Q51. Please explain the work the Department is doing with CFSA to better serve the mental health needs of foster children in Maryland.

DBH Response:

In FY15, CFSA provided $537,000.00 to DBH to ensure children and youth placed in foster homes including Maryland are fully engaged and have easy access to behavioral health services and supports. DBH contracted with the six of its certified providers know as Choice Providers to provide services to the children, youth and their families. Choice Provider agencies are reimbursed for travel, outreach and engagement efforts, participation in CFSA's Review Evaluate and Direct (RED) Team and Family Team meetings, and non-reimbursable costs related to service delivery. A robust array of mental health services and supports, including evidence-based practices, are now available to youth placed in Maryland through the public behavioral health system.

In addition in FY15, DBH published Certification Standards for Child Choice Providers. The Moratorium was lifted and existing certified MHRS providers had the opportunity to apply for Certification as a Child Choice Provider. The establishment of this Certification process supported the transition choice provider identification solely based on contract awards to an established set of quality measures. Therefore, effective in FY16, in order to be a Child Choice Provider, DBH certified child-serving providers must meet at least three of the five standards below:

- 70% overall CSR System Performance score (most recent score prior to application)
- 80% Quality Score MHRS Provider Scorecard (the most recent prior to application)
- 80% compliance administration rate of the DBH approved standardized Assessment (CAFAS/PECFAS) instrument for enrolled child/youth consumers.
- 70% of enrolled consumers discharged from an acute care facility receive a post-discharge appointment within seven days, and 80% of consumers discharged from an acute care facility receive a post-discharge appointment within 30 days.
- 80% of Diagnostic and Assessment reports for all children are completed within 30 days of the initial interview.

As a result of the certification process, three providers (First Home Care, Community Connections and DC/MD Family Resources Inc.) were certified. These three providers were member of the original choice provider network who have all demonstrated the capacity, competency and commitment to serving CFSA youth in Maryland. One provider is located in Landover, Maryland and the two other providers have satellite offices in Maryland.

Q52. 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.

DBH Response:

During FY15, CFSA in partnership with DBH developed a protocol to include DBH Choice Providers and other child-serving agencies in the Review Evaluate and Direct (RED) and Family Team Meeting (FTM) processes conducted at CFSA. This protocol is used to ensure that children being placed in foster care have early access to mental health services provided by Choice Providers. The goal is to decrease the amount of time between removal and enrollment and enrollment and service initiation as well as to minimize negative adjustments, decrease emotional and behavioral symptoms related to the trauma, and reduce multiple placement disruptions. The involvement of the Choice Providers in the FTMs facilitates the early engagement of biological parents and family members in mental health services. The child and parents/family member's first appointment with the provider is scheduled during this meeting. During FY 15 there were 240 RED team meetings held for children removed from their home and entering foster care, however 91 of the RED team meetings included infants. Of the 149 RED Teams remaining, 56 meetings had youth with existing enrollments. Of the 93 RED Team meetings eligible for a provider to attend, 73 or 79 per cent were matched to a DBH provider who attended the RED Team. For the 21 per cent of children that were not matched, these cases involved criminal charges, guardianship, adoption disruptions and or refugees entering care.

Choice Provider	FY15 (RED) Attended	FY15 Existing Enrollments	FY15 New Enrollments Generated from Choice Provider RED Team Participation
Community Connections	13	5	10
Family Matters	5	0	4
First Home Care	36	19	30
Hillcrest	9	12	7
Maryland Family Resources	6	0	10
Universal	0	0	0
Other DBH CSA/Provider	4	20	5
Total	73	56	66

Provider participation during the RED and Family Team Meeting processes has become a value added component of teaming at CFSA. This has resulted in improved social worker provider relationships, communication and information sharing.

DBH co-located staff implementing a fast track referral form in an effort to streamline CFSA's mental health referral process for children entering foster care. These forms are completed by the DBH co-located staff in collaboration with the assigned social worker.

Q53. Please explain the work the Department has been doing to treat children/youth exposed to violence in their communities or at home.

DBH Response:

The DBH School Mental Health Program (SMHP) provides school-based crisis emergency response support to DCPS and DCPCS that have experienced a major tragedy or crisis including community violence that is related to a current or former student. The SMHP has assigned teams that are dispatch immediately upon notification to the school and provide group processing and supports using William Steele's model from the Institute for Trauma and Loss in Children (TLC). Structured Sensory Interventions for Traumatized Children, Adolescents and Parents (SITCAP) is a trauma debriefing model. The team uses this model to help youth cope, calm the school climate, and identify youth that may need further one on one support. The SMHP also partners with the Children and Adolescent Mobile Psychiatric Service mobile team (ChAMPS) to conduct joint responses for children/youth exposed to violence in their communities or at home.

ChAMPS in partnership with the DBH Adult Mobile crisis team also provides individual and community crisis response after a violent incident, often at the request of the DC Metropolitan Department (MPD). They provide crisis assessment, interventions to stabilize the child and referral and linkage support to a DBH certified Core Services agencies to ensure comprehensive assessment and treatment.

Additionally, the following screening and assessment instruments are utilized by several providers that specialize in trauma treatment to identify children exposed to traumatic events and trauma symptoms:

- Child Stress Disorder Checklist of the District of Columbia (CSDC-DC)
- UCLA PSTD Reaction Index

There are currently three trauma-focused evidence-based practices available to children and their families that addresses the needs of children/youth exposed to violence. Child Parent Psychotherapy for Family Violence (CPP-FV), Trauma Focused Cognitive Behavioral Therapy (TF-CBT), and Trauma Systems Therapy (TST).

Child Parent Psychotherapy for Family Violence (CPP-FV) – This is an early childhood relationship-based treatment intervention to address children's exposure to trauma or maltreatment. CPP-FV sessions are conjoint with the child's parent(s) or caregiver(s) focusing on improving the child's development trajectory CPP-FV helps restore developmental functioning in the wake of violence and trauma by focusing on restoring the attachment relationship that was negatively affected by trauma. CPP-FV is geared toward young children, ages zero (0) through six (6), who suffer from traumatic stress and often have difficulty regulating their behaviors and emotions during distress. CPP-FV is offered at the DBH Early Childhood Treatment Center.

Trauma Focused Cognitive Behavioral Therapy (TF-CBT) – Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a psychotherapeutic intervention designed to address significant emotional and behavioral difficulties related to traumatic life events. TF-CBT sessions focus on addressing the child's posttraumatic stress disorder, depression, anxiety,

externalizing behaviors, sexualized behaviors, feelings of shame, and mistrust. TF-CBT also provides parents or caregivers with the tools needed to reinforce the content covered with the child between sessions and after treatment has ended. This service can be delivered in the home or in a clinic setting. TF-CBT is offered by four DBH providers: First Home Care, Maryland Family Resource Center, Community Connections and Hillcrest Children and Family Service

Trauma Systems Therapy (TST) - TST is a comprehensive phase-based model designed to treat traumatic and emotional stress experienced by children and adolescents. It is a phase based model that helps the youth gain control over emotions and behavior and seeks to restore the natural balance between the developing youth and her/his social environment. TST is offered by four agencies in the District: First Home Care, Maryland Family Resource Center, PSI and Contemporary Family Services.

Q54. 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?

DBH Response:

DBH is a member of the city-wide interagency Commercially Sexually Exploited Children (CSEC) Committee hosted by the chief presiding Judge at the DC Superior Court. A DBH representative also attends the monthly CSEC Case Management meeting held at the DC Child Advocacy Center: Safe Shores to assist with clinical support and troubleshooting any systems and access issues.

DBH offers nine evidence-based practices to children, youth and their families in the District. Three of them (Trauma Focus Cognitive Behavior Therapy (TF-CBT), Child Parent Psychotherapy for Family Violence (CPP-FV) and Trauma Systems Therapy (TST) practices are specifically geared toward treating children and youth who have been traumatized, including those identified as commercially sexually exploited. The Families First program which is responsible for the implementation of evidence-based practices is exploring with these three trauma model experts whether additional specialized adaptation and or booster trainings on CSEC is available to support trained clinicians to treat this population. DBH also met with FAIR Girls, a community based organization that provides crisis intervention, court advocacy, and support services to girls ages 11 to 24 involved in sex trafficking, to discuss collaboration with trauma EBP providers on future trainings.

Additionally, DBH offers Transition to Independence Process (TIP) service to all youth and young adults between the ages of 14-29. TIP is an evidence-supported practice that demonstrates improvement in real-life outcomes for youth and young adults with emotional/behavioral difficulties. The TIP system prepares youth and young adults with emotional and behavioral difficulties for their movement into adult roles through an individualized process, engaging them in their own futures planning process, as well as providing developmentally-appropriate services and supports. It serves youth and young adults (ages 14-29), their families, and other informal key players in a process that facilitates their movement towards greater self-sufficiency and successful achievement of their goals. Young people are encouraged to explore their interests and future as they relate to each of the following domains: employment and career, education, living situation, personal effectiveness/wellbeing, and community-life functioning.

DBH in partnership with the Child Family Services Agency (CFSA) supports the Wayne Place program which provides transitional housing and life skills for young people ages 18-24 who are homeless, aging out of the foster care system or exiting the children's mental health system and lack the family support.

Q55. 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.

DBH Response:

On February 23, 2015, DBH awarded a contract to Children's National Medical Center to support the development and implementation of DC Mental Health Access in Pediatrics (DC MAP) program. DC MAP is a child mental health consultation program which offers free consultation to pediatric primary care providers in the District from a team of mental health professionals (psychiatrists, social workers, psychologists, and care coordinators). It is staffed jointly by clinicians from Children's National Health System and Medstar Georgetown University Hospital. The clinical team provides several specific types of support to pediatricians and their staff. Consultation and supports includes bi-monthly webinars and topic focused newsletters, on site educational seminars as requested by pediatric practices and phone consultation pertaining to any child mental health topic within 30 minutes of receiving a call during regular business hours.

DC MAP began providing services to a pilot group of pediatricians in May, 2015 and became available to all DC pediatricians and their staff in September, 2015. Between June and December, 2015 the following webinars and newsletters were presented, providing information to assist pediatricians in managing moderate mental health concerns:

- City-Wide Educational Webinars (Bimonthly):
    - September 2015: *ADHD: An update and practical approaches for primary care*, Matthew Biel, MD, MSc
    - December 2015: Depression and Mood Disorders, David Call, MD
- Newsletters (Bimonthly): Newsletters enable us to provide education to providers, while also serving as a reminder about using DC MAP services. Thus, our newsletters spotlight a particular topic in addition to providing basic information about using DC MAP.
    - August 2015: Spotlight on ADHD
    - October 2015: Spotlight on securing developmental and educational resources from infancy through school age
    - December 2015: Spotlight on autism spectrum disorder

During this same time period, twenty recruitment presentations were conducted to encourage pediatricians and their staff to utilize the services of DC MAP to be able to effectively manage mild to moderate mental health concerns. In FY 16, DC MAP will continue to reach out to pediatric primary care providers to increase their awareness of the support, education, and training available. Also DBH is working to develop a secure mechanism for sharing important/relevant mental health history with the DCMAP when they contact the Access Help Line about a youth in DBH's provider network.

Q56. Please explain the work the Department is doing with the Department of Health Care Finance to improve care coordination.

DBH Response

DBH and the Department of Health Care Financing (DHCF) continue to collaborate on efforts to provide quality services to the residents of the District who have serious mental illnesses. Several joint initiatives include:

Health Homes
This new service delivery model is envisioned to significantly improve the quality of life for individuals with serious mental illness (SMI). Nationally, individuals with SMI die 25 years before the general population of preventable diseases. The overall goal of DC's Medicaid Health Home benefit is to leverage the existing services delivered by Core Service Agencies, to build a more systematic, person-centered approach to coordinating and integrating the full array of primary health, behavioral health, acute care, long term services and supports and social services to reduce preventable hospitalizations and avoidable emergency room visits. With approximately 4,900 consumers during the initial phase, the District will join 19 other states who have implemented Health Homes. Implementation of this service begins in January 2016.

Transitional Care from Nursing Homes
DBH, DHCF and the Office of Aging work together to ensure individuals currently living in Nursing Homes who are medically able, Medicaid eligible and express an interest in moving into the community are afforded the full range of necessary resources in order to effectuate a return to the community as quickly as possible. For those with mental illnesses, DBH ensures that the person is engaged with a CSA and mental health services and supports are included in the discharge planning prior to discharge.

State Innovation Model
DBH is participating in DHCF's State Innovation Model (SIM) grant in the development of new ways to maximize Medicaid for better outcomes. Specifically, DBH is an active member of the Care Delivery, Community Workgroup, Payment Models, and HIE integration workgroups, and the DBH Director is a member of the SIM Advisory Committee. These workgroups are developing a Health Homes 2 model for individuals with chronic medical conditions; alternative payment models that will allow the District to enhance its care coordination services; and enhancement of the IT support structure to resolve data issues that prevent optimal care coordination.

Q57. Provide an update on the Department's efforts to increase trainings for peer specialists.

DBH Response

In January, 2015, DBH added a winter session for the Peer Specialist Certification Training (PSCT). Thirteen individuals completed all requirements and graduated from the FY2015 winter session. Additionally, 18 individuals graduated from FY2015 summer session of the DBH PSCT, for a total of 31 peer specialists certified in FY2015. DBH has certified 107 peer specialists since the program began in 2011.

Q58. 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?

DBH Response:

DBH does not have a designated home visiting program. Nonetheless, services for adults such as Community Support and Assertive Community Treatment as well as Intensive Home and Community Based Services for children and youth can be provided in the home. For a description of these services, please see the DBH Response to Question 75.

Q59. Please provide an update on the Wayne Place Project. How many youth were served in FY15 and FY16 to date?

Department of Behavioral Health in partnership with Child and Family Services Agency (CFSA) blended funding to develop and implement the Wayne Place Apartment Community. Wayne Place provides transitional housing and life skills development for youth and young adults transitioning into adult roles and functioning. This program is designed to extend learning opportunities and support the launching of young adults who are committed to preparing and demonstrating their ability to learn relevant skills and assume responsibility and functioning related to adulthood work and/or school and community functioning; while also addressing their housing needs by providing housing opportunities. Residents of Wayne place are homeless young adults age 18-24 who are aging out of the foster care system or exiting the children's mental health system and lack the family support required successful transition into adulthood. All young people participating in the program are enrolled in DBH's Transition to Independence Process (TIP) and or aftercare services through a collaborative.

In FY 15, DBH executed two Memorandum of Understandings (MOU) with CFSA and Department of General Services (DGS) to support the implementation of the Wayne Place project. For the care coordination and planning, implementation evidence-based-practices and recovery supports MOU with CFSA, DBH transferred $171,342.45 in TAY grant funds to CFSA to fund operational costs and two (2) Transition Specialists responsible for care coordination and Wayne Place transitional housing facility. To support rent and necessary renovations, DBH executed a MOU with DGS and transferred $215,752.00 to cover these costs.

In FY16, DBH amended both MOUs and transferred $323,351.66 to CFSA and $322,478.00 to DGS to continue the Wayne Place operation.

In FY 15, thirty-eight (38) young adults lived at Wayne Place between April 1, 2015 and September 30, 2015. Forty-six (46) young adults were interviewed (screened) during this timeframe. A total of eighty-one (81) referrals were received during this timeframe, of which (38) 47% received related services (lived at Wayne Place).

April 1, 2015 to September 30, 2015

Fiscal Year 2015- Cumulative Data								
Agency	**Total # of applications received**	**Total # of applications denied during ranking**	**Total # of applications denied after interview**	**Total # of applications pending an interview**	**Total # of applicants interviewed, approved & moved in**	**Total # of applicants interviewed approved but never moved in**	**Total # of applicants that were no show for interview**	**Totals**
DBH	49	13	2	11	21	2	0	**49**
CFSA	32	1	2	7	17	2	3	**32**
Total:	**81**	**14**	**4**	**18**	**38**	**4**	**3**	**81**

In Quarter 1, FY 16, thirty-four (34) young adults lived at Wayne Place on October 1, 2015, and six (6) moved into Wayne Place between October 1, 2015 and December 31, 2015. Consequently a total of forty (40) young adults received related services (lived at Wayne Place). Also, a total of seven (7) referrals were received during this timeframe. Of the seven (7) referrals, six (6) young adults were interviewed and accepted (86%).

October 1, 2015 to December 31, 2015

Fiscal Year 2015- Cumulative Data								
Agency	**Total # of applications received**	**Total # of applications denied during ranking**	**Total # of applications denied after interview**	**Total # of applications pending an interview**	**Total # of applicants interviewed, approved & moved in**	**Total # of applicants interviewed approved but never moved in**	**Total # of applicants that were no show for interview**	**Totals**
DBH	2	0	1	1	0	0	0	2
CFSA	5	0	0	0	5	0	0	5
Total:	**7**	**0**	**1**	**1**	**5**	**0**	**0**	**7**

Q60. Please explain the work the Department is doing to work with other District agencies to address the K2/synthetic drugs epidemic.

DBH Response:
The Department has responded to District agency partner's requests for training and technical assistance such as:

1. Supported the Executive Office of the Mayor (EOM) Office of Asian and Pacific Islanders in delivering a series of targeted trainings on synthetic drugs;
2. Collaborated with the Mayor's Office of Latino Affairs Ward 1 and 2 DC-Prevention Centers in a Mock Council Hearing on synthetic drugs for youth at a DBH sponsored annual Forum;
2. Presented to 400 Office of State Superintendent of Education central office and transportation employees on alcohol, tobacco and other drug use risks to include synthetic drugs;
3. Partnered with DCRA to disseminate their District Synthetic Drug Laws signs to merchants licensed by them;
4. Partnered with the US Attorney's Office to increase awareness of synthetic drug risks and harm at DC General Homeless Shelter, Central Union Mission, and CCNV Homeless Shelter.
5. Represented the Department on the Criminal Justice Coordinating Council Synthetic Drug Workgroup providing community specific information, social marketing information, and basic substance use information.
6. Launched the I-71 Public Awareness "The Blunt Truth, in collaboration with the Department of Health and Marijuana Task Force". The primary goal of "**The Blunt Truth"** campaign is to educate the youth and young adults about the harms of marijuana usage, and increase awareness of the Districts marijuana laws.
7. Currently developing FY2016 K2 Zombie campaign educating adult residents throughout the District on synthetic drug use. Additional target groups include youth and adults in the criminal justice system, parolees, and transitional aged youth (18-26).

The objective of the new campaign:

a) Educate the public about the harmful effects of synthetic drugs.
b) Implement personal health assessment inventory.
c) Encourage target audience to seek assistance from DBH through the 24 hour access helpline, seek medical help, and use employee assistance programs.
d) Prevent new users of synthetic drugs.

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Q61. 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.
DBH Response:

The Child and Adolescent Functional Assessment Scale (CAFAS) and the Preschool and Early Childhood Functional Assessment Scale (PECFAS) has been fully implemented at the Department of Human Services (DHS) Parent and Adolescent Support Services (PASS) and Alternatives to the Court Experience Diversion Program (ACE), the Department of Youth Rehabilitation Services (DYRS), across all providers of the Department of Behavioral Health (DBH) and for both in home and out of home children/youth at the Child and Family Services Agency (CFSA). On December, 1, 2015 the CAFAS was implemented for the youth substance use disorder treatment teams (ASTEP- Adolescent Substance Use Treatment Enhancement Program) thus ensuring that youth receiving either mental health or substance use services will have a common functional assessment. The Office of State Superintendent of Education (OSSE) has committed funds to support the implementation of a pilot program in the schools and is close to finalizing a contractual agreement with Multi-Health Systems (MHS), the proprietor of the CAFAS/PECFAS tool, 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.

Currently to support the sharing of CAFAS/PECFAS results, a LEAD agency document was created to identify the responsible parties in completing the CAFAS/PECFAS when a child or youth is involved with multiple provider agencies; and promote the precept of "One CAFAS, One Child." The LEAD agency table has been shared with all child-serving agencies administrating the CAFAS/PECFAS and supports teaming and collaboration to ensure each agency providing a service to a child or youth is consulted for the accurate completion of the assessment and then can access the completed report.

Data warehouse development is ongoing. A business plan detailing the requirements of the data warehouse was developed in August, 2015. DBH is partnering with other data sharing initiatives currently underway in the district to maximize and streamline resources. One such initiative between DHS, DBH, CFSA and OCTO is the development of a data sharing system to support DC Cross Connect initiative. DC Cross Connect is focused on the sharing of information on consumers and their families involved across all three systems (DHS, CFSA, and DBH). The second version of this data sharing system will include a component called "CAFAS Aware", where providers from the aforementioned agencies can search and determine if a CAFAS/PECFAS has been completed by one of the three agencies. This is the first step in the development of a data warehouse that will accommodate all of the CAFAS/PECFAS assessments for every child or youth across all child-service agencies.

Q62. 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.

DBH Response:

a. The creation of a Behavioral Health Ombudsman Program.

The Department of Behavioral Health (DBH) Ombudsman Program was established in February 2015. The first task was to open an office. The direct toll free number for the Ombudsman is (844) 698-2924, and email contact is DBH.HELP@dc.gov. The Office is located at 821 Howard Rd., SE. The Ombudsman conducts educational sessions on how to navigate services for DBH consumers.

Progress made to date includes:

- Conducted an assessment of current processes and procedures for the collection of complaints and developed a work plan to support the implementation of the office.
- Established values to provide a clear platform for the development of policies and standard operating procedures.
- Active recruitment for an Advisory Council, receiving a diverse group of candidates to include consumers, advocacy group and District agency representatives. It is expected that selections will be occur by February 15, 2016.
- Development of a database to centralize complaints and grievances

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.

The development of the comprehensive plan crossed administrations. This work has been reinvigorated by the new Administration. A meeting with DCPS, DCPCSB, DOH and community partners was convened in December, 2015 to explore vision, current resources and services, and resources required to expand program. This collaborative work continues through a work plan of action items toward finalizing a unified vision of a comprehensive plan. A key step to this process is also the collaboration between DBH, DOH, and schools to conduct a School Health Needs Assessment. This effort is being led by DOH and will result in a better understanding of the behavioral and health care needs of school-aged children, which would include the resource mapping and mapping of current mental health and substance use screening portals in the District.

In addition, the Department of Behavioral Health and the Office of the State Superintendent of Education Wellness and Nutrition Services are conducting an analysis of the current health education standards and determine the degree to which they align with the actual behavioral health needs of District youth.

As a part of this process, specific recommendations for making changes to the standards were developed. In December, 2015, these recommendations were submitted to the Office of the State Superintendent of Education for inclusion with the additional stakeholder recommendations forwarded by OSSE to the State Board of Education for the consideration of the State Board of Education Review Committee.

c. *The creation of a behavioral health resource guide for parents and guardians.*
d. *The creation of a behavioral health resource guide for youth.*

The Behavioral Health Resource Link was launched in December 2015 and posted on the DBH website at http://dbh.dc.gov/service/children-youth-and-family-services.

It is a resource directory of mental health and substance use disorder services as well as a comprehensive listing of additional resources to foster self-reliance and recovery. It is a "one-stop-shop" for youth and their families to find information and resources and has the capacity to filter services that target youth specific segments of the site. Additionally, there is capacity for users to customize and create a folder of favorites that is available under password protected access and can be printed on demand by the user. Collaboration continues with partners to develop printed materials in collaboration with youth which provide behavioral health information and resources in a manner that is attractive to youth and will enhance social marketing to youth.

Q63. *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.*

DBH Response:

The DBH School Mental Health Program (SMHP) operated in 64 DC Public and DC Public Charter Schools in FY15. The program served 44 DCPS schools and 20 DC Public Charter Schools. Forty four schools were Tier 1 with one FTE serving each school and there were 20 Tier 2 schools, with .5 FTE serving each school. The program to date in FY16 has provided prevention, early intervention and treatment services to 68 schools and is actively recruiting clinicians to serve two additional schools to fill all 70 targeted schools.

Please see attachment for the listing of the participating schools.

Q64. 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.

DBH Response

DBH does not monitor or have access to the internal DCPS information that is requested. DBH is aware that DCPS has entered into at least one formal Memorandum of Agreement (MOA) with a DBH Core Service Agency (CSA) to provide community support services in select schools. DBH is also aware that some additional CSAs are also providing community support services in DC Public and DC Charter schools, and in some cases, therapeutic services in some of the same schools where the DBH school mental health program is located.

Q65. Please provide a comprehensive plan for mental health services in schools in the District.

DBH Response

The school mental health program has grown steadily and is now located in 68 public and public charter schools. DBH plans to expand to another two schools during this school year. DBH is working with the Deputy Mayors for Health and Human Services and Education, the DCPS Chancellor, the DC Public Charter School Board, and other partners on a comprehensive plan to expand to all schools.

The comprehensive school mental health program model is a coordinated behavioral health system designed to create a positive school culture that promotes mental wellness and provides timely access to high quality services for children, youth and their families. This model enables:

- Better coordination between DC Public Schools, DC Public Charter Schools, DBH, and community agency clinicians
- Unique, school specific program development
- Increased interaction with behavioral health team and school faculty with direct reporting to the principal, and
- Greater emphasis on treatment and utilizing evidence-based practices .

With this integrated model of care, the behavioral health team coordinates with school leaders to create the conditions of learning shown through research to be linked to academic success, graduation and post-secondary success. Behavioral health services and supports will be aligned with academic interventions to maximize student achievement.

Q66. 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 quarter of FY15. How many teachers and other personnel completed the online training in FY15 and FY16 to date?

DBH Response:

The DC Department of Behavioral Health is providing online interactive Behavioral Health Training Suite for K-12 Faculty and Staff on how to identify, approach and refer students showing signs of psychological distress to appropriate support services. As part of the South Capitol Street Memorial Amendment Act of 2012, all school personnel throughout the District are required to complete these courses.

The Middle School (MS), High School (HS), and *How to Refer* modules of the online interactive Behavioral Health Training Suite were launched in October 2014 and the Elementary School (ES) module was launched in January 2015. The ES module was also launched in Child Development Centers during Summer of 2015. These trainings can be accessed via www.supportdcyouth.com. Work continues in promoting completion compliance. As of the end of FY 15, 3145 users completed the courses. As of December, 2015 of FY16, 389 additional users had completed the courses. Of the 4282 total users who have activated accounts in the training system to date, 82.53% (3534) have completed the courses.

Evaluation Summary: Overall Survey Results

The following historical data is pulled from ***At-Risk for High School Educators (ARHS)*** and ***At-Risk for Middle School Educators (ARMS)*** pre- post- and follow-up course surveys.

Would you recommend this course to your colleagues?	**ARHS**		**ARMS**	
Yes	92.47%		100%	
How would you rate your ability to recognize when a student's behavior is a sign of psychological distress?	Pre n=1223	Post n=877	Pre n=422	Post n=352
High or Very High	53.81%	86.32%	49.28%	86.64%
How likely are you to recommend mental health support services?	Pre	Post	Pre	Post
Likely or Very Likely	94.88%	97.83%	92.95%	98.87%
How would you rate your preparedness to discuss with a student your concern about the signs of psychological distress they are exhibiting?	Pre	Post	Pre	Post
High or Very High	47.87%	84.15%	44.50%	85.79%

The following historical data is pulled from the ***At-Risk for Elementary School Educators*** *(ARES)* pre- and post-course surveys.

Would you recommend this course to your colleagues?	ARES	
Yes	96.67%	
How would you rate your preparedness to recognize when a student's behavior is a sign of psychological distress?	Pre n=1145	Post n=709
High or Very High	47.16%	85.11%
How would you rate your preparedness to motivate a parent whose child is exhibiting signs of psychological distress to seek help?	Pre	Post
High or Very High	41.27%	81.84%
How likely are you to try helping parents be informed about mental health support services available to a student exhibiting signs of psychological distress?	Pre	Post
Likely or Very Likely	89.39%	97.48%

Q67. 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 youth have received services through? the Adolescent Community Reinforcement Approach (ACRA) in FY15 and FY16?

DBH Response:

Substance use disorders services for adolescents are provided through the Adolescent Substance Abuse Treatment Expansion Program (ASTEP). Four certified substance use disorder treatment providers specialize in providing these services to youth. They are:

- Federal City Recovery Services
- Hillcrest Children's Center
- Latin American Youth Center
- Riverside Treatment Center

Adolescents in need of treatment may either self-refer or be referred by a parent/guardian or significant person in their life to any of the ASTEP providers. A youth can go directly to one of the four providers. Parental consent is required for youth under age of 16. Screening, assessment, out-patient and in-patient treatment and recovery services and supports are provided. In addition, every youth receives a mental health screening. If a youth screens positive, he/she receives a comprehensive mental health assessment and an individualized treatment plan is developed to support integrated behavioral health care.

In FY15, DBH was awarded the State Youth Treatment Grant (SYT) to support our continuation of integrated care to adolescents and youth ages 12-24 years with co-occurring mental health and substance use disorders. The SYT grant requires that all service providers have the capacity to deliver services using the evidcnce-based Adolescent Community Reinforcement Approach (A-CRA) and to develop an infrastructure to coordinate substance use and mental services. Funds from this grant are used to:

1. Continue to train and certify ASTEP providers in the Adolescent Community Reinforcement Approach (A-CRA). Eleven therapists have been trained in this service modality and are completing the certification process.
2. Provide service contracts to ASTEP providers for the implementation of ACRA services. This supports start-up, infrastructure and program development.
3. Engage an evaluation contractor to conduct a process and outcome evaluation of the project as required by SAMHSA.
4. Continue conducting readiness activities, training and fidelity monitoring of this evidence based practice, and providing workforce development technical assistance to Providers identified as having a need to increase and or improve the workforce supporting ACRA.

During FY15, ASTEP providers delivered ACRA services to one -hundred forty nine (149) children and youth, exceeding the targeted bench mark by 68%. In FY16, sixty (60) children and youth have received services to date.

Q68. 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.

DBH Response:

DBH currently fund two children's mental health services with local dollars.

1. High Fidelity Wraparound care coordination and supports services. High Fidelity Wraparound is a promising practice that uses the Child and Family Team (CFT) facilitation process to achieve positive outcomes by providing structured, creative and individualized plans for children and their families. The CFT, along with the care coordinator assigned to the case, monitors the plan to ensure that each child and family receive the support they need.

In September 2015, DBH convened a meeting with DHCF and the System of Care consultant from Georgetown University technical assistance center to explore Medicaid reimbursement for DBH locally funded High Fidelity care coordination services. Currently, care coordination service which is a major component, is reimbursable under the Medicaid Manage Care Organizations (MCO), not DBH Mental Health Rehabilitation Services (MHRS). Work between DBH and DHCF is ongoing to further examine the possibility of this service becoming fully Medicaid reimbursable.

2. Court-ordered psychological and psychiatric evaluations conducted by contracted psychologists and psychiatrists at the government operated Assessment Center.

Since DBH is already exploring Medicaid reimbursement options for Wraparound services with DHCF, these court-ordered evaluations will be also explored.

Q69. 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"Tier2"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.*

DBH Response:

a. *A list of participating schools and please indicate whether a school is a "Tier 1"or"Tier2"school;*

Please see attachment for the list of participating schools.

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 diagnoses;*
f. *The referral source (i.e. walk-in, teacher);*

Table 1 below describes the utilization data for the School Mental Health Program.

Table 1. SMHP Utilization Data		
	SY 14-15 (**FY 15)**	SY 15-16 (F**Y 16)**
# of students referred to SMHP clinician	2810	626
# of students referred and seen by SMHP clinician	2276	484
# of students on caseload	692	519
# of students referred to outside services (e.g., housing, food, etc.)	225	98
# of students referred to outside mental health services (CSA /MCO Provider)	214	58

2,810 students were referred to the SMHP and 2,276 students met with a clinician, were triaged and directed to the appropriate level of care. Nearly 48% of referrals came from Primary Project. The remaining referrals were made by a variety of other individuals including teachers (15%), school counselors and/or social workers (10%), administrators (8%), and families (6%). A smaller number of youth were referred by other individuals (e.g. other students, nurse, etc.) or

were identified through other means (e.g. SOS screening, etc.). Common diagnoses included disorders in the following categories: Mood Disorders, Adjustment Disorders, Attention-Deficit Disorders, and Behavior Disorders. Some referrals needed short-term supports, whereas others required more long-term services. For students and families who needed additional supports, linkages were made to the Managed Care Provider (MCO), a DBH CSA or DBH Mental Health Services Division (MHSD). Specifically, 225 students and families were referred for outsides services (e.g. housing, food, etc.) and 214 students and families were referred for additional mental health services. Clinicians assisted with the linkages and provided follow-up as needed.

g. The number of students participating in prevention programs:

During the SY14-15, 1803 prevention sessions and 790 early intervention sessions were conducted by the SMHP clinicians and approximately 20,000 students participated in the programs. This represents a duplicated count of participants as some children may have participated in multiple prevention and early intervention programs during the school year. Question #70 will provide further detailed information regarding the prevention and early intervention programs implemented by the SMHP clinicians.

h. Whether the current programs are meeting the existing need for services, and if not, what is being done to meet the total need;

DBH school mental health program clinicians currently are available in 70 of the 228 DC public (113 schools) and public charter schools (62 Public Charter Schools with 115 campuses). Specifically, DBH clinicians are assigned to 50 (44%) DC public schools and 20 (17%) public charter schools. Of the 70 targeted schools, 64% have a full-time DBH clinician and 36% have a part-time DBH clinician.

Results from the annual satisfaction surveys administered to participating schools, 70% of administrators indicated they felt that the range of services is adequate for their school. The remaining administrators have verbalized a need for either more clinician time (primarily those schools that have a part-time clinicians) or an additional clinician in their building. DBH is working with DCPS, DC Public Charter Board and other community partners to assess school needs and identify other potential partnerships and resources for schools, in order to fully assess and develop a plan to meet the needs of schools Districtwide.

i. What prevention programs and services were offered through SMHP in FY15 and FY16 to date;

This question is the same question as question #70 and will be answered in detail in the response to question #70.

j. Any plans to expand the program and barriers to expansion;

DBH SMHP expanded into 8 new schools in FY15 raising the total to 64 schools. 4 were DCPS schools and 4 were DC Public Charter Schools. The program is still recruiting for the remaining vacant positions to fill 70 total schools. Once the program is fully staffed, it will serve 50 DCPS and 20 DC Public Charter Schools. Recruitment for qualified independently licensed candidates

who possess the necessary clinical experience has been challenging. In addition the program has experienced some staff turnover which led to school vacancies.

k. How many FTEs serve each school.

One clinician is assigned to at least one school (Tier 1) or in some cases, two schools (Tier 2). At Tier 2 schools, clinicians spend 2.5 days per week at each school. The breakdown for FY15 was 44 Tier 1 schools and 20 Tier 2 schools.

Q70. What kinds of primary prevention SMHP program 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.

DBH Response:

Primary prevention services are available to the entire student body, the school staff, or parents/guardians (depending on the target audience for a particular intervention). The aim is to prevent the development of serious mental health problems and to promote positive development among children and youth. Program examples included staff professional development, mental health/educational presentations (e.g., social skills building) for students, staff or parents/guardians, and evidence-based or informed school-wide or classroom-based programs such as sexual abuse prevention and violence prevention programs.

The evidence-based or evidence-informed primary prevention programs implemented and the number of schools implementing each program in SY 14-15 and to date in SY 15-16 is shown in the table below.

Name of Prevention Program	# of Schools that Implemented Program SY 14-15 (FY 15)	# of Schools that Implemented Program SY 15-16 SY (FY 16) As of Nov. 15
Connect With Kids- Adventures and Character Education Series (What Works Clearinghouse endorsed, evidence-informed violence prevention program)	**8**	6
Good Touch Bad Touch (National Mental Health Association Clearinghouse endorsed, evidence-based sexual abuse prevention program that teaches the skills needed to prevent or interrupt abuse)	**19**	9
Healthy Boundaries (National Mental Health Association Clearinghouse endorsed, evidence-based sexual abuse prevention program for 7th-9th graders that teaches the skills needed to prevent or interrupt abuse)	2	2
Love is Not Abuse (Evidence-informed program for students that teaches youth about teen dating violence)	**6**	4
Signs of Suicide (SOS) (SAMHSA approved, evidence-based depression	**8**	3

and suicide prevention program)		
Too Good For Violence (SAMHSA approved, evidence-based violence prevention program)	**29**	17
Question, Persuade, and Refer (QPR) SAMHSA approved, evidence-based Gatekeeper Training for Suicide Prevention	0	1

Areas of increased utilization from FY14 are bolded.

Early Intervention Services:

Students identified at elevated risk for developing a mental health problem are offered one of a number of early intervention services. The aim is to prevent the escalation of identified risks and development of more serious mental health problems. These interventions could include involvement in support groups, skill building groups (e.g., social skills or anger management group), and training or consultation for families and teachers who work with identified children.

The evidence-based secondary prevention programs being implemented and the number of schools implementing each program in SY 14-15 and to date in SY 15-16 is shown on the chart below.

Secondary Prevention Program	# of Schools that Implemented Program SY 14-15 (FY 15)	# of Schools that Implemented Program SY 15-16 (FY 16) Through November 30th, 2015
Primary Project (SAMHSA approved, evidence-based program targeting students displaying early school adjustment difficulties and may be "at risk" for socio-emotional difficulties)	28 Schools and 17 Child Development Centers	29 schools and 12 Child Development Centers (8 sites are pending)

The following table summarizes the clinical services implemented for SY 14-15 and to date in SY 15-16.

Clinical Activity	SY 13-14 (FY14)	SY 14-15 (FY 15)	SY 15-16 To Date
# of new students referred	1644	**2313**	720
# of students on caseload	646	**692**	516
# of individual counseling sessions	8500	**9336**	2464
# of group counseling sessions	68	**87**	5
# of family counseling sessions	532	357	62

Increased utilization numbers from FY14 are bolded. Referrals from Primary Project were 1348.

A description of the evidence-based or evidence-informed prevention, early intervention, and treatment programs implemented by SMHP staff are provided below:

SMHP APPROVED PROGRAMS

SY15-16

PREVENTION PROGRAMS

Good Touch/Bad Touch

Elementary and Middle Schools
An evidence-based primary prevention/education curriculum developed for pre-school -6th grade students as a tool to teach children the skills needed to prevent or interrupt abuse. Good Touch/Bad Touch is endorsed by The National Mental Health Association Clearinghouse. *Healthy Boundaries* is available for students in 7th-8th grade and focuses on teaching students about abuse, sexual harassment, and bullying.

Question, Persuade, and Refer (QPR)

Elementary, Middle and High Schools
An evidence-based prevention program developed for individuals (e.g., teachers, staff members, etc) to learn how to recognize the warning signs of suicide, and to teach how to question, persuade, and refer an individual in crisis.

Love is Not Abuse

High Schools
An evidence-informed prevention program developed for high school students. Love is Not Abuse teaches youth about teen dating violence and the curriculum focuses on the 3 goals: increasing youths' understanding of dating violence and abuse, challenging misconceptions that support dating violence, and helping youth to identify help-seeking behaviors if they are in an abusive relationship.

Signs of Suicide (SOS)

Middle and High Schools
A SAMHSA approved, evidence-based program developed for middle school and high school students. SOS is a depression awareness and suicide prevention program that teaches students how to ACT (acknowledge, care and tell) when they or a friend experience symptoms of depression or suicide. Students are screened for depression and suicide risk and referred to appropriate services if needed.

Too Good for Violence

Elementary, Middle and High Schools
A SAMHSA approved, evidence-based violence prevention program that reduces aggression and improves student behavior for middle and high school students. Too Good for Violence emphasizes four areas including; conflict resolution, anger management, respect for self and others, and effective communication.

Coping Cats Program- "Keeping your Cool" The Anger Management Workbook - A SAMHSA approved, evidence-based anger management program that teaches strategies that can be employed by both boys and girls, ages 10-17, to help them cope with a variety of anger-arousing situations. Whereas the original Keeping Your Cool Workbook relied heavily on sports-related situations, this new edition has a wider range of appeal, with new attention to gender and diversity issues. The workbook addresses not only the anger issues experienced by boys, but also the social aggression that characterizes the anger experienced by girls at that age. Attention is also paid to specific anger-arousing situations that are experienced by minorities.

EARLY INTERVENTION PROGRAMS

Primary Project
A SAMHSA approved, evidence-based program targeting students in PreK through 3rd grade who may be displaying early school adjustment difficulties and may be "at risk" for additional socio-emotional difficulties. Students who are screened and meet specific criteria meet with a paraprofessional who provides direct services to the children.

Parent Cafés
Elementary, Middle and High Schools
An evidence-informed parenting program which includes small group discussions among parents that promote individual self-reflection and peer-to-peer learning based on five research-based protective factors: parental resilience, social connections, knowledge of parenting and child development, concrete support in times of need, and social and emotional competence of children. Cafés are facilitated by a host in small groups where parents explore topics led by questions from the tool "Parent Café in a box."

Ask 4 Help – (k-5)
Yellow Ribbon's Elementary Ask for Help® is an evidence informed curriculum specializing the ongoing development and reinforcement of the following protective factors in children and youth. By the end of the curriculum, students will understand what feelings are (definitions); understand, recognize and express their own feelings and those of others; recognize what they need: the difference between needs and wants; differentiate between tattling and telling; know how to identify helps (trusted adults); know how to ask for help for themselves and for others.

TREATMENT PROGRAMS

Cognitive-Behavioral Intervention for Trauma in Schools (CBITS)
Elementary, Middle, and High Schools
A SAMHSA approved, evidence-based program targeting youth between the ages of 10 and 15 years old who have experienced a violent or traumatic event. Students are screened for symptoms of depression and post-traumatic stress disorder and participate in a cognitive behavioral therapy focused group. The main goals of the group are to reduce symptoms related to trauma, to build resilience, and to increase peer and parent support.

Incredible Years (Dina Dinosaur Group)
Elementary Schools
A SAMHSA approved, evidence-based program targeting children between the ages of 4 and 8 years old who may be experiencing aggressive or "disruptive" behaviors. The program focuses on teaching children social skills, problem solving skills and anger management strategies.

Trauma-Focused Cognitive Behavioral Therapy
Elementary, Middle, and High Schools
A SAMHSA approved, evidence-based program targeting children and adolescents between the ages of 4 and 18 years old who may be experiencing symptoms related to trauma and/ or violence. The core components of Trauma-Focused Cognitive Behavioral Therapy include: psychoeducation, relaxation skills, affective modulation skills, cognitive coping, trauma narrative, in-vivo exposure, conjoint parent and child sessions, and enhancing personal safety.

Stop and Think - Twenty therapy sessions provide opportunities to teach children to be less impulsive. Activities in the workbook teach children to recognize and identify their feelings and learn to be problem-solving "detectives" in a variety of situations. (129 pages) There is a therapist manual to accompany the workbook.

SMHP SUPPLEMENTAL PROGRAMS

PREVENTION

Botvins Life Skills Training Program
DCPS Schools - Elementary Only
DC Charter Schools – Elementary, Middle, and High Schools
A SAMHSA approved, evidence-based substance abuse prevention program that addresses the most important factors leading children and adolescents to use drugs. The program teaches a combination of drug resistance skills, self-management skills, and general social skills, and can be implemented with children in 3rd to 12th grades.

Connect with Kids
Elementary, Middle, and High Schools
An evidence-informed program that improves student behavior in significant and important ways across multiple character skills, including teasing and bullying behaviors, cheating and lying, respect for classmates and teachers, violence prevention, and academic perseverance. The What Works Clearinghouse selected the program as an effective results oriented curriculum. The *Adventures* Series can be implemented with students in PreK – 3rd grades and the character education series targets elementary, middle, and high school students. Connect with Kids also produces videos on specific topics (e.g., bullying and depression) that can be used with middle and high school students.

EARLY INTERVENTION

Chicago Parent Program
Elementary, Middle and High Schools

A parenting program for parents with children between the ages of 2 and 5 years old that aims to increase parenting self-efficacy and positive parent behavior, promote positive and consistent discipline strategies, and reduce child behavior problems.

Incredible Years (Parenting Program)

Elementary, Middle and High Schools

A SAMHSA approved, evidence-based program for parents with children between the ages of 0 and 12 years old that focuses on increasing parent's involvement in their child's school environment as well as provides parents with the tools and knowledge necessary to parent effectively. This program helps to promote children's academic, social and emotional competencies as well as reduce conduct problems.

Parenting Wisely

Elementary, Middle and High Schools

A SAMHSA approved, evidence-based program for parents with children between the ages of 3 and 18 years old. Parenting Wisely can be implemented in a variety of formats. Parents have the ability to use a CD-ROM or on-line formats to learn parenting skills that help to reduce behavior problems in their children. The program can also be implemented by a clinician in a group format.

Treatment Programs

Stark's Cognitive-Behavioral Therapy for Depression - Taking Action

Elementary and Middle Schools

An evidence informed program, based on a Report by the Surgeon General, that targets 9-13 year old girls experiencing feelings of depression. Taking Action is a cognitive behavioral intervention that uses interactive activities to teach problem solving skills, coping skills and cognitive interventions. (While the curriculum was created for use with girls, it can also be adapted for boys as well as for younger and older children).

Adolescents Coping with Depression (CWD-A)

Middle and High School

The Adolescent Coping with Depression is a SAMHSA approved evidence based program that is a cognitive behavioral group intervention that targets specific problems typically experienced by depressed adolescents. These problems include discomfort and anxiety, irrational/negative thoughts, poor social skills, and limited experiences of pleasant activities. The program consists of 16 -2 hour sessions in mixed gender groups up to 10 adolescents.