care has changed; and for individual who have been on the waiting list the longest.

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[i] Section 103 of the McKinney-Vento Act, as amended by the HEARTH Act defines the four (4) categories of homeless:

1) Individuals and families who lack a fixed, regular, and adequate nighttime residence and includes a subset for an individual who resided in an emergency shelter of place not meant for human habitation and who is exiting an institution where he or she temporarily resided;
2) Individuals and families who will imminently lose their primary nighttime residence;
3) Unaccompanied youth and families with children and youth who are defined as homeless under other federal statutes who do not otherwise qualify as homeless under this definition; and
4) Individuals and families who are fleeing, or are attempting to flee, domestic violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or family member.

Q36. Please provide an update on DBH's work with the Department of Housing and Community Development (DHCD) for the 300 units that have been set aside for individuals with mental illness.

DBH Response

DBH continues its partnership with DHCD for the development of Permanent Supportive Housing (PSH) for DBH consumers with serious mental illnesses. To date, 197 units have been built and are occupied. Another 152 units are in the Pipeline: 17 units under construction at North Capitol Commons, a development with DHCD; 99 units in the Pipeline from the 2013 Consolidated NOFA, and 36 units in the Pipeline from the 2014 Consolidated NOFA.

DBH currently has $2.869 million available for capital projects through its partnership with DHCD. The Consolidated NOFA that closed in October 2015 received six project applications that included requests for DBH funds totaling $1.764 million for 42 units. The applications are currently undergoing threshold review at DHCD. Any remaining funds are expected to be available for the next Consolidated NOFA.

Q37. Please provide a list and narrative description of any DBH partnerships with District agencies in FY15 and to date in FY16 to address homelessness for DBH consumers. In addition, please provide the number of individuals served, the types of housing placements available, and the employees/s responsible for coordinating the partnership.

DBH Response:

In FY15 and FY16 to date, the Homeless Outreach Program (HOP) has served a total of 573 consumers. The HOP Coordinator took the lead role to coordinate partnerships to address consumer needs. The Homeless Outreach Program does not provide housing placement services, but has a federal grant that contributes to the housing placement of homeless individuals through partnerships. Also, HOP completes assessments which contribute to the Coordinated Entry System's mission of identifying the most vulnerable individuals.

Below is a list of the agencies HOP has partnered with and a summary of the coordinated efforts between them.

<u>Advisory Neighborhood Commissioners:</u> HOP participated in meetings with the ANC in Foggy Bottom around neighbor's concerns with camping, and public nuisances. Also, HOP participated in community safety walks with ANC Commissioners, residents and DC Council Members to address issues of health and safety in various neighborhoods in DC. HOP receives reports of homeless activities from some ANC's and through the office of neighborhood engagement. HOP responded to the various requests for outreach and intervention.

<u>Office on Aging:</u> HOP worked with the Office on Aging's Disability Resource Center to discuss and develop plans to support for homeless disabled citizens who are residing in low barrier shelters but require a different level of care.

<u>Office of Asian and Pacific Islanders:</u> HOP has coordinated with OAPI on providing a translator for a Vietnamese and a Korean family in efforts to offer them housing.
Office of the Attorney General: HOP has worked with the OAG to provide testimony for probable cause hearings in support of FD-12 petitions, in support of request for In-patient and Out-Patient Commitments.

<u>Office of the Chief Medical Examiner:</u> HOP receives information about the death of suspected homeless individuals from OCME. If the consumer is an active DBH consumer, this information is forwarded to the community support agency and the DBH Office for Coordinated Care for their information.

<u>Child and Family Services Administration:</u> HOP coordinates with CFSA when they encounter a homeless teen or a mother with a child who is being FD12ed.

<u>Court Services and Offender Supervision Agency:</u> HOP receives referrals from this agency to provide emergency assessments, outreach and linkages for homeless citizens supervised by this agency.

Department of Disability Services: Homeless Outreach has collaborated with DDS on providing support services and referrals to citizens who meet criteria for this agency's services and are homeless.

Fire and Emergency Medical Services: HOP and this agency meet as members of the Emergency Rounds Meetings to identify homeless, vulnerable citizens who are high utilizers of EMS services and in need of mental health services.

Department of Human Services -
Adult Protective Services: Homeless Outreach has worked with APS to conduct assessments of vulnerable citizens who are evicted or at imminent risk of being evicted, to provide information about resources, and complete assessments of risk. HOP has referred vulnerable cases to APS.
Economic Security Agency: Homeless Outreach has referred or taken consumers to the ESA offices for the Supplemental Nutrition Program, and Medical Assistance. We have also conducted emergency assessments of distraught consumers who presented at ESA and expressed desperate need for Mental Health interventions.
Emergency Rental Assistance Program: Homeless Outreach makes referrals to ERAP for callers who are in fear of becoming homeless, in hopes that they can receive services through that program.
DHS Homeless Services: Homeless Outreach works closely with our partners at DHS Homeless Services Program under the Family Services Administration to identify vulnerable encamped homeless citizens and reach out to provide services aimed at moving homeless citizens off of the streets and into Permanent Supportive Housing. This office and HOP collaborate closely with the Office of the Deputy Mayor on HHS to identify encampments, reach out to campers, providing information and services. This agency and HOP are also present at encampment clean ups to provide oversight and support. Also, the Homeless Outreach Program and the Mobile Crisis team are part of the cold weather emergency response along with our partners at DHS and their contractors (Low-Barrier Shelters and U.P.O.), HSEMA, OSSE, APRA and DCPS, DC Parks and Recreations, and MPD. The teams are out during these emergencies conducting outreach, information sharing, assessment of hypothermia risk, transportation to shelters and warming centers, and emergency petitions for safety.
Homeless Shelters: HOP provides in reach to the contracted Homeless Shelters in DC to conduct emergency assessments, support emergency access to psychiatric, substance use, and medical care, and provides counseling, and other support services. HOP interns have worked with shelter staff on running groups at the women's shelters.

Executive Office of the Mayor – Deputy Mayor of Health and Human Services: Homeless Outreach works collaboratively with the EOM/DMHHS for the purposes of discussing, advocating for, and addressing the needs of homeless citizens, housed citizens, and implementation of the encampment protocol.

Health Care Financing: Homeless Outreach assists homeless citizens in applying for medical assistance. Additionally, HOP works with HCF and other providers to gather information required for Skilled Nursing Levels of Care for citizens with declining medical and mental capacities who are in need of a different level of care.

Inter-agency Council on Homeless: HOP works collaboratively, in partnership with the ICH to develop policies that oversee the general needs of the homeless in the District. HOP has advocated for homeless citizens to participate actively with the ICH.
DC Public Libraries: Homeless Outreach has been called in to consult with DCPL about homeless issues, and provide emergency services to homeless citizens in crisis at a number of DC Libraries.

Metropolitan Police Department: Homeless Outreach works collaboratively with MPD to execute emergency petitions (FD-12), assess consumers at the request of MPD, as well as during the cold weather emergency. HOP has worked in collaboration with MPD at community meetings and on community safety walks. HOP participated in one of the CIO training classes at the Police Training Academy.

Department of Motor Vehicles: Homeless Outreach works with DMV to secure identification for homeless individuals by helping those eligible residents collect necessary documents to qualify for identification cards.

Department of Parks and Recreations: Homeless Outreach has participated in meetings with DPR aimed at addressing the use of public spaces by all citizens and homeless encampments in DC parks and playgrounds. HOP also participates in the clean-up of encampments located in the District's parks and playgrounds.

DC Public Schools: Homeless outreach works with DC Public Schools in community meetings aimed at addressing the impact of encamped homeless citizens on school grounds.

Department of Public Works: Homeless Outreach and DPW work together under the EOM DMHHS to implement the encampment protocol and clean up designated public spaces.

Q38. Please provide an update on the following forensic programs, including the number of individuals served in FY15 and to date in FY16, along with a description of the services provided:

A. Pre-booking diversion – DBH Court Liaison and Options Program
B. Post-booking diversion – DBH Jail Liaisons and D.C. Linkage Plus Program
C. Outpatient Competency Restoration Program;
D. Frequent Users of Enhanced Services;
E. N Street Village Recovery; and,
F. Any other jail diversion or forensic activities undertaken during FY15 and to date in FY16. Please indicate any partnerships with other District agencies or programs.

DBH Response:

DBH provides a wide variety of services to consumers involved in the criminal justice system. Pre-Booking Services include services provided within the DC Superior Court by the DBH Court Liaison and the Options Program which provide support to individuals in navigating the court system, DBH also provides competency evaluations and outpatient restoration with a court order from DC Superior Court. Post-Booking Services include services provided in the D.C. Jail through the DBH Jail Liaisons, the D.C. Linkage Plus Program, and the DBH Re-Entry Coordinator who coordinates services for consumers returning to the District from the Bureau of Prisons. Consumers already linked to community providers continue to receive services through existing agencies unless the consumer is incarcerated for more than six months.

A. Pre-booking Diversion Programs

Court Liaison

The DBH Court Liaison co-located at DC Superior Court screens consumers with behavioral health issues to ensure eligibility for Pre-Trial Services mental health supervision teams, makes referrals for mental health services to the Urgent Care Clinic and screens and authorizes services for the Options Program. She also authorizes ACT services in coordination with the DBH ACT Coordinator.

	FY 15	FY 16 1Q
Total Consumers Screened	87	32
Homeless	34	8
Veterans	4	1
Service Referred to		
SSU/PSA	72	18
Urgent Care Clinic	30	6
Pre-Booking Diversion-Options Program	28	7
ACT Authorizations	194	70

Options Program

Consumers who are not currently linked to DBH and have a history of non-compliance with court dates are referred to Options. The Options program is to provide behavioral health services and additional supports which encourage consumers to appear in court and comply with pre-trial

supervision requirements. The Options Program is contracted to Community Connections, a community based provider.

Options Program	FY 15	FY 16 1Q (Oct and Nov only)
Total Consumers Served	57	23
Provided Transitional Housing (of the total served)	23	7

B. Post Booking Programs -Services to Incarcerated Individuals

Jail Liaisons

DBH employs three Jail Liaisons who work at D.C. Department of Corrections Facilities. The Liaisons screen and link consumers requiring behavioral health services to providers and helps ensure care continues for those inmates already enrolled with a mental health provider. The Liaisons helps providers get access to inmates. DBH received a grant in FY 2014 through the Department of Justice to support women experiencing co-occurring disorders at the D.C. Jail facility.

	FY 15	FY 16 1Q
Total Screened	989	153
Individuals with MI	855	52
Re-linked to DBH	508	77
Newly Linked	275	66

D.C. Linkage Plus Program

The D.C. Linkage Plus Program serves consumers with misdemeanor and felony charges previously not connected to a provider or who have been inactive for a period of time. The goal is to engage individuals involved with the criminal justice system with behavioral health services during their incarceration to support treatment upon their release and help avoid continued involvement in the criminal justice system. Consumers are linked prior release from jail with specific supports to help them make court appearances and adhere to conditions of release as ordered by the Court. Individuals are seen at D.C. jail within 48 hours of referral or if returning from a Bureau of Prisons facility, they are seen immediately upon return to the community. The program is operated under contract with Green Door, a community based provider.

	FY 15	FY 16 1Q
Total Consumers Served	203	138
Total New DCLP Consumers Served	52	7
Transitional Housing Referrals	8	1
Permanent Housing Referrals	11	2

Prison Re-Entry Services

The Re-Entry Coordinator is co-located at Court Services and Offender Supervision Agency, The Coordinator screens and assesses consumers returning to the District from correctional facilities operated by the Bureau of Prisons through phone communication with consumers in prisons, video conferencing and through record reviews of previous behavioral health treatment either in the DBH system of care or from BOP treatment records.

	FY 15	FY 16 1Q
Total Seen	868	133
Total with Mental Health /Co-occurring Issues	248	99
Referrals to ACT	12	0
Already linked to provider (Re-linked and care coordination)	226	88
Newly Linked provider/ACT program	22	11

C. Outpatient Competency Restoration

Outpatient Competency Restoration Program

Court ordered referrals are made to the Outpatient Competency Restoration Program (OCRP) after a finding of incompetence following a full competency evaluation by DBH's Forensic Legal Service**.** Defendant's suitability for the program is based on information presented in the Forensic Legal Services assessment, Pretrial Services report, and attorneys. Defendants with violent histories or current violent felony charge may not be suitable for the program. Defendants with substance abuse histories may be suitable but abstinence from drug and/or alcohol abuse is required for participation. All defendants are asked to sign an agreement for participation in the program. The OCRP provides intake, psycho-educational groups, competency evaluations (as requested by the Court) and individual mental health interventions and referrals needed to assist the individual in gaining or re-gaining competency.

	FY 15	FY 16 Q1
Total Participants	131	31
Average Participation per Weekly Group Sessions	102	27

Pre-Trial and Assessment Competency Evaluations

Court ordered referrals are made for an evaluation of a defendant's competency to stand trial. Defendants are presumed competent to stand trial unless factors are identified which may

interfere with their understanding of the legal system. A judicial official or attorney can request that a defendant's competency to stand trial be evaluated by a licensed mental health clinician, stationed at the DC Superior Courthouse. Defendants are initially ordered to have a competency screening examination performed. If the defendant is opined incompetent or the evaluation is indeterminate, there can be an order for the defendant to undergo a full competency evaluation.

The service utilization data for this service is shown on the chart below.

	FY 15	FY 16 Q1
Total Competency Screenings	443	180
Total Full Competency Evaluations	271	81

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D. Frequent Users of Service Enhancements

This program which targeted homeless consumers who had histories of recidivating from jail and emergency psychiatric programs ended in 2012. The Homeless Outreach Team and Mobile Crisis Services work closely together to address this challenge.

E. N Street Village Recovery Housing

N Street Village provides transitional housing to women with behavioral health concerns. Priority is given to consumers enrolled in the Linkage Program and/or leaving DC jail.

	FY 15	FY 16 1Q
Total Served in transitional housing	25	13
Number began benefits	5	0
Number moved into Permanent Housing	6	0

Q39. Please provide an update on the work of the Court Urgent Care Center (CUCC). Please include:

- a. *The services provided;*
- b. *Eligibility requirements to receive services;*
- c. *The number of individuals served in FY15 and to date in FY16 and the referral source for individuals (i.e., DBH Jail Liaison, Pre-Trial Services Agency, D.C. Misdemeanor and Traffic Court, etc.); and,*
- d. *Any costs associated with the program.*

DBH Response:

The goal of the Court Urgent Care Clinic is to identify and provide immediate services to persons in need of mental health and/or substance abuse assistance who become involved with the Court for mainly misdemeanor offenses. Individuals in need of care are connected to appropriate mental health and substance abuse services. The ultimate outcome is minimizing recidivism within the criminal justice system and improving the behavioral health of the consumers served. The services provided are:

1. Identifying the behavioral health, medical and supports service needs of individuals who come in contact with the criminal justice system who require on-going treatment services
2. Conducting behavioral health screening, assessment and referral services
3. Providing urgent care treatment services to stabilize individuals identified by the Court
4. Referring and linking identified individuals to appropriate community-based or residential treatment services, and
5. Providing on-going mental health treatment and aggressive case management services to individuals who prefer to receive their services at the UCC.

Individuals who have contact with the court system and display the need for mental health and/or substance abuse services are eligible to receive assessment, treatment and referral services through the UCC. An individual may be referred by any judge, attorney, pre-trial worker, or probation officer. The UCC also receives referrals from the DBH Court Liaison Social Worker and accepts self-referrals. The UCC works closely with the Traffic and Misdemeanor Community Court, the Mental Health Community Court and Youth Mental Health Community Courts. Clients are referred from different court divisions including the criminal, community, family, and domestic violence. The number of individuals referred from the various sources and specific services are shown on the chart below.

During FY14, the entire UCC staff received training in the delivery of co-occurring enhanced services. This training was conducted to ensure that individuals who present at the Court will receive integrated substance abuse and mental health screening, assessment and treatment when appropriate.

The services provided at the UCC are delivered through a contract with DBH. The FY 15 contract amount was $675,812. In FY16 to date, the total expenditure for this service is $118,600.56 through a DBH contract.

Description of Services	**FY15:** ***October 1, 2014-September 30, 2015***	**FY16 YTD:** ***October 1, 2015 - November 30, 2015***
Referrals		
Referral Sources to the UCC:		
-Traffic and Misdemeanor Court	145	6
-Mental Health Court	71	8
-Criminal Court (Various Judges)	33	7
-Pre-Trial Services (PSA)	113	36
-US Marshal Service	0	0
-Department of Behavioral Health (DBH)	24	1
-Mayor's Liaison	22	2
-CSOSA	13	5
-Family Court	36	0
-Lock-up*	294	8
-Attorney	3	5
-Other	63	6
Total Referrals Seen	**817**	**84**
*An additional 404 individuals were seen but declined services.		

Q40. Please provide a description and an update on the Behavioral Court Diversion program including:

a. *Which youth are eligible to participate in the program;*
b. *The process or protocol for selecting or referring youth to the program;*
c. *The number of youth who participated in FY15 and to date in FY 16, the type of status offense they were alleged to have committed, the referral source (i.e., judge, probation officer, prosecutor, etc.) and the outcomes for youth in the program;*
d. *The recidivism rate of the youth participants and an explanation of how recidivism rates are measured;*
e. *Any costs associated with the program; and,*
f. *The program's capacity and any expansion plan or barriers to expansion*

DBH Response

The Juvenile Behavioral Diversion Program has operated within the DC Superior Court Juvenile Division since January 2011. This program links and engages juveniles in appropriate community-based mental health services and supports. Court-involved juvenile status offenders are given the option of voluntarily participating in mental health services rather than being prosecuted. The goal is to reduce behavioral symptoms that may contribute to juveniles' involvement with the criminal justice system and to improve their functioning in the home, school, and community. This program is intended for children and youth who are often served within multiple systems who are at risk of re-offending without linkage to mental health services and other important supports. Participants are enrolled from six months to a year and are required to attend regular court monitoring meetings and participate in mental health services.

a. *Which youth are eligible to participate in the program;*

Eligibility Criteria. This program serves juvenile offenders under the age of 18 who are available to participate in community-based mental health services. Eligible youth offenders are those with pending charges of possession or use of alcohol or controlled substances, possession of drug paraphernalia with intent to deliver or sell, disorderly conduct, forgery, theft, and shoplifting or receiving stolen property, pandering, sexual solicitation, traffic offenses, indecent exposure, gambling, assault and credit card fraud. In addition, the Office of the Attorney General may permit or decline allowing a youth to participate in the program on a case by case basis. Youth who are charged with offenses involving a weapon, child sexual abuse, felony assault, homicide or voluntary manslaughter are not eligible to participate.

b. *The process or protocol for selecting or referring youth to the program;*

Referral Process. A juvenile offender can be referred by the initial hearing judge, the juvenile calendar judge, the offender's lawyer or probation officer to the Office of Attorney General (OAG). Once a juvenile is deemed legally eligible and screened for a mental health diagnosis, a referral is made to the Suitability Committee. The Suitability Committee chaired by DBH is composed of members from Court Social Services, the Child's Guidance Clinic, DBH mental health and substance use providers, and the Child and Family Services Agency (CFSA), as needed.. The Committee makes recommendations for appropriate mental health services for a youth whether accepted in the program or not. The Committee also monitors and analyzes the

data from the Juvenile Behavioral Diversion Program to develop recommendations to improve the quality of this effort.   All youth enrolled in JBDP receive mental health services through the DBH provider network and are supervised by Court Social Services.

c. The number of youth who participated in FY15 and to date in FY 16, the type of status offense they were alleged to have committed, the referral source (i.e., judge, probation officer, prosecutor, etc.) and the outcomes for youth in the program;

Number of Youth Served. The data related to this program are collected for calendar year. In calendar year 2015, 46 youth were involved in JBDP. As of January 2016, 31 youth are enrolled in the JBDP. The Court Social Services Child Guidance Clinic is now compiling data for the 2014 program using the Conner's Score tool to measure outcomes.

Type of Offenses	Number of Offenses
Assault (Threats, Simple Assault, Assault on Police	22
Theft (Shoplifting, Theft II)	7
Robbery – UUV-Burglary	4
Destruction of Property/Fare Evasion	5
Runaway	6
Truancy	2
Sex Abuse	1
Possession of Weapon	4
Assault with Weapon	2
Total	53*

* Some youth have multiple charges.

d. The recidivism rate of the youth participants and an explanation of how recidivism rates are measured;

Recidivism Rate. The Court Social Services' Child Guidance Clinic is responsible for collecting and analyzing this data. Recidivism is defined as "a plea or found involved" in a crime one year after completion of the program. The data for 2013 showed a recidivism rate of 13 per cent—far lower than the national average of 43 per cent to 50 per cent. 2014 data is being compiled.

e. Any costs associated with the program

Costs Associated with the Juvenile Behavioral Diversion Program
The cost to the Department is the salary and fringe costs for one FTE social worker which is $115,034.00.

f. The program's capacity and any expansion plan or barriers to expansion

Program Capacity and Expansion Plan

The capacity for JBDP is 60 youth which is sufficient at this time.

Q41. Please provide a description of the program and activities within the Children and Youth Services Division, including the FY15 and FY16, to date, performance measures and outcomes.

DBH Response

RTC Reinvestment Program - provides clinical monitoring for CFSA placed youth and youth for whom DC Medicaid has authorized payment for treatment in a PRTF. RTCRP focus on the five primary objectives: 1.) assuring the treatment program meets the clinical needs identified in the treatment plan; 2.) assuring that the clinical program is adequate to meet the psychiatric and behavioral needs of the child/youth; 3.) assuring appropriate and adequate lengths of stay through the monitoring of medical necessity for continued stay; 4.) participating in discharge planning and working collaboratively with CFSA (for CFSA placements only) and other DC Agencies (i.e., DYRS) as appropriate to assure services are in place upon discharge; and 5.) following discharged youth for at least six months after discharge to support the child's/youth's successful reintegration into the community.

FY15 Performance Measure

- Decrease the ALOS in PRTF by 5% when compared to FY14 rate.
- Decrease the number of youth in PRTFs by 5% when compared to FY14 rate.
- PRTF staff will participate in 80% or more of the Treatment Team meetings held for youth involved in on-going treatment in PRTFs and those discharged.
- Increase the percentage of youth discharged from PRTF who receive ACT/CBI services upon discharge by 5%.

FY15 Performance Outcomes

- The Average Length of Stay (ALOS) for FY 15 was 9.4 months.
- There were 113 youth in PRTF placements in FY15 compared to 125 in FY 13. This represents a 10% decrease.
- A total of 500 Treatment Team meetings were held for youth in PRTFs. DBH staff participated in 96.6% (N=483) of these sessions.
- A total of 62 youth were discharged from PRTF. Thirty-seven of the 62 or 58% received Assertive Community Treatment (ACT), Community Based Intervention (CBI), or Transition to Independence/Assertive community Treatment (TACT).

FY16 Performance Measure

- Decrease the ALOS in PRTF by 5% when compared to FY15 rate.
- Decrease the number of youth in PRTFs by 5% when compared to FY15 rate.
- PRTF staff will participate in 80% or more of the Treatment Team meetings held for youth involved in on-going treatment in PRTFs and those discharged.
- Increase the percentage of youth discharged from PRTF who receive ACT/CBI services upon 5%.

The DC System of Care Expansion Implementation Project, the DC Gateway Project

The DC System of Care Expansion Implementation Project, the DC Gateway Project, is funded through a 4 year grant from the Substance Abuse and Mental Health Services Administration. Its focus is on the development and strengthening of the infrastructure and services to children, youth and their families with mental health concerns across the District and across child serving systems.

The activities focus on the following six areas:

1. Identify and implement a functional assessment instrument for children and youth.
2. Develop and implement a training and certification process for parent and youth peer support.
3. Develop and implement strategies to improve identification and access to mental health services.
4. Improve early identification of mental health concerns and linkage through integration of primary care and mental health.
5. Develop and implement a social marketing plan that promotes community awareness of children's mental health and decreases stigma.
6. Develop cross agency strategies to support the continued decrease in the use of 'high end' services (i.e. Psychiatric Residential Treatment Facilities, Residential Treatment Centers, Non-public schools, treatment foster care) and reinvestment of savings in community based services.

FY 15 Performance Measures

- CAFAS/PECFAS to be implemented across DBH providers and CFSA. Develop pilot use of CAFAS/PECFAS within DCPS and DC Public Charter. Data warehouse to support cross agency data sharing and collaboration developed.
- Continue training of Certified Family Peer Specialists (two training cycles) including strengthening/revision of the training curriculum and development of employment opportunities.
- Develop Youth Peer Specialist training curriculum. Development initially will focus on the engagement and coaching of youth to be integrally involved in the development of this curriculum.
- Implement Universal Intake form across all 5 DC Collaboratives. Identify in collaboration with DHS strategies for utilization within shelter population. Work with Access Helpline, DYRS, and development of online resource guide to strengthen the linkage process.
- Implement second round of Learning Collaborative to expand social emotional screening of children during well child visits to pediatric providers. Support this screening through specific billing codes for screening process. Develop mental health/psychiatric resources/consultation for pediatric providers through DC-MAP.
- Continue provision of Youth Mental Health First Aid trainings across DC. communities including culturally diverse and faith based communities.
- Conduct Children's Mental Health Awareness Day event in DCPS and DC Public Charter elementary schools. Finalize brochure describing DBH services and how to access mental health services for providers and develop a second brochure focused on the community at large. Expand mental health awareness message through social marketing and media strategies including development of a "branding" strategy and collaboration with Creating Community Solutions initiative.

- Continue to work with OSSE to identify funding to support a pilot project to return 20 youth from non-public school placement with tracking of associated savings and reinvestment in community programming.

FY 15 Performance Outcomes

- On November 1, 2014 the CAFAS/PECFAS was implemented across all DBH providers. On July 1, 2015 the CAFAS/PECFAS was implemented for both in home and out of home youth served by CFSA. OSSE is currently finalizing a contract with Multi-Health Systems (MHS), owners of the CAFAS/PECFAS assessments to utilize their web-based system. DC Public Schools and DC Public Charter Schools have identified pilot schools to proceed with implementation as soon as the contract is finalized. Cross agency work with OCTO has developed a detailed description of the components necessary to develop a data warehouse that will support the sharing of information with plans to begin an initial level of data sharing in FY 16.
- Two sessions of Family Peer Specialist training were conducted in March and August of 2015. There were 3 graduates in June and 8 in October. Data was collected using surveys and focus groups that has resulted in ongoing modification and strengthening of both the classroom instruction and the practicum experience.
- In May, 2015 a youth driven group was convened to develop the Youth Peer Specialist Training program. This group has developed the core components of the program with the first training class to be held in the summer of 2016.
- The Universal Intake form is available for use at all 5 Collaboratives by the mental health co-located staff. In FY 16 efforts are being focused on identifying the critical drivers that support timely easy access to the right services.
- A second round of the MH Learning Collaborative was completed in June. The contract to support development of DC-MAP was awarded in February, 2015. In May, 2015 DC MAP consultation services became available to a pilot group of pediatricians with full roll out in September, 2015. On October 27, 2015 DHCF issued Transmittal No. 15-39 which includes a new code for Mental Health Screening and includes a modifier to identify screenings that uncovered a potential problem.
- Youth Mental Health First Aid has been provided across diverse community organizations including faith based groups, family run organizations, the Collaboratives, Advocates for Justice and Education, Ward 7 Health Alliance, school nurses, educational staff, DYRS staff, CFSA resource parents, etc.
- In May, 2015 numerous Children's Mental Health Awareness Day events were conducted including poster development at several elementary schools with display at the Wilson Building, distribution of mental health awareness wristbands, a 6 week radio public service announcement (PSA) campaign, and the development of 3 PSAs by a group of youth. A brochure has been developed and the initial roll out of the resource guide occurred in December, 2015. A broad social marketing campaign to increase MH awareness particularly for youth in wards 5, 7, and 8 is currently underway in collaboration with the Creating Community Solutions initiative.
- The educational funding need to support youth being returned from nonpublic placement was not available. Current efforts are focused on developing funding alternatives for High-fidelity Wrap-around to increase the availability of funds by DBH, CFSA, and OSSE to support community based services.

FY 16 Performance Measures

- Conduct pilot study of CAFAS/PECFAS within DCPS and DC Public Charter schools. Implement the CAFAS across substance use disorder providers (ASTEP). Continue development of data warehouse to support cross agency data sharing and collaboration. Development to occur in collaboration with other data sharing projects.
- Continue training of Certified Family Peer Specialists (two training cycles) including ongoing strengthening/revision of the training curriculum and practicum opportunities.
- Continue development of Youth Peer Specialist training program with a focus on continuing a youth driven process. Conduct the first training of Youth Peer Specialists training curriculum. Support broad engagement of youth in various initiatives including Youth MOVE and social marketing initiatives.
- Continue the development and expansion of DC-MAP.
- Continue provision of Youth Mental Health First Aid trainings across DC communities including culturally diverse and faith based communities. Conduct Children's Mental Health Awareness Day event as a part of the FY 16 social marketing campaign to increase MH awareness and decrease stigma particularly for youth in wards 5, 7, and 8. Continue collaboration with Creating Community Solutions initiative.
- Collaborate with DHCF to identify and implement alternative funding strategies for High-fidelity Wraparound.

FY 16 Performance Outcomes (to date)

- Staff at ten DCPS and three Public Charter schools have been trained as CAFAS raters with the pilot ready for implementation once the contract is finalized. ASTEP (substance use disorder providers) were trained as raters in November, 2015 and began administering the CAFAS in December, 2015.
- The Family Peer Specialist training curriculum has been revised with the next class of Family Peer specialists scheduled to begin in January.
- The youth continue to meet weekly to finalize development of the Youth Peer Specialist training.
- Weekly meetings with a youth led group occur to develop a social marketing campaign in collaboration with the Creating Community Solutions initiative. Kick-off of the DBH portion of the campaign is scheduled for March, 2016.

School Mental Health and Early Childhood Programs

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

FY15 Performance Measures

- Child and Adolescent Functional Assessment Scale (CAFAS)/Preschool and Early Childhood Functional Assessment Scale (PECFAS) is conducted at admission, every 90-days and a discharge to determine the child's functioning across eight life domains: At School, At Home, in the Community (delinquency), Behavior Toward Others, Moods/emotions, Self Harm, Substance Use, and Thinking (assessing irrationality)
- Increase in level of functioning over the course of treatment

FY15 Performance Outcomes

- Preliminary analyses indicate that 60% of cases with an improvement in CAFAS total score of 10 points or greater. 81% of cases with an improvement score on PECFAS of 10 points or greater.

FY16 Performance Measures

- Child and Adolescent Functional Assessment Scale (CAFAS)/Preschool and Early Childhood Functional Assessment Scale (PECFAS) is conducted at admission, every 90-days and a discharge to determine the child's functioning across eight life domains: At School, At Home, in the Community (delinquency), Behavior Toward Others, Moods/emotions, Self Harm, Substance Use, and Thinking (assessing irrationality)
- Increase in level of functioning over the course of treatment

FY16 Performance Outcomes

- Data is being collecting and will be analyzed at the end of the academic year.

Early Childhood Mental Health Consultation Program – Healthy Futures: Mental health professionals provide center-based and child and family- centered consultation services to the staff and family members at 26 Child Development Centers (CDCs). Services are provided to improve social-emotional competence among young children and increase the knowledge of children's mental health issues among staff and family members. DBH clinicians also conduct individual child and classroom observation, screen for the early identification of social-emotional concerns and refer and link children and their families to community resources and mental health services when required.

FY15 Performance Measures

- Strengths and Difficulties Questionnaire (SDQ): Teacher perceptions of the prevalence and severity of children's behavior problems
- Devereux Early Childhood Assessment (DECA): an assessment completed by teachers and parents for children receiving child-specific consultation services to assess areas of strength and need and to assess change over time. Arnett Global Rating Scale of Caregiver Behavior: Assesses the interactions between teachers and the children

FY15 Performance Outcomes
Key findings from the Year Five program evaluation conducted by Georgetown University (2015) are described below:

- 1,366 young children in 130 classrooms in 26 CDCs had access to consultation. CDCs were located throughout the district, with a concentration in Ward 8.
- This year, only two children were expelled from any of the CDCs in the sample. Consistent with the four previous years of the Healthy Futures project, the expulsion rate of the CDCs being served was consistently below the national average of 6.7 children per 1,000 (Gilliam, 2005). ECMHC provides CDC staff with skills and resources to handle difficult child behaviors and to limit expulsions.
- Across the sample, 15% of children had a behavioral concern, according to their teachers. These behavioral concerns were primarily externalizing, including disruptive behavior.
- Among the 54 children involved in child-specific consultation, teachers reported statistically significant reductions in their behavioral concerns and improvements in their self-regulation, initiative, and total protective factors after 3-4 months of consultation.
- Teachers who received programmatic consultation demonstrated significantly increased positivity during interactions with children, as well as reduced permissive and punitive behaviors.
- This year's evaluation placed an emphasis on understanding the question of dose.

FY16 Performance Measures
Healthy Futures:

- Strengths and Difficulties Questionnaire (SDQ): Teacher perceptions of the prevalence and severity of children's behavior problems
- Arnett Global Rating Scale of Caregiver Behavior: Assesses the interactions between teachers and the children
- Devereux Early Childhood Assessment (DECA): an assessment completed by teachers and parents for children receiving child-specific consultation services to assess areas of strength and need and to assess change over time.

Primary Project: The Department of Behavioral Health/School Mental Health Program (DBH/SMHP) provides Primary Project, an evidenced-based, early intervention/ prevention program for identified children in prekindergarten (age 4) through third-grade who have mild problems with social-emotional adjustment in the classroom. Primary Project services are provided to children attending child development centers, and, DC public and charter schools that receive on-site services from a DBH/SMHP or Healthy Futures clinician.
Primary Project involves two major components: 1) screening for identification of level of need for service (early intervention/prevention or more intensive service, i.e., counseling/therapy), and, 2) the Primary Project intervention for children identified as having mild adjustment problems in the classroom. The "intervention" is a one-to-one, non-directive play session provided at school by a trained paraprofessional (Child Associate) under the supervision of a Primary Project Program Manager.

FY15 Performance Measures

- Teacher-Child Rating Scale (T-CRS) is the screening tool used to measure the child's functioning in the classroom in the following areas: Task Orientation, Behavior control, Assertiveness and Peer Social Skills.

FY15 Performance Outcomes

- Results from baseline and follow-up T-CRS screenings indicated participating students, on average, showed improvements across all four empirically-derived school adjustment scales – Task Orientation, Behavior Control, Assertiveness, and Peer Social Skills

FY16 Performance Measures

- Teacher-Child Rating Scale (T-CRS) is the screening tool used to measure the child's functioning in the classroom in the following areas: Task Orientation, Behavior control, Assertiveness and Peer Social Skills

FY16 Performance Outcomes

- Data is being collecting and will be analyzed at the end of the academic year.

Child and Youth Clinical Practice Unit – This unit is responsible for early mental health screenings for children at risk of removal and entering the child welfare system. The unit provides on going consultation to CFSA social workers and community providers. This unit also provides oversight and monitoring of Community Based Intervention Services (CBI) and implementation of evidence-based practices available in the children's mental health system of care.

FY15 Performance Measures

- Expand the implementation of Evidence-Based Practices to include Trauma Systems Therapy (TST).
- Increase utilization of FFT from 323 youth served to 340
- Increase utilization of MST from130 youth served to 140
- 75% of eligible children and youth initially removed or re-entering the foster care will receive a mental health screening.

FY15 Performance Outcomes

- DBH partnered with Evidence-Based Associates to select and train four child-serving CSAs in Trauma Systems Therapy (TST).
- 370 youth received FFT services at the end of FY15.
- 140 youth received MST services in FY15.
- 86% of eligible children and youth initially removed or re-entering the foster care system have received a mental health screening.

FY16 Performance Measures

- DBH and CFSA will collaborate to train 300 persons in TST which include CFSA biological parents and the Department of Parks and Recreation Staff.

- Increase mental health screenings and consultations, for in-home families and children and youth entering care and therefore increase in enrollments by 10%
- Track and monitor the number of CBI authorizations/ benefit approvals, to ensure that 75% of children approved/authorized are engaged in services within 72 hours.

FY16 Performance Outcomes

- In the Fall of FY15, DBH selected and launched TST training for three additional providers. DBH partnered with Evidence-Based Associates to select and train four child-serving CSAs in Trauma Systems Therapy (TST) in the Fall of FY15.
- Mental health screenings and consultations being collected and will be analyzed al basis.
- This data is not available at this time.

Clinical Support Services Unit – This unit is responsible for the Assessment Center which provides mental health consultation and support as well as conducts forensic mental health assessments and evaluations for court involved children and youth in the juvenile justice and child welfare systems and domestic relations cases being heard in the Family Court Division. The unit also provides oversight to the two Care Management Entities (CMEs) who delivers wraparound services aimed at diverting youth from psychiatric residential treatment facilities. In addition the unit provides technical assistance and coaching to certified providers within the network on best practice delivery models and how to integrate the Community Service Reviews (CSR) indicators into supervision. In FY15 the Juvenile Adjudicatory Competency Program was established to conduct competency evaluations for youth engaged in the juvenile justice system and provide restoration services.

FY15 Performance Measures

- Complete evaluations for abuse, neglect and domestic relations cases within 45 days of referral and juvenile cases within 15 days of referral.
- Establish and implement Juvenile Adjudicatory Competency Program.
- Increase utilization of High Fidelity Wraparound to 360.
- Increase utilization of Juvenile Behavioral Diversion Program from 60 youth within year.
- Exceed CSR score for children system by 10%.

FY15 Performance Outcomes

- 745 evaluations were completed through the Assessment Center. Of the 745evaluations, 459 evaluations were for abuse and neglect cases, 167 domestic relations and 119 evaluations were for youth engaged in the juvenile justice system. The average number of days from abuse, neglect and domestic relations cases was 47; a 2 day improvement from last year and juvenile cases within 15 days of referral meeting our goal of completion.
- The Juvenile Adjudicatory Competency Program was established in FY15. A total of 17 competency evaluations were court ordered and completed.
- There was a decrease in High Fidelity Wraparound utilization from 355 in FY14 to 319 in FY15.
- 46 Youth were enrolled in the Juvenile Behavioral Diversion Program.

- A new CSR protocol was implemented in FY15. The overall system performance rating was 49% which represents baseline for the new protocol.

FY16 Performance Measures

- Continue completion of evaluations in a timely manner for child welfare and domestic relations cases within 45 days and juvenile cases within 15 days.
- Develop and implement Restoration component of Juvenile Adjudicatory Competency Program.
- Increase enrollment within Juvenile Behavioral Diversion Program (JBDP) to 60 youth.
- Increase utilization of High Fidelity Wraparound 5% of FY 15 utilization.
- Develop data collection and reporting mechanisms in iCAMS to capture data for programs within unit.

FY16 Performance Outcomes

- Data will be collected and will be analyzed at the end of year.
- 31 youth currently enrolled in JBDP. Provide refresher trainings for attorneys and judges to promote program and its effectiveness. First training was held in November 2015 and a second is scheduled for January 22, 2016.
- utilization of High Fidelity Wraparound 5% of FY 15 utilization
- Began the development of user stories with ARE and iCAMS.

The Parent Infant Early Childhood Programs (PIECE)

The PIECE program provides mental health services to children ages 3 – 7.6 years old and their families who present with challenging social/emotional behaviors that are disruptive at home, school and the community. The Early Intervention and Treatment Program seeks to provide comprehensive services to children and families that focus on supporting cognition, language, motor skills, adaptive skills and social emotional functioning. The program utilizes a number of treatment modalities as well as evidence based practices (Parent Child Interaction Therapy and Child Parent Psychotherapy)

FY15 Performance Measures

- To reduce severity of functional impairment within the following domains: School, Home, Community, Behavior Toward Others, Mood and/or Emotions, Self-Harmful Behavior, Substance Abuse, and Thinking, as measured by the CAFAS/PECFAS subscales.
- Increased collaboration with DCPS and Public Charter Schools (IEP meetings, MDT meetings and classroom observations).

FY15 Performance Outcomes

- In FY15, children between the age of 5 and 9 were administered the CAFAS and saw a 29% decrease (14 total score points), while children younger than age five received the PECFAS and saw a 43% decrease (23 total score points) in the average total score from the initial assessment to the most recent assessment across the following domains: School, Home, Community, Behavior Toward Others, Mood and/or Emotions, Self-Harmful Behavior, Substance Abuse, and Thinking.
- PIECE clinicians attended four school-based meetings in FY15.

FY16 Performance Measures

- To reduce severity of functional impairment within the following domains: School, Home, Community, Behavior Toward Others, Mood and/or Emotions, Self-Harmful Behavior, Substance Abuse, and Thinking, as measured by the CAFAS/PECFAS subscales.
- Increase collaboration with DCPS and Public Charter Schools (IEP meetings, MDT meetings and classroom observations).

Now Is The Time (NITT): Healthy Transitions

The Now is the Time: Healthy Transitions grant is 5 year grant from the Substance Abuse and Mental Health Services Administration. Its focus is to develop a system of care for Transition Age Youth and young adults.

FY15 Performance Measures

- Hire TAY Project Director and Youth Coordinator for the grant.
- Develop the scope of work and release RFP solicitation for three (3) CSAs to hire Transition Specialists as required by the grant.
- Ensure there is a fully executed MOU with CFSA to support the co-location of staff for the Wayne Place Transitional Housing facility by Spring 2015.
- Engage, educate and establish a referral protocol with current TIP providers for the service provisions for Wayne Place Residents.
- Fill the 22 DBH slots in the Wayne Place Transitional Housing facility.

FY15 Performance Outcomes

- MOU with CFSA for Transition Specialists at Wayne Place was fully executed
- TAY Project Director and Youth Coordinator were hired in July 2015.
- Support collaborative efforts to promote youth voice and choice.
- Partnered with CFSA to and established a process for Wayne Place Transitional Housing facility.
- Conducted presentations to all the TIP providers on the availability Wayne Place Transitional Housing units for DBH TAY ages 18-23 ½.
- Developed and implemented a referral protocol with current TIP providers for the service provisions for Wayne Place Residents.
- Partnered with the SOC and SYT grants on the development of three year social marketing campaign designed to raise awareness and reduce stigma among youth and young adults.
- In partnership with the Adult Services division a scope of work for RFP solicitation for two (2) CSAs to continue the TAY Supportive Employment Program was developed.

FY16 Performance Measures

- Release RFP solicitation targeting up to three CSAs to build the infrastructure of a TAY system of care.
- Educated the provider community of the grant goals to garner interest.
- Provide orientation, training and technical assistance to successful providers.
- Conduct outreach and education to potential referral sources.

- Submit TAY grant utilization data to SAMHSA in accordance with the established timelines.
- Participate in all Wayne Place operational processes including the admission and discharge processes.

FY16 Performance Outcomes

- Draft RFP solicitation targeting up to three CSAs was submitted to the contract office.
- TAY team met with all TIP and Supported Employment providers to educate them about the grant goals and garner interest.
- TAY Youth Coordinator conducts regular presentation at schools across the District.
- Project Director submitted TAY grant utilization data to SAMHSA in accordance with the established timelines.
- TAY Project Director is involved in all Wayne Place operational processes including the admission and discharge processes.

42. Please provide an update on the Agency's early childhood mental health projects, including any studies or reports.

a. For the Parent Child Infant Early Childhood Program include a description of the services provided, the type of clinicians employed, their capacity and the number of children served in FY15 and to date in FY16.
b. For the Early Childhood Mental Health Consultation Project, list the child care centers that are participating, the services they have received and provide any progress/outcome measures available.
c. For the Behavioral Health Access Project, list the number of individual patients who participate in the Project, the number of pediatric primary care providers who have been using the Project, and any efforts made by DBH to engage other pediatric primary care providers in using the Project.

DBH Response:

a. For the Parent Infant Early Childhood Program (PIECE) include a description of the services provided, the type of clinicians employed, their capacity and the number of children served in FY15 and to date in FY 16.

The PIECE Program has two components:

1) The Early Intervention and Treatment Services Program – Provides mental health services to children ages 3 – 7.6 years old and their families who present with challenging social, emotional and disruptive behaviors that causes impairment in functioning at home, school and the community. The Early Intervention Program seeks to provide comprehensive services to children and families that focus on supporting cognition, language, motor skills, adaptive skills and social emotional functioning. The program utilizes a number of treatment modalities as well as two evidence-based practices: Parent Child Interaction Therapy and Child Parent Psychotherapy (PCIT) and Child Parent Psychotherapy (CPP).
2) The second component of the PIECE Program focuses on improving and supporting the mental health of parents of children birth to three years of age. The Department of Behavioral Health and PIECE Program will work to address the mental health challenges of women and men who reside in wards 5, 6, 7, and 8. Our focus is to ensure that these families who reside in low income areas have access to comprehensive psychiatric care. The goal of this component is to strengthen the parent child-dyad.

Services provided:

- Developmental Screenings
- Diagnostic assessment
- Individual/family therapy
- Psycho-educational and parenting groups
- Art/play therapy
- Crisis intervention
- Psychological evaluations (as needed)
- Case management
- Home and school visitation
- Child Parent Psychotherapy (CPP)
- Parent Child Interaction Therapy (PCIT)
- Referral and linkage to community based services
- Court evaluations
- Medication evaluation and monitoring
- Psychiatric evaluations

Clinical Staff:

- LICSW (3)
- LGSW (3)
- Clinical Psychologist (1)
- License Professional Counselor/Art Therapist
- Child Psychiatrist (3)

Parent Infant & Early Childhood Enhancement Program Data

Fiscal Year	Capacity	Total Served
FY13	120	138
FY14	120	193
FY15	120	122
FY16 – 1st Qtr.	140	71

b. *For the Early Childhood Mental Health Consultation Project, list the child care centers that are participating, the services they have received and provide any progress/outcome measures available.*

The Early Childhood Mental Health Consultation Project, known as the *Healthy Futures Program* was developed with assistance from Georgetown University Center for Human Development and follows a nationally recognized model. The program is serving 26 Child Development Centers located throughout the District in wards 1, 2, 4, 5, 6, 7 and 8. All Wards are represented with the exception of Ward 3, which already had adequate services. The following Child Development Centers participated in the program in FY15:

1) Barbara Chambers Children's Center
2) Big Mama's Children Center
3) Board of Child Care
4) CentroNia
5) CentroNia Annex
6) First Rock Baptist CDC
7) Happy Faces CDC
8) Ideal I Child CDC
9) Ideal II Child CDC
10) Kiddies Kollege
11) Kids Are US Learning Center I
12) Kids Are US Learning Center II
13) Kingdom Kids CDC
14) Martha's Table CDC
15) Matthews Memorial Baptist Church CDC
16) Northwest Settlement House CDC
17) Paramount CDC
18) Randall Hyland Private School
19) Saint Philip's CDC
20) Saint Timothy Episcopal CDC
21) Southeast Children's Fund I CDC
22) Southeast Children's Fund II CDC
23) Step by Step Therapeutic Child Care
24) Sunshine Early Learning Center
25) Wee Wisdom CDC
26) Vision of Victory CDC

The goal of the Healthy Futures Program is to offer both center-based and child and family-centered consultation services, provided by a mental health professional, to early care and education providers and family members that build their skills and capacity to:

- Promote social emotional development

- Prevent escalation of challenging behaviors
- Increase appropriate referrals for additional assessments and services

Table 1 highlights utilization date for FY15 of the Early Childhood Mental Health Consultation Program. During FY 15, 147 children were formally referred to the consultants and 861 observations were conducted across the centers. In addition, 96 staff and parent presentations were conducted by the consultants on topics such as Social Emotional Development and Stress Management. Consultants also provided 271 face-to-face parent consultations, 1907 teacher/staff consultations, and 895 consultations with Center Directors.

The Table below compares FY14 and FY 15 utilization data.

Table 1. Early Childhood Mental Health Consultation Utilization Data

Service Provided	**FY 14**	**FY 15**
# of students formally referred for child-specific services	91	147
# of prevention/early intervention sessions	263	380
# of staff and parent presentations	83	96
# of observations	522	861
# of face-to-face parent consultations	226	271
# of teacher/staff consultations	1919	1907
# of consultations with Center Director	607	895
# of children referred for outside services (not MH services)	5	5
# of abuse/neglect reports	1	0

Program data for FY 15 continued to show positive results and are highlighted below:

- 1,366 young children in 130 classrooms in 26 CDCs had access to consultation. CDCs were located throughout the district, with a concentration in Ward 8.
- This year, only two children were expelled from any of the CDCs in the sample. Consistent with the four previous years of the Healthy Futures project, the expulsion rate of the CDCs being served was consistently below the national average of 6.7 children per 1,000 (Gilliam, 2005). The rate for Healthy Futures sites was 1.5%.
- Across the sample, 15% of children had a behavioral concern, according to their teachers. These behavioral concerns were primarily externalizing, including disruptive behavior.

- Among the 54 children involved in child-specific consultation, teachers reported statistically significant reductions in their behavioral concerns and improvements in their self-regulation, initiative, and total protective factors after 3-4 months of consultation.
- Teachers who received programmatic consultation demonstrated significantly increased positivity during interactions with children, as well as reduced permissive and punitive behaviors.

c. *For the Behavioral Health Access Project, list the number of individual patients who participate in the Project, the number of pediatric primary care providers who have been using the Project, and any efforts made by DBH to engage other pediatric primary care providers in using the Project.*

In an effort to promote integration of behavioral health and primary care, DBH developed the Quality Improvement Mental Health Learning Collaborative (Learning Collaborative) and the DC Mental Health Access in Pediatrics (DC-MAP) program. The initiatives initially were identified as the Behavioral Health Access Project. There are includes two primary initiatives: 1) annual, universal mental health screening through the pediatric primary care provider and 2) DC Mental Health Access in Pediatrics (DC MAP), a child mental health consultation program. The Learning Collaborative began in February 2014 and the second cycle of learning and quality improvement activities was completed in June, 2015. A total of 138 pediatricians and staff, representing 15 practices enrolled in Round two. Participating practices served children in all wards across the District and serve approximately 80% of the children with Medicaid.

The results of an Evaluation conducted with the ten (10) practices that participated in both rounds of training indicated the following:

- Statistically significant improvements in practices readiness to address mental health issues. Using the American Academy of Pediatrics (AAP) Mental Health Practice Readiness Inventory, readiness was assessed in five domains: community resources, health care financing, support for children and families, clinical information system redesign, and decision support for clinicians. On this 3-point scale in which 3 = We do not do this well—significant practice change is needed and 1 = We do this well—substantial improvement is not currently needed, the overall practice average across the 5 domains improved significantly from baseline (2.3) to project completion (1.5).
- Increased provider confidence in their ability to perform mental health screening (N=65)
  - 88% felt very or somewhat prepared to implement universal mental health screening;
  - 94% felt very or somewhat prepared to identify mental health issues with their patients;
  - 85% felt very or somewhat prepared to address mental health issues with their patients.
- Chart audits indicated improvements in practices from baseline (2013) to completion (May 2015):

- Completing mental health screening (from 1% to 72%)
- Billing for screening (from 0.5% to 89%)

The DC Collaborative for Mental Health in Pediatric Primary Care continued to work with the Department of Health Care Finance to disseminate information on coding policies and procedures. On October 27, 2015, DHCF issued Transmittal No. 15-39, which included a new code to bill for Mental Health screening (96127) that allows for the distinction between mental health screening and developmental screening (96110). The development of this specific code for mental health screening will support the collection of data on the number of screens completed and the number of positive screens across the District.

The Learning Collaborative concluded in June, 2015. The responsibility for continued outreach to pediatric primary care providers along with ongoing education, training and technical assistance had been assumed by the DC MAP (Mental Health Access in Pediatrics) program, which is funded through a contract with DBH. Between July 1, 2015 and December 31, 2015, DC MAP conducted two (2) citywide educational webinars and published three (3) topic focused newsletters. Twenty (20) recruitment presentations were conducted at pediatric provider offices with follow-up presentations conducted at several locations.

Q43. Please provide an update on the Department's work with the DC Collaborative for Mental Health in Pediatric Primary Care.

DBH Response:

The DC Collaborative for Mental Health in Pediatric Primary Care is focused on providing the education, training, and support necessary to implement annual, universal mental health screening within a pediatric primary care practice across the District. The Mental Health Learning Collaborative conducted an initial nine month training series for pediatricians and their staff from February through October, 2014.

Due to requests from participants to continue the project and need to reach additional practices, the Learning Collaborative was extended through June, 2015. This second round featured five new webinars on mental health topics along with the original core project components (3 plan-do-study-act cycles, continued technical assistance from quality assurance and mental health coaches, and monthly chart audits, team leader calls, and practice team meetings). This quality improvement structure not only provided training to pediatricians and their staff; but also supported the development and implementation of increased annual screening of all children for mental health concerns. A total of 138 pediatricians and staff, representing 15 practices enrolled in Round two. Of the 15 practices, 14 (93%) completed all requirements including attending webinars, conducting practice team meetings and all data reporting requirements. Participating practices served children in all wards and serve approximately 80% of the children in the District with Medicaid.

The results of an evaluation conducted with the ten practices that participated in both rounds of the Mental Health Learning Collaborative indicated:

- Statistically significant improvements in practices readiness to address mental health issues. Using the AAP Mental Health Practice Readiness Inventory, readiness was assessed in five domains: community resources, health care financing, support for children and families, clinical information system redesign, and decision support for clinicians. On this 3-point scale in which 3 = We do not do this well—significant practice change is needed and 1 = We do this well—substantial improvement is not currently needed, the overall practice average across the 5 domains improved significantly from baseline (2.3) to project completion (1.5).

- Increased provider confidence in their ability to perform mental health screening (N=65)
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    - Completing mental health screening (from 1% to 72%)
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Q44. Please provide an update on the work of the children mobile crisis teams. What services are provided? How many individuals were served in FY15? To date in FY16? Please be sure to specifically speak to the work of the Children and Adolescent Mobile Psychiatric Service (ChAMPS), as well as any related services.

a. What is the process in determining what calls are deployable and non-deployable?
b. What is the response time for deployable calls? Please include the longest and shortest response times that occurred in FY15 and FY16 to date.
c. How many mobile crisis teams are there? How are calls triaged to ensure that a team is available upon request?
d. Please explain the nature of the training DCPS staff participated in as well as the number of staff who were trained.

DBH Response:

In FY 15, the Children and Adolescent Mobile Psychiatric Service (ChAMPS) entered its seventh year of operation under a contract with Anchor Mental Health of Catholic Charities Archdiocese of Washington. The purpose of the children mobile crisis service is to provide immediate access to mental health services for children and youth in psychiatric distress. The goal is to stabilize youth within their homes and/or the community and avert inpatient hospitalization and placement disruptions.

The mobile team provides onsite crisis assessment to determine the mental health stability of a youth and their ability to remain safe in the community. The crisis team assists in the coordination of acute care assessments and hospitalizations when appropriate. Post-crisis follow-up interventions are also conducted up to 30 days after the initial crisis intervention; to ensure linkage to a DBH mental health provider for ongoing treatment. The population of focus is children and youth 6-18 years of age with the exception of youth who are committed to the Child and Family Service Agency (CFSA) served until age 21.

In FY 15 ChAMPS received a total of 1409 calls, of which 894 (63%) were deployable and 515 (37%) were non-deployable. There were a total of 828 (92%) deployments of the deployable 894 calls. The reasons for non-deployment vary from one call to the next. Some primary reasons include:

- Clinical Consultations and resources inquiries.
- Cancelled calls, crisis intervention is no longer needed
- Child leaves the school building prior to ChAMPS arrival and parent refuse to consent for in home assessment.
- Incomplete information, such as location of the youth, name of youth from referral source.

In all the above circumstances, all attempts are made to collaborate with the parents, schools and referring parties to obtain information, consent and/or accommodate schedule, in order to deploy on the case. Follow-up is also provided to determine the need for future services.

There were a total of 88 (11%) hospitalizations resulting from the deployments, of which 56 were the result of involuntary emergency room evaluations (FD-12s), and 32 were voluntary. Of the total calls received, 205 calls were related CFSA-involved youth. The total unduplicated number of children and youth serviced in FY 15 was 817.

In addition to deployments resulting from crisis calls during FY15, ChAMPS participated 59 in community outreach and education events. The staff provided informational and follow up services to eight District of Columbia Public Schools (DCPS) and Public Charter Schools (DCPCS). Due to higher volumes of calls from DCPCS, staff participated in team meetings to foster successful working relationships and effective service delivery, including continuity of care for clients. Staff also worked closely with CFSA to ensure that there was useful transfer of information regarding shared cases. ChAMPS continue to be a major community resource for children, youth, families and the community at large.

ChAMPS FY 15 and FY 16 to date Program Statistics Summary

	Total Children Served-Unduplicated	Total Calls Rec'd	Total Deployments	CFSA Youth	Total Fd-12s	Total Cases Resulting In Acute Care Admissions
FY 15	817	1409	828	205	51	88
FY 16	234	402	282	71	38	56

a. *What is the process in determining what calls are deployable and non-deployable?*

All calls are triaged and assessed by a licensed clinical manager. Based on the result of the assessment, calls are deemed deployable or non-deployable. Non-deployable calls are defined as informational calls related to programmatic facts, community resource inquiries and clinical consultations (caller seeking consult to problem solve mental health concerns). All other calls involving children and youth in psychiatric crisis are defined as deployable calls. A team of two crisis workers are generally deployed to assess and stabilize the youth in crisis.

b. *What is the response time for deployable calls?*

Per the awarded contract, the established response time for deployments is one hour. In FY 15, response time for deployments averaged 32 minutes and in quarter one of FY 16 the response time for deployments averaged 34 minutes. For the 1st quarter of FY 16 the shortest response time was approximately eight (8) minutes and the longest was one (1) hour and 40 minutes.

c. *How many mobile crisis teams are there? How are calls triaged to ensure that a team is available upon request*?

Currently, there are 13 full time crisis specialists and 8 part time workers assigned to the ChAMPS program. Typically, teams are deployed in pairs; however, workers can be deployed individually when the program is experiencing high call volume. The hours of 12pm-6pm are when the highest volume of calls are generally occurs. In addition, there are 3 clinical managers and 1 director who can also be deployed if call volumes exceed normal levels. Calls are triaged

according to imminent risk and prioritized by 1) danger to self/others; 2) availability of a mental health clinician at the deployment site; and 3) linguistic need. The clinical managers maintain contact with the caller while the deployed team is in route to the scene of the crisis.

d. *Please explain the nature of the training DCPS staff participated in as well as the number of staff who were trained.*

During the 2014-2015 school year, ChAMPS hosted eight outreach and educational sessions for to various DCPS and DCPCS elementary, middle and high schools geared toward all staff. Training content included education on access and utilization of ChAMPS, crisis response, assessment, de-escalation, stabilization and crisis intervention. The specific number of participants who attended each of these sessions was not tracked, so this data is not available.

Q45. Please provide an update on the work of the Psychotropic Monitoring Group (PMG) and their collaboration with the District of Columbia Drug Utilization Review Board in developing a protocol for identifying children above age five (5) prescribed four (4) or more psychotropic medications.

   a. *Has the report of findings complied and analyzed by the PMG been completed? If so, please provide the results of that report and any other reports by the group written in FY14, FY15, and FY16 to date.*
   b. *Please provide an update on how many cases this group has review and the outcomes.*

DBH Response:

The Psychotropic Monitoring Group (PMG) is developing a protocol for youth in foster care under five years of age who are prescribed psychotropic medications or youth up to 21 years old concurrently prescribed four or more psychotropic medications.

Due to challenges obtaining data through the Drug Utilization Review Board, the PMG altered its approach in FY 15. The PMG requested claims data from the Department of Health Care Finance for all youth prescribed psychotropic medications in FY14. The data identified the following numbers for the two targeted categories:

1) Six youth under the age of five were prescribed psychotropic medications, and
2) Fifteen youth were prescribed four or more psychotropic medications concurrently in FY14

The PMG examined both categories:

1) The six youth under the age five included:
   a. Three were most likely prescribed these medications for seizures rather than a psychiatric disorder given their ages and the type of medication prescribed.
   b. Three were most likely prescribed these medications for difficulty falling asleep or anxiety before a medical examination, such as a blood test or MRI, given their ages (0 to 5 years old) and the type of medication prescribed.
   c. Two who were five years old in FY14, and prescribed a medication approved by the FDA for children as young as 3-4 years old.
2) The fifteen youth prescribed four or more psychotropic medications likely included:
   a. Youth who were prescribed four or more psychotropic medications at different times rather than concurrently over the course of FY14.
   b. Youth who were in an out-of-state residential facility at some point in FY14, where they may have received a psychotropic medication on a single occasion as an emergency intervention, rather than as part of their daily medication regimen.

CFSA now is reviewing the monthly treatment notes for these youth to determine the actual number of youth who were concurrently prescribed four or more psychotropic medications.

The PMG plans to conduct its FY15-16 review in February with quarterly reviews thereafter.

Q46. How many days, on average, does it take to connect children who have been screened as needing mental health services to a core service agency? What is being done to ensure timely access to care?

a. To the extent possible, please break down days based on type of care (e.g. medication management, CBI, community support, etc.).

DBH Response:

Number of Days from Screening to First Service. DBH has staff co-located at CFSA and the five Collaboratives who are responsible for screening children and youth at-risk of removal and those removed from their homes. The data presented below, reflects the results of those screenings. The number of days on average between screening and the receipt of the first service, by service type occurred within 24 days in FY15 which has reduced from 47 days in FY14.

a. To the extent possible, please break down days based on type of care (e.g., medication management, CBI, community support, etc.)

FY 2015 Screenings		
Service Type	Number of Screenings	Between Screening and First Service Received
ACT	7	30
CBI	140	2
Community Support	1131	26
Counseling	18	27
Crisis Services	55	21
D&A	109	42
Medication Somatic	51	19
Supported Employment	1	1
Transition Support Services	1	0
Total	1513	

Ensuring Timely Access to Care. In addition to co-locating DBH staff at CFSA who are responsible for screening children and youth as soon as they are removed, during FY15, DBH in partnership with CFSA developed a protocol where DBH Choice Providers and other child-serving agencies are notified and invited to attend the Review Evaluate and Direct (RED) team meeting within 24 hours of the removal. DBH providers are also invited and attend the CFSA facilitated Family Team Meetings (FTM) for removed children. The child's first appointment with the provider is scheduled during this meeting with bio parents/family members and foster parents input. This protocol is used to ensure that children being placed in foster care have early access to mental health services. The goal is to decrease the amount of time between removal and enrollment and enrollment and service initiation. This also minimizes the impact of negative adjustments to foster care, decrease emotional and behavioral symptoms related to the trauma,

and reduce multiple placement disruptions. The involvement of the DBH Choice Providers in these teaming processes facilitates early engagement of biological parents and family members in mental health services.

DBH, CFSA and the Choice Providers meet monthly to address barriers and track and monitor the process.

Additionally, DBH staff co-located at CFSA has been trained in a clinical consultation model and started supporting CFSA program units. Using this consultation model, DBH co-located staff is assigned to CFSA units and act as a clinical consultant and behavioral health system expert. They work directly with CFSA social workers supporting them on how to utilize screening and trauma assessment scores to conceptualize and understand complex cases and determine right fit of behavioral health services. They also serve as liaisons between CFSA and DBH on any access issues that impede timeliness to behavioral health care.

CFSA also invested in the expansion of DBH co-located staff to their in-home units at the five collaboratives where four additional DBH clinicians are placed to provide behavioral health screening and consultation.

Q47. How many days, on average, does it take for a child who has been referred to a core service agency to actually start receiving care? What is being done to ensure timely access to care? To the extent possible, please break down days based on type of care (e.g. medication management, CBI). Please provide a comparison between FY14, FY15 and to date in FY16.

DBH Response:

Number of Days from Referral to First Service. As indicated by the chart below, days between enrollment and the receipt of the first service, by service type usually occur within 20 days of the service request.

Age 0-17	FY12		FY13		FY14		FY15	
Service Type	Total Number of Newly Enrolled Consumers	AVG Days Between Enrollment and First Service Received	Total Number of Newly Enrolled Consumers	AVG Days Between Enrollment and First Service Received	Total Number of Newly Enrolled Consumers	AVG Days Between Enrollment and First Service Received	Total Number of Newly Enrolled Consumers	AVG Days Between Enrollment and First Service Received
CBI	50	22	70	21	64	18	50	25
Community Support	560	23	477	23	555	20	518	21
Counseling	10	40	15	36	18	19	11	50
Crisis Services	56	5	57	10	65	6	67	8
D&A	129	19	128	21	152	17	107	18
Day Services	-	-	2	21	-	-	-	-
Medication Somatic	72	13	24	28	5	26	3	20
Team Meeting	-	-	-	-	-	-	1	8
Unique Total	**877**	**21**	**773**	**22**	**859**	**18**	**757**	**20**

*FY 16 data is not available at this time.

DBH monitors system-wide data on the time from referral to the date of the first service. DBH Technical Assistance team reviews this data with clinical directors and supervisors at the respective agencies to monitor the degree to which children/youth receive an appointment within seven days of a child/youth's referral date. A Technical Assistance plan is developed in cooperation with each provider agency that includes strategies to improve timely services for their consumers, how progress will be monitored and reported on an on-going basis.

To further assure timely access to care, the new Integrated Care Management System (iCAMS) will allow system-level, agency-level and individual data to be more easily collected, reported and analyzed. Alerts will notify service providers and DBH of any missed appointments. Care coordination will be immediately activated to continue the child's engagement in his/her treatment and recovery plan and prevent any interruption in continuity of care.

Q48. During FY15, what percentage of children discharged from a hospital were seen within the community within seven days?

DBH Response

In FY15, there were six hundred twenty-four (624) children and youth discharged from acute care hospitals. Of the six hundred twenty-four children and youth discharged, sixty-one percent (61%) were seen in the community within seven days and seventy-five percent (75%) were seen within thirty days.

Q49. Please explain the work the Department is doing with Child and Family Services Agency to better serve the mental health needs of foster children in the District. How long does it take for a child who has been identified as needing mental health services before they are connected to those services? During FY15, what percentage of children were screened within 30 days of entering or re-entering care? Has there been a decrease in time to linkage to first services from FY 14 and FY15? If available, please provide any documentation that shows that children are receiving more timely services. What efforts have been made to improve more timely services?

DBH Response

The Department of Behavioral Health continues to develop a robust array of services to meet the mental health service needs of the District's children and youth in foster care. In addition to efforts to build capacity, DBH and Child Family Services Administration (CFSA) developed a process for connecting children and families with Core Service Agencies immediately after removal occurs. Providers are notified of removal and invited to participate in a Review, Evaluate and Direct (RED) and Family Team Meeting teaming processes which occurs within 72 hours of the removal. During the RED Team Meeting, details of the cases are discussed; providers begin engagement with family members and schedule appointments at a time most convenient for families which improves the timeliness of service initiation. CFSA and DBH anticipate that having providers engaged earlier in the process when children are entering care will increase access to care in a timely manner. The DBH staff co-located in CFSA's clinical unit closely track this data.

Co-located DBH staff at CFSA has also been charged with a new role of consultation and group supervision with each unit within CFSA. Using the RED team framework as a consultation model, co-located DBH staff are assigned to CFSA units and act as a consultant and mental health system expert. They work directly with CFSA social workers to utilize assessment scores, conceptualize complex cases, and determine right fit of behavioral health services. They serve as a liaison for any troubleshooting access issues to timeliness of care.

In FY15, DBH and CFSA signed a Memorandum of Understanding (MOU) to support a streamlined screening and assessment process and to provide behavioral health support to the CFSA In-Home division. The expansion of co-located staff to CFSA In-home units provides four Behavioral Health Coordinators placed at the five Collboratives to provide mental health screening and consultation to social workers, CFSA families and community members coming to the Collaboratives for support. During FY15, these four co-located staff served 1,210 unduplicated children and youth and made 2149 contacts that include 240 behavioral health screening, clinical consultations, and linkages.

In FY15, a total of 266 children/youth involved in foster care were referred for mental health assessments and treatment through the CFSA's clinical services unit. Linkages occurred within an average of 2.1 days in FY15, which represents a 50 per cent decrease when compared to the FY14 average of 4.3 days. In addition, in FY 15, the average number of days from linkage to first services was 22 days—a decrease from 27 days in FY14.

Q50. Please explain the work the Department has been doing with the Child and Family Services Agency on trauma-informed care.

DBH Response:

DBH participates as a member of CFSA's Trauma Informed Practice Team. Both agencies have been working very closely to expand trauma informed care within the District since the award of the SAMHSA System of Care (SOC) Expansion Implementation grant to DBH and the ACF grant to CFSA in FY12. Throughout FY15, weekly calls and face-to face meetings between the staff of both agencies were conducted to plan and collaborate on the development of a trauma informed system of care. To date in FY16, these planning activities continued. This close partnership has resulted in several joint initiatives:

1. Monthly meetings are held with the providers who are part of DBH's Behavioral Health Child Choice Provider Network that serve CFSA-involved children and youth. Specific protocols for treating children and youth identified with trauma-related behavioral health needs are developed during these sessions.

2. CFSA provides funds to support the training of community providers on trauma-specific evidence-based practices. This includes Trauma Systems Therapy and Trauma Focused Behavioral Therapy. In addition, CFSA provides funds to support the local Medicaid match requirement for these services.

3. DBH has added Trauma Systems Therapy (TST) as an evidence-based practice within its service array. During FY 15 Three child and youth serving providers submitted applications to become TST provider sites. All three providers (Family Matters of Greater Washington, Hillcrest Children and Family Center, Adoptions Together were selected and trained in TST. This expanded the TST provider network to now seven (7). These agencies are now able to deliver TST services and supports to children and youth including those involved in foster care system. In addition, to ensure there is consistency in trauma tools in DC, CFSA trained the DBH TST providers on the Child Stress Disorder Checklist (CSDC) trauma screen instrument, which is currently being utilized by CFSA to identify children and youth requiring trauma-informed services.

4. CFSA provides funding to DBH for a trauma grant coordinator. This clinician is co-located at CFSA and is responsible for providing implementation support to CFSA social workers and DBH core service agency staff certified to provide TST.

5. DBH has co-located clinicians at CFSA and the Collaboratives to provide mental and behavioral health screening and link CFSA-involved to services for In-Home and Out of Home placement units. These clinicians are also trained in the TST model and utilizing the trauma assessment scores as the basis of their clinical consultation with social workers CFSA.

6. DBH and CFSA are utilizing the same evaluator for both the DBH System of Care and the CFSA Trauma grants.

7. DBH partnered with the model developers of both TST and Intensive home and Community-Based Services (CBI Level II & III) to examine how the work of both services can be integrated to adequately support and stabilize youth assessed as needing to begin services at the Safety Phase of TST. This melding of the two distinct models is unprecedented but necessary to provide a high dosage of intensive support through a trauma-focused lens to our most vulnerable children that are extremely emotionally dysregulated and are often at the highest risk of decompensating which often leads to multiple placement disruptions.

8. DBH presented at the 2015 Annual Family Court Conference on Trauma. The DBH panelist highlighted the trauma models offered in the District and the work done to ensure youth are matched with trauma services when appropriate.

9. In FY15, DBH worked with DHCF to successfully amend the State Plan Amendment and have both Trauma Focused- Cognitive Behavioral Therapy (TF-CBT) and Child Parent Psychotherapy (CPP), both trauma models, added to MHRS as a Medicaid reimbursable service.