

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 Attachment 1 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
 - Sodexo
 - 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.

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.

Advisory Neighborhood Commissioners: 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.

Office on Aging: 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.

Office of Asian and Pacific Islanders: 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.

Office of the Chief Medical Examiner: 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.

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

Court Services and Offender Supervision Agency: 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

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: <i>October 1, 2014- September 30, 2015</i>	FY16 YTD: <i>October 1, 2015 - November 30, 2015</i>
Referrals		
Referral Sources to the UCC: -Traffic and Misdemeanor Court -Mental Health Court -Criminal Court (Various Judges) -Pre-Trial Services (PSA) -US Marshal Service -Department of Behavioral Health (DBH) -Mayor's Liaison -CSOSA -Family Court -Lock-up* -Attorney -Other	145 71 33 113 0 24 22 13 36 294 3 63	6 8 7 36 0 1 2 5 0 8 5 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 JBDDP 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 JBDDP. As of January 2016, 31 youth are enrolled in the JBDDP. 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 JBDDP 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 from 130 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 on a 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 745 evaluations, 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 – 1 st 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 | 15) Matthews Memorial Baptist Church
CDC |
| 2) Big Mama’s Children Center | 16) Northwest Settlement House CDC |
| 3) Board of Child Care | 17) Paramount CDC |
| 4) CentroNia | 18) Randall Hyland Private School |
| 5) CentroNia Annex | 19) Saint Philip’s CDC |
| 6) First Rock Baptist CDC | 20) Saint Timothy Episcopal CDC |
| 7) Happy Faces CDC | 21) Southeast Children’s Fund I CDC |
| 8) Ideal I Child CDC | 22) Southeast Children’s Fund II CDC |
| 9) Ideal II Child CDC | 23) Step by Step Therapeutic Child Care |
| 10) Kiddies Kollege | 24) Sunshine Early Learning Center |
| 11) Kids Are US Learning Center I | 25) Wee Wisdom CDC |
| 12) Kids Are US Learning Center II | 26) Vision of Victory CDC |
| 13) Kingdom Kids CDC | |
| 14) Martha’s Table 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 data 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)
 - 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 has 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 new code should be used with the TS modifier to identify screening that uncovered a potential problem that requires follow-up or a referral. 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.

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 compiled 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 Collaboratives 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.

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 dispatched 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 PTSD 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.

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 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	
	Pre	Post	Pre	Post
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 evidence-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 “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.*

DBH Response:

- a. A list of participating schools and please indicate whether a school is a “Tier 1” or “Tier 2” 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 (FY 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 outside 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 clinician) 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 7 th -9 th 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.

Q71. 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.

DBH Response:

Administrators were asked to complete a midyear and end of the year satisfaction survey asking for feedback regarding the services provided by the SMHP clinicians. During SY 14-15, thirty (53 per cent) of the administrators returned the midyear survey (N=57) and 44 (75 per cent) administrators returned the end of the year survey (N=59). Overall, the results from both of the surveys were extremely positive and the administrators were satisfied with the SMHP services.

The majority of administrators reported that SMHP clinicians were knowledgeable about mental health issues of the students at their schools, were professional and had a caring attitude, and adhered to and complied with the school policies in conjunction with the implementation of the program. In addition, they reported that clinicians were available and provided services and support to children and families, as well as, the teachers and staff. For example, almost all of the administrators at midyear (93 per cent) and at the end of the year (91 per cent) indicated that clinicians worked collaboratively with school staff, parents/guardians and students to meet the mental health needs of the school. Approximately 86 per cent of the administrators also reported that the clinicians were flexible and available to see students and families as needed. In addition, nearly all of the administrators (97 per cent at midyear and 93 per cent at the end of the year) reported that they felt comfortable consulting with the SMHP clinician regarding a student with a social or emotional concern and 86 per cent of the administrators at midyear and at the end of the year were satisfied with the outcome of the consultation.

While the majority of administrators (83 per cent) were satisfied with the quality of services, 30 per cent of the administrators at the end of the year indicated the range of services was not adequate. Of these individuals approximately half indicated the need for a full-time clinician or requested an additional SMHP clinician to be placed at their school. This is consistent with the FY 14 surveys. At this time, the SMHP does not have any additional clinicians to place in the schools who have requested increases in either clinician time or an additional clinician.

Overall the results of the survey were extremely positive, and all but two of the administrators indicated that they would like for the SMHP to continue providing services at their schools.

Q72. Please provide an update on the implementation of iCAMS for SMHP and how this has improved the integration of care.

DBH Response:

All aspects of SMHP treatment services are fully integrated in iCAMS. Full integration in iCAMS moved the program from paper-based client records to a centralized electronic health record system that establishes one record for each consumer regardless of the program or service assignment across all DBH mental health provider network. As a result, SMHP clinicians are better able to coordinate care and collaborate with other mental health providers/agencies ensuring an integrated approach to care. This shared access to consumer's record supports communication and information sharing across agencies and programs and serves as a significant strength in the system of care in the District. Integration in iCAMS has supported improvement in continuity of care for consumers, communication and data sharing in real time.

The SMHP is also working with the iCAMS team to customize the system to track the prevention services and supports delivered to children and youth.

Q73. 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 individual 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.*

DBH Response

a. How many individual were served in FY15?

In FY 15, a total of 319 children and their families were served in the High Fidelity Wraparound process. In the first quarter FY16, a total of 188 children and families are receiving Wraparound.

b. How many children were diverted from PRFT placements? Please provide a breakdown for the school and community-based programs.

Of the 319 children and families who received wraparound in FY15, 154 (48% of total wraparound population) were referred from the District of Columbia Public Schools. 100% of youth served by the school-based wraparound initiative were diverted from placement in PRTF. Of the 165 (52% of total wraparound population) youth receiving wraparound in the community, 158 (96%) youth were diverted from PRTF and continue to receive services within the community and 7 (4% of the sub population) were placed in PRTFs. Of the 319 children who received wraparound services 98% were diverted from PRTF placement.

c. What community-based organizations provide the case management for the Wrap Program? How many children did each serve?

In FY15, DC Choices and two Collaborative agencies through the Healthy Families Thriving Community Council provided High Fidelity Wraparound through a contract with DBH. See chart below. A solicitation for High Fidelity Wraparound was issued in April 2015. As a result of the Request For Proposal (RFP) evaluation process, Choices was selected as the Care Management Entity.

Community-Based Organization	Number of Children Served in FY15	Number of Children Served in FY16
DC Choices	269	188
Healthy Families Thriving Community Council Far Southeast Family Strengthening Collaborative/ Georgia Avenue Collaborative	50	N/A*
Total	319	188

* Healthy Families thriving Community Council is no longer a Wraparound contractor.

d. Please provide any outcome evaluations or reports of the program from the past two years.

See Attachment 1 of 2 - FY 14 Evaluations
Attachment 2 of 2- FY 15 Evaluations

Q74. 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?

DBH Response:

In FY15, the DC Office of the State Superintendent of Education (OSSE) provided \$1,575,284.00 to DBH to support the implementation of High Fidelity Wraparound for one hundred and twenty (120) students in Students Forward Program (formerly Full Service Schools). High Fidelity Wraparound was provided at the following schools: Cardozo EC High School, Elliot Hines Middle School, Hart Middle School, Jefferson Middle School, Johnson Middle School, Kelly Miller Middle School, Kramer Middle School, Sousa Middle School, Stuart Hobson Middle Schools and Stanton Elementary School.

The following services are provided to children, youth and families in the High fidelity Wraparound process:

Individualized Planning - Child and Family Team meetings are conducted for all children referred for wraparound. A multidisciplinary team comprised of the family and representatives of all of the agencies serving the youth attend these meetings. The goal is to develop and individualized support plan to maintain the child within his home and community.

Care Coordination – Enhanced planning and coordination is provided for children and youth who are multi-system involved with histories of high utilization of inpatient, emergency room, psychiatric residential facility high dosage of behavioral health services. Intensive coordination is also provided to youth with a diagnosis of bipolar, or depression and who might have issues related to adherence and discontinuation of certain medications.

Mental Health Rehabilitation Services – Children and youth are linked to a DBH provider to receive any of the following mental health services offered through DBH: diagnostic/assessment, medication/somatic, counseling, community support, crisis/emergency, Community Based Intervention (CBI) levels 1 through 4.

Non-Traditional Supports and Services - Flexible funding is used to provide a wide variety of needed services and supports that are not otherwise funded within the system of care.

DC Choices is the contracted Care Management Entity (CME) responsible for Wraparound in the schools. The Care Coordinators are responsible for service coordination, linkage to appropriate services and monitoring of the service delivery. They also provide interventions and supports to families in crisis. Care Coordinators have access to flexible dollars that can be used to secure a wide array of support and resources for students and their families, ranging from a highly intensive service such as respite to community based mentoring, family mentoring support, sport and club registration as identified in the coordinated plan of care. These funds are used to purchase non-traditional services and supports not otherwise funded and are deemed necessary to keep youth with their families, in their schools and community.

Youth Served in FY15 and FY16

School	FY 15 - Number of Youth Served	FY 16 1st Quarter - Number of Youth Served
Cardozo EC	10	8
Eliot Hine Middle School	15	10
Hart Middle School	27	19
Jefferson Middle School	11	4
Johnson Middle School	17	12
Kelly Miller Middle School	28	20
Kramer Middle School	10	9
Sousa Middle School	10	11
Stanton Elementary School	13	9
Stuart Hobson Middle School	13	10
Grand Total	154	112

Q75. 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. Please provide any reports or studies used to determine the impact of a decrease in day services rates on community providers

DBH Response:

All MHRS services are available to eligible consumers regardless of coverage. The service array for a consumer is determined by medical necessity.

There are eleven basic MHRS Reimbursable Services. Two new services were added to the MHRS Reimbursable Services: Trauma Focused Cognitive Behavioral Therapy and Child Parent Psychotherapy for Family Violence.

MHRS Service	MHRS Service Description
Diagnostic/ Assessment	A Diagnostic/Assessment is an intensive clinical and functional evaluation of a Consumer’s mental health condition that results in the issuance of a Diagnostic Assessment Report with recommendation for service delivery that provides the basis for the development of an Individualized Recovery Plan (“IRP”) for adults or an Individualized Plan of Care (“IPC”) for children and youth. A Diagnostic/Assessment shall determine whether the Consumer is appropriate for and can benefit from MHRS, based upon the Consumer’s diagnosis, presenting problems and recovery goals. The Diagnostic/Assessment shall also evaluate the Consumer’s level of readiness and motivation to engage in treatment.
Medication/ Somatic Treatment	Medication/Somatic Treatment services are medical interventions including: physical examinations; prescription, supervision or administration of mental health-related medications; monitoring and interpreting results of laboratory diagnostic procedures related to mental health-related medications; and medical interventions needed for effective mental health treatment provided as either an individual or group intervention. Medication/Somatic Treatment services include monitoring the side effects and interactions of medications and the adverse reactions a Consumer may experience, and providing education and direction for symptom and medication self-management. Group Medication/Somatic Treatment shall be therapeutic, educational and interactive with a strong emphasis on group member selection, facilitated therapeutic peer interaction and support.
Counseling	Counseling services are individual, group or family face-to-face services for symptom and behavior management; development, restoration or enhancement of adaptive behaviors and skills; and enhancement or maintenance of daily living skills. Adaptive behaviors and skills and daily living skills include those skills necessary to access community resources and support systems, interpersonal skills and restoration or enhancement of the family unit and/or support of the family. Mental health support and consultation services provided to Consumers’ families are reimbursable only when such services and supports are directed exclusively to the well-being and benefit of the Consumer.
Community Support	Community Support services are rehabilitation supports considered essential to assist the Consumer in achieving rehabilitation and recovery goals. Community Support services focus on building and maintaining a therapeutic relationship with

MHRS Service	MHRS Service Description
	<p>the Consumer. Community Support activities include:</p> <ol style="list-style-type: none"> 1. Participation in the development and implementation of a Consumer’s IRP/IPC and Community Support Individualized Service Specific Plan (“ISSP”); 2. Assistance and support for the Consumer in stressor situations; 3. Mental health education, support and consultation to Consumers’ families and/or their support system, which is directed exclusively to the well-being and benefit of the Consumer; 4. Individual mental health service and support intervention for the development of interpersonal and community coping skills, including adapting to home, school and work environments; 5. Assisting the Consumer in symptom self-monitoring and self-management for the identification and minimization of the negative effects of psychiatric symptoms which interfere with the Consumer’s daily living, financial management, personal development or school or work performance; 6. Assistance to the Consumer in increasing social support skills and networks that ameliorate life stresses resulting from the Consumer’s mental illness or emotional disturbance and are necessary to enable and maintain the Consumer’s independent living; 7. Developing strategies and supportive mental health interventions for avoiding out-of-home placement for adults, children and youth and building stronger family support skills and knowledge of the adult, child or youth’s strengths and limitations; and 8. Developing mental health relapse prevention strategies and plans.
Crisis/Emergency	<p>Crisis/Emergency is a face-to-face or telephone immediate response to an emergency situation involving a Consumer with mental illness or emotional disturbance that is available twenty-four (24) hours per day, seven (7) days per week. Crisis/Emergency services are provided to Consumers involved in an active mental health crisis and consist of immediate response to evaluate and screen the presenting situation, assist in immediate crisis stabilization and resolution and ensure the Consumer’s access to care at the appropriate level. Crisis/Emergency services may be delivered in natural settings and the Crisis/Emergency provider shall adjust its staffing to meet the requirements for immediate response. Each Crisis/Emergency provider shall obtain consultation, locate other services and resources, and provide written and oral information to assist the Consumer in obtaining follow-up services. Each Crisis/Emergency provider shall also be a DMH-certified provider of Diagnostic/Assessment or have an agreement with a Core Services Agency or a Core Services Agency’s affiliated Sub provider to assure the provision of necessary hospital pre-admission screening.</p> <p>This service includes Child and Adolescent Mobile Psychiatric Service (ChAMPS) This is a crisis response and stabilization service for all children and adolescents residing in the District of Columbia. The service is available to respond to mental health crisis 24 hours a day, seven day a week.</p>
Day Services	<p>Day Services is a structured clinical program intended to develop skills and foster social role integration through a range of social, psycho educational, behavioral and cognitive mental health interventions. Day Services are rendered only in a DMH-certified Community Mental Health Rehabilitation Services Agency and are not eligible for reimbursement when provided in the home, community setting or residential facility of 16 beds or less. Day Services are curriculum-driven and psycho educational and assist the Consumer in the retention or restoration of community living, socialization and adaptive skills. Day Services include</p>

MHRS Service	MHRS Service Description
	cognitive-behavioral interventions and diagnostic, psychiatric, rehabilitative, psychosocial, counseling and adjunctive treatment. Day Services are offered most often in group settings, and may be provided individually.
Intensive Day Treatment	Intensive Day Treatment is a structured, intensive and coordinated acute treatment program that serves as an alternative to acute inpatient treatment or as a step-down service from inpatient care, rendered by an inter-disciplinary team to provide stabilization of psychiatric impairments. Intensive Day Treatment services are rendered only in a DMH-certified Community Mental Health Rehabilitation Services Agency's site and are not eligible for reimbursement when provided in the home, community setting or residential facility of 16 beds or less. Intensive Day Treatment is time-limited and provided in an ambulatory setting for no less than five hours a day, seven days a week. Daily physician and nursing services are essential components of this service.
Community-Based Intervention	<p>Community-Based Intervention services are time-limited intensive mental health intervention services delivered to children, youth and adults and intended to prevent the utilization of an out-of-home therapeutic resource by the Consumer (i.e., psychiatric hospital or residential treatment facility). Community-Based Intervention is primarily focused on the development of Consumer skills and is delivered in the family setting in order for the Consumer to function in a family environment. These services are available twenty-four hours a day, seven days a week.</p> <p>The basic goals of Community-Based Intervention services are to:</p> <ol style="list-style-type: none"> 1. Diffuse the current situation to reduce the likelihood of a recurrence, which if not addressed could result in the use of more intensive therapeutic interventions; 2. Coordinate access to covered mental health services; 3. Provide mental health service and support interventions for Consumers that develop and improve the ability of parents, legal guardians or significant others to care for the person with mental illness or emotional disturbance. <p>Community-Based Intervention services shall be multi-faceted in nature and include situation management, environmental assessment, interventions to improve Consumer and family interaction, skills training, self and family management, and coordination and linkage with covered mental health rehabilitation services and supports and other covered Medicaid services in order to prevent the utilization of more restrictive residential treatment. Community-Based Intervention services shall be delivered primarily in natural settings and shall include in-home services. In-home services - regarding medications and behavior management skills; dealing with the responses of the Consumer, other caregivers and family members; and coordinating with other mental health rehabilitation treatment providers - include support and consultation to the Consumer's families and/or their support system, which is directed exclusively to the well-being and benefit of the Consumer. There are four levels of CBI Services. One level is described above the other three levels are described in a-c as follows:</p>
a. Functional Family Therapy	This is a service designed for children and youth between the ages of 10 and 18 with documented histories of moderate to serious behavioral problems that impair functioning in at least one domain of the child/youth's life, e.g. home or school and may be at risk of a disruption in placement. Eligible candidates and their caregiver (s) must be willing to participate in the treatment for its duration. This service is billed under Community-Based Intervention.

MHRS Service	MHRS Service Description
b. Multisystemic Therapy (MST)	MST services are intended for children and youth who are experiencing serious emotional disturbance with a documented behavioral concern with externalizing (aggressive or violent) behaviors or a history of chronic juvenile offenses that has or may result in involvement with the juvenile justice system. This level is delivered in accordance with the MST Model. Eligible consumers shall have a permanent care giver who is willing to participate for the duration of the CBI treatment and be at risk for out-of- home placement within thirty (30) days or currently in out-of-home placement due to the consumer’s disruptive behavior, with permanent placement expected to occur within thirty (30) days. This service is billed under Community-Based Intervention.
c. Intensive Home & Community Based Service (IHCBS)	IHCBS services are delivered in accordance with the IHCBS model as adopted by DBH. Eligible consumers for this service have situational behavioral problems that require short-tem, intensive treatment; currently dealing with stressor situations such as trauma or violence and requires development of coping and management skills; recently experienced out-of-home placement that requires development of communication and coping skills to manage the placement change; is undergoing transition from adolescence to adulthood and requires skills and supports to successfully manage the transition; recently discharged from an inpatient setting such as acute hospitalization or psychiatric residential treatment facility or is an adult parent or caregiver with a clinically significant mental health concern and the parent or caregiver will be parenting a child or youth returning from a residential treatment center within the next ninety (90) days. This service is billed under Community-Based Intervention.
Assertive Community Treatment (ACT)	<p>Assertive Community Treatment (ACT) is an intensive integrated rehabilitative, crisis, treatment and mental health rehabilitative community support provided by an interdisciplinary team to children and youth with serious emotional disturbance and to adults with serious and persistent mental illness. ACT services are provided to Consumers in accordance with the IRP/IPC with dedicated staff time and specific staff to Consumer ratios. Service coverage by the ACT Team is required twenty-four (24) hours per day, seven (7) days per week. The Consumer’s ACT Team shall complete a comprehensive or supplemental assessment and develop a self-care-oriented Individualized Service Specific Plan (ISSP) (if a current and effective one does not already exist).</p> <p>Services offered by the ACT team shall include:</p> <ol style="list-style-type: none"> (1) Mental health-related medication prescription, administration and monitoring; (2) Crisis assessment and intervention; (3) Symptom assessment, management and individual supportive therapy; (4) Substance abuse treatment for Consumers with a co-occurring addictive disorder; (5) Psychosocial rehabilitation and skill development; (6) Interpersonal social and interpersonal skill training; and (7) Education, support and consultation to Consumers’ families and/or their support system, which is directed exclusively to the well-being and benefit of the Consumer. <p>Assertive Community Treatment shall include a comprehensive and integrated set of medical and psychosocial services for the treatment of the Consumer’s mental health condition that is provided in non-office settings by the Consumer’s ACT Team. The ACT Team provides community support services that are interwoven with treatment and rehabilitative services and regularly scheduled team meetings.</p>
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

MHRS Service	MHRS Service Description
	parents or caregivers with the tools needed to reinforce the content covered with the child between sessions and after treatment has ended. Consistent with EPSDT requirements, TF-CBT services are available to individuals under age four (4) and through ages eighteen (18) to twenty (20) who meet the clinical criteria for coverage under the TF-CBT MHRS program and also meet the criteria for program enrollment, but for their age. This service is billable under Trauma Focused Cognitive Behavioral Therapy.
Child and Parent Psychotherapy for Family Violence (CPP-FV)	Child-Parent Psychotherapy for Family Violence (CPP-FV) is a 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. This service is billable under Child-Parent Psychotherapy for Family Violence.

Non Medicaid Reimbursable Mental Health Services

PROGRAM	Service Description
Contracted Community Residential Services	DMH has contracts with 4 DMH certified MHRS providers with licensed Community Residential Facilities (CRF) to provide 24 hour supervised care, support and management to 201 consumers.
Supported Independent Living	This program provides a safe home setting and community environment for consumers as they recover from mental illness. The goal is to provide assistance to consumers as they move to less restrictive levels of care by providing life skills training designed to support community tenure.
Adult Crisis Stabilization Beds	DMH operates two Residential Crisis Stabilization facilities with the capacity to serve 15 consumers. These structured residential treatment facilities are an alternative to psychiatric inpatient hospitalization for persons in need of acute amelioration of psychiatric symptoms, but who are able to contract for safety and are assessed able to receive this treatment outside of an inpatient setting.
Supported Employment	<p>Supported Employment is an evidence-based employment model for consumers 18 years of age or older with serious and persistent mental illness or serious emotional disturbance. It seeks to prepare consumer for competitive employment as part of their mental health recovery based treatment.</p> <p>Supported employment consists of community-based employment in integrated work settings that are consistent with the strengths, resources, priorities, concerns, abilities, capabilities, interests and informed choice of the consumer. It is designed for consumers for whom competitive employment has not traditionally occurred, or for whom competitive employment has been interrupted or has been intermittent as a result of a significant disability.</p> <p>Supported Employment has therapeutic service components that are reimbursable under Medicaid. Most Supported Employment services are vocational in nature and are not eligible for Medicaid reimbursement.</p>
Court Urgent Care Clinic (CUCC)	The Court Urgent Care Clinic is located within the DC Superior Court. The clinic serves individuals who have contact with the court system and are found to be in need of mental health services. This includes individuals referred from the District of Columbia Misdemeanor and Traffic Community Court, other criminal Division courtrooms and

PROGRAM	Service Description
	the District of Columbia Pre-Trial Services Agency. Through assessment, evaluation, treatment services and intensive case management, clients are treated and triaged to specific providers within both the public and private delivery systems to meet their short and long term goals.
High Fidelity Wrap Around Services	The purpose of this initiative is to implement community-based alternative services for District youth at risk for or returning from an out of home Psychiatric Residential Treatment Facility (PRTF) placement and for youth who have experienced multiple placements and/or hospitalizations.
Early Childhood Treatment	This program provides mental health services to children between the ages of zero and eight with a primary focus on children between the ages of zero and five years. The program provides early intervention with an array of services designed to prevent, reduce and treat emotional and behavioral problems, promote social and emotional competence in the child and assess and reduce stressors for the parents/family to promote a healthy home environment. The program provides comprehensive assessments for the parent(s), infant and child as well as treatment services, such as psychiatric services, psychotherapy, counseling, case management, play and art therapy, home visitation services (as needed), parenting psycho-education and support groups, and outreach and linkage to other community-based services, as needed. All District of Columbia children are eligible for this program.
Health Futures: Early Childhood Mental Health Consultation	Healthy Futures is an early childhood mental health consultation program providing Center-based and Child and Family Centered Consultation in 27 child development centers throughout the District. Early childhood mental health consultation involves a professional consultant with mental health expertise working collaboratively with early care and education staff, programs and families to improve their ability to prevent, identify, and respond to mental health issues among children in their care. In contrast to direct therapeutic services, ECMHC offers an indirect approach to reducing problem behaviors in young children and, more broadly, promotes positive social and emotional development. An Early Childhood Mental Health Clinical Specialist staffs each Child Development Center one day per week, providing a range of consultative services, as well as referral and linkage to more intensive mental health services as needed.
Health Start Program	The Healthy Start Program is an interagency collaborative partnership between the Department of Health (DOH) and the Department of Mental Health (DMH) that was established to provide a support network for pregnant and parenting women throughout wards 5, 6, 7 and 8, i.e. catchment areas in DC indicating high rates of infant mortality. This project was initiated to reduce infant mortality, provide resources and ensure support for pregnant and parenting women and their children and families. The primary goals of the project are to first identify and reach women who have: 1.) children between the ages of zero and two and 2.) current or past histories of depression and 3.) to provide them with the support necessary to establish both strong attachments with their infant/child and safe, healthy living environments; critical elements towards the promotion of healthy development in infants and children. Through this program, women receive individualized services consisting of: individual and family therapy, psychiatric, psychological, or counseling services and outreach and linkage to additional community services, as needed. This program serves any woman living in Wards 5, 6, 7 and 8. The Healthy Start Project is one of 15 programs of its kind in the country.
Primary Project	The Primary Project is a school-based, early intervention and prevention program designed to enhance school related competencies and reduce social, emotional and school adjustment difficulties in children attending school, grades K-3. Young children with early school adjustment difficulties are identified through the use of carefully developed screening and detection methods. Children with the following observable behaviors are most often appropriate for the program: excessive shyness, anxiety, withdrawal, defiance, moodiness, demonstrated problems engaging other peers in

PROGRAM	Service Description
	positive relationships, demonstrated mild physical aggression or children who generally experience school as unpleasant. Children are systematically screened to identify those with emerging difficulties but may also be recommended for participation in the program by teachers, other school personnel or parent(s). Children who are selected as appropriate candidates for the program and whose parents have given consent are then paired with specially trained Child Associates who work utilizing a child-led play philosophy. Parent(s) are encouraged to communicate directly with the program manager when any questions arise or to schedule a visit to the playroom.
Assessment Center	The Assessment Center evaluators provide mental health consultation services via court-ordered assessments for children, youth and families involved with the Family Division of DC Superior Court. DMH's Assessment Center conducts forensic mental health assessments and evaluations for court involved children and youth in the juvenile justice and child welfare systems. It also provides mental health evaluations for parents and families who have domestic relations cases being heard in the Family Court Division of the DC Superior Court. The mental health professionals conduct the following evaluations: psychological, neurological, psycho-educational, psychiatric, psycho-social and attachment (bonding) evaluations.

The rate reduction for day treatment services has not been implemented. Meanwhile, DBH is using medical necessity as the criterion for participation and is continuing to closely monitor expenditures.

See Attachment. MHRS rates.

- Q76. 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.*

DBH Response:

Please see Attachment. MHRS Medicaid Payments Average Length of Time

- Q77. 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.*

DBH Response:

Please see Attachment. MHRs Local Payment Average Length of Time

Q78: 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.*

DBH Response:

Please see Attachments 1 and 2, MHRS Utilization data for FY15 and to date in FY16, and MHRS Managed Care vs. Fee-for-Service breakdown by MCO payer and Alliance.

All non-Medicaid enrollees are determined for MHRS based on 300% of Federal poverty level for child/youth, and 200% of Federal poverty level for adults.

Q79: *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:*

- *Whether or not the provider utilizes the Medicaid MHRS program, the locally-funded MHRS program, or both;*
- *The amount of their Human Care Agreements (HCA);*
- *The amount of their purchase orders;*
- *Actual expenditures under the purchase order;*
- *Any modifications that were made to a HCA or purchase order, including an explanation for the modification;*
- *Number of individuals served per purchase order. Please provide a breakdown by Medicaid vs. non-Medicaid enrollees;*
- *Service utilization per purchase order; and,*
- *Any complaints, investigations, or audits of the provider by DBH and the results of any such investigation or audit.*

DBH Response

- Whether or not the provider utilizes the Medicaid MHRS program, the locally-funded MHRS program, or both;
- The amount of their Human Care Agreements (HCA);
- The amount of their purchase orders;
- Actual expenditures under the purchase order;
- Any modifications that were made to a HCA or purchase order, including an explanation for the modification;
- Number of individuals served per purchase order. Please provide a breakdown by Medicaid vs. non-Medicaid enrollees;
- Service utilization per purchase order; and,

See Attachment 1 of 4. Certified MHRS Provider FY14 Claims Status
Attachment 2 of 4. Certified MHRS Provider FY15 Claims Status
Attachment 3 of 4. Certified MHRS Provider FY16 Claims Status
Attachment 4 of 4. Provider Claims Audit Report

Q80: Please provide the following information for MHRS providers for FY14, FY15, and to date in FY16:

- Rate of claims denial, broken out by provider;*
- Average length of time between when claims are submitted by providers and when they are determined to be “clean” by DBH;*
- Average length of time between when a “clean” locally-funded claim is submitted to DBH and when it is adjudicated;*
- Average length of time between when a “clean” locally-funded claim is adjudicated by DBH and when it is paid;*
- Rate of “clean” Medicaid claims transmitted by DBH to DHCF within 5 working days of receipt;*
- Average length of time between when a “clean” Medicaid claim is submitted to DHCF and when it is adjudicated;*
- Rate of claims paid within 30 days of being warranted, broken out by provider; and,*
- Average length of time, broken out by Medicaid and non-Medicaid claims, between when a claim is first submitted and when payment is received.*

DBH Response:

The rate of “clean” claims transmitted by DBH to the DHCF within 5 days of receipt is 100%.

Please see FY 15 Question 80. Attachment 1 of 3, Rate of Claims Denial FY 14
FY 15 Question 80. Attachment 2 of 3, Rate of Claims Denial FY 15
FY 15 Question 80. Attachment 3 of 3, Rate of Claims Denial FY 16

Q81. Please provide a list of all programs funded by DBH. Please include:

- Whether the programs are evidence based; and,
- The evaluation methods used to determine the impact of the programs.

DBH Response

Service/Programs	Evidence-Based?	Evaluation
Mental Health Rehabilitation Services	Standards set by regulations	DBH conducts annual community service reviews to measure system performance and conducts consumer satisfaction surveys. It also issues a twice yearly report that reviews service utilization and costs.
Assertive Community Treatment Mental Health Rehabilitation Services (MHRS)	Yes	Dartmouth Fidelity Scale- conducted annually
Critical Time Intervention	Yes	Center for Urban and Community Services, Training and Consultation, New York, New York
Supported Employment (MHRS through community support)	Yes	Dartmouth Fidelity Scale- conducted annually
Critical Time Intervention	Yes	Center for Urban and Community Services, Training and Consultation, New York, New York
Supported Residential Services (licensed community residential facilities, supported independent living and rental subsidies)	No	Contract specialists conduct annual evaluations of performance of housing operators
Peer Support <ul style="list-style-type: none"> • Peer drop-in center • Peer specialists training • Peer advocacy 	SAMHSA recognized	Consumer surveys are used to evaluate the impact of the programs.
Comprehensive Emergency Psychiatric Program includes mobile crisis services and homeless outreach	No	DBH conducts annual community service reviews to measure system performance and conducts consumer satisfaction surveys. It also issues a twice yearly report that reviews service utilization and costs.
Care Coordination (New Directions)	No	An annual evaluation is based upon progress made on specific outcome measures required by the contract.
Health Homes	Yes	annual evaluation is conducted of improvements an individual's overall quality of health.
Urgent Care Clinic		Annual evaluation of performance of the contractor

Functional Family Therapy (FFT).	Yes	FFT utilizes standardized assessment tools to measure outcomes, the Outcome Questionnaire (OQ, Youth Outcome Questionnaire (Y-OQ) to track and monitor specific youth clinical outcomes and Therapist Outcome measure (TOM) to measure adherence and model fidelity.
Parent Child Interaction Therapy (PCIT)	Yes	PCIT utilizes the Eyeberg Child Behavior Inventory (ECBI), a 36-item parent report scale which measures treatment progress in children between the ages of 2 and 6 and evaluates the long-term effects of PCIT treatment. The Dyadic Parent-Child Coding System (DPICS) is a behavioral coding system that measures the quality of parent-child social interactions.
Trauma Focused-Cognitive Behavior Therapy (TF-CBT)	Yes	UCLA Post-Traumatic Stress Disorder Reaction Index (PTSD-RI) is completed before and after participation in TF-CBT. to measures PTSD Severity Score pre and post treatment. PTSD-RI evaluation component of this measure has 20 items that assess the frequency of occurrence of post-traumatic stress disorder symptoms during the prior month according to both child/youth self-reports and reports of their parents/caregivers (children ages 4-18).
Multi-systemic Therapy(MST) and Multi-systemic Therapy-Problem Sexual Behaviors (MST-PSB)	Yes	The Therapist Adherence Measure - Revised (TAM-R), the Supervisor Adherence Measure (SAM) and the Consultant Adherence Measure
Transition to Independence Process (TIP)	Evidence-Supported	Transition to Adulthood Program Information System (TAPIS) Progress Tracker QUARTERLY v5.0 is a Transition Progress and Outcome Indicators : Employment, Education, Living Situation, Placements, Parenting/Children Status, Program Exit/Return, and YP's Personal and Community Functioning.
Adolescent Community Reinforcement Approach (A-CRA)	Yes	The Global Appraisal of Individual Needs (GAIN)-Initial (GAIN-I or GI) is a bio-psycho-social tool that integrates research and clinical assessment to do diagnosis, placement, individualized treatment planning, program evaluation and meets major reporting requirements.
Intensive Home & Community Based Services (CBI II & III)	Evidence Supported	Annual Fidelity Reviews that measures staff/case ratio cultural competency, training, supervision, service location and intensity compliance
Juvenile Adjudicatory Competency	No	One year post-discharge study is

Program		conducted to determine recidivism for discharge youth.
High Fidelity Wraparound	Promising Practice	Child and Adolescent Needs and Strengths (CANS)
Health Futures: Early Childhood Mental Health Consultation	Yes	<ul style="list-style-type: none"> • Strengths and Difficulties Questionnaire: 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	Yes	Teacher-Child Rating Scale screening tool used to measure the child's functioning in the classroom in Task Orientation, Behavior control, Assertiveness and Peer Social Skills
Assessment Center	No	N/A
School Mental Health Program (SMHP)	Evidence Supported	Child and Adolescent Functional Assessment Scale (CAFAS)/Preschool and Early Childhood Functional Assessment Scale (PECFAS) is conducted at admission, every 90-days and at 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)
Juvenile Behavioral Diversion Program	No	Connors Pre and Post Assessment
DC Mental Access in Pediatrics (DC MAP)	Yes	The American Academy Pediatrics Mental Health Practice Readiness Inventory to assess in five domains—community resources, health care financing, support for children and families, clinical information system redesign, and decision support for clinicians. DBH also is conducting surveys to support quality improvement.
Children/Youth Emergency Services	No	Annual evaluation of the performance of the contractor. Monitor number of calls, deployments, response time and diversions from inpatient psychiatric hospitalizations.

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Q82. 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.

DBH Response

EBP and Provider	Medicaid Code/Rate		Capacity	FY16 Enrollment
FFT	H2033 HU	57.42	99	90
First Home Care			35	24
Hillcrest Children and Family Center			35	28
(DHS) Parent and Adolescent Support Services	N/A	N/A	29	38
PCIT	90804	Variable MCO rates	35	34
DBH PIECE Program			25	15
Mary's Center			10	19
TF-CBT	H004ST	35.74	96	57
First Home Care			18	6
Community Connections			24	13
MD/DC Family Resources			15	21
Hillcrest Children and Family Center			22	15
Universal Healthcare			17	2
CPP-FV	H004HT	35.74	35	35
DBH PIECE Program			25	33
Post Permanency Center of Adoptions Together			10	2
MST	H2033	57.42	36	26
Youth Villages			36	26
MST-PSB	H2033	57.42	8	4
Youth Villages			8	4
TIP	H0036	21.97	532	406
The Family Wellness Center			15	4
MBI Services Inc			102	85
Life Enhancement Services			39	37
Community Connections			57	102
Family Preservation Services			57	51
Universal Healthcare			66	15
Green Door			20	3

DHS – Teen Parent Assistance Program	N/A*		68	76
Total Family Care Coalition	N/A		68	10
Far Southeast Family Strengthening Collaborative	N/A		40	23
A-CRA	H2033	57.42	125	62
Hillcrest Children and Family Center			35	39
LAYC			20	16
Federal City Recovery Services			35	0
Riverside			35	7
TST (Billable under Counseling)	H0036	21.97	80	34
Contemporary Family Services			25	6
First Home Care			25	13
MD/DC Family Resources			20	13
PSI			10	2
Total			1043	748

*Not a MHRS Provider

- e. *Any quality assessment or outcome measures that have been put in place to assess the program.*

In FY 15, DBH continued to fine tune the EBP dashboard, designed to track fidelity and effectiveness EBP services. The EBP dashboard closely monitors progress of each evidence-based practice implementation on five key outcome and performance measures: (1) staffing (2) capacity (3) utilization (4) quality and (5) discharges. The dashboard is accessible at <http://dbh.dc.gov/service/children-youth-and-family-services>.

Evidence-Base Practice	Measurement of Fidelity
Standard Multi-systemic Therapy (MST)	MST uses The Therapist Adherence Measure - Revised (TAM-R), The Supervisor Adherence Measure (SAM) and The Consultant Adherence Measure (CAM).
MST-PSB	Therapist Adherence Measures (TAMs) and other key indicators of adherence are being tracked by the MST Associates consultant and have met model adherence standards.
Functional Therapy (FFT)	FFT utilizes standardized assessment tools to measure outcomes, the Outcome Questionnaire (OQ, Youth Outcome Questionnaire (Y-OQ) to track and monitor specific youth clinical outcomes and Therapist Outcome measure (TOM) to measure adherence and model fidelity.
Trauma Focused-Cognitive Behavior Therapy (TF-CBT)	UCLA Post-Traumatic Stress Disorder Reaction Index (PTSD-RI) is an outcome measure completed before and after participation in TF-CBT. It measures PTSD Severity Score pre and post treatment. PTSD-RI evaluation component of this measure has 20 items that assess the frequency of occurrence of post-traumatic stress disorder symptoms during the prior month according to both child/youth self-reports and reports of their parents/caregivers (for children ages 4-18).
Child Parent Psychotherapy	CPP primarily utilizes the Trauma Symptom Checklist for Young

for Family Violence (CPP-FV)	Children (TSCYC) and the Child Behavior Checklist (CBCL) pre and post treatment among several other assessment tools available to this model.
Parent Child Interaction Therapy (PCIT)	PCIT utilizes the Eyeberg Child Behavior Inventory (ECBI), a 36-item parent report scale which measures treatment progress in children between the ages of 2 and 6 and evaluates the long-term effects of PCIT treatment. The Dyadic Parent-Child Coding System (DPICS) is a behavioral coding system that measures the quality of parent-child social interactions.
Transition to Independence Process (TIP)	TIP uses the following Fidelity QI Tools: <ul style="list-style-type: none"> • Practice Probe: Personal Effectiveness and Wellbeing (Form for Interviewing three TF's separately). Newly revised. • YP Focus Group Interview Form • TIP Model Organizational survey and interview forms Fidelity is measured 1 year after the provider has been utilizing TIP. Depending on the providers scores on the fidelity review, follow up reviews complete or partial can be initiated as near as 6 months.
Adolescent –Community Reinforcement Approach (ACRA)	ACRA utilizes a DSR (audio recording) monitored through the EBTx system to review sessions or procedures as fidelity measure. Outcomes can be measured by calculating the number of DSRs that are passed or procedures passed relative to the total rated to get a percentage of fidelity. After certification, fidelity checks are conducted at random to provide clinicians with feedback and supervision to implement the evidence based practice accurately.
Trauma Systems Therapy (TST)	TST utilizes the Child Stress Disorder Checklist of the District of Columbia (CSDC-DC) trauma assessment tool. The CSDC-DC tool gathers firsthand accounts of trauma history, current symptoms and exposures. The tool communicates the extent of the child's trauma history, the extent the trauma history is impacting the child's functioning, and some understanding of the areas in which a child is struggling to emotionally regulate so that specific trauma interventions and approaches can be developed to address the child's challenges. CSDC-DC is administered to children and adolescents ages 2 to 20 years old.

Supported Employment

Evidenced Based Practice Supported Employment is a jointly funded program. The Department of Behavioral Health and The Rehabilitation Services Administration provide funding to ten (10) community service providers who serve over 1000 district residents with severe and persistent mental illness. DBH funding is a combination of local dollars and Medicaid reimbursable services. The rate for all services is 74.44 per hour. The billing codes are H2025 (Local dollars) and H2023 (Medicaid).

DBH Supported Employment staff facilitates a nationally recognized Evidenced Based Practice Fidelity Review. The review is comprehensive with measures that highlight best practices that produce employment outcomes with high customer satisfaction. Fidelity Action Plans are implemented for all service below the good to excellent range and are monitored by DBH staff.

Employment Outcomes are collected monthly. Quarterly reports are shared with the Dartmouth College Evidenced Based Practice Center. Outcome data is compiled and compared by program and by State.

Provider	Capacity	Current Enrollment
Anchor Mental Health	120	120
Community Connections	140	140
Contemporary Families Services	120	120
Deaf Reach	40	23
Green Door	140	140
MBI Health Services	60	60
Psychiatric Center Chartered	80	80
Psychiatric Rehab Services	40	40
Pathways to housing	50	40
PSI Family Services	80	60
Totals	870	823

Assertive Community Treatment

Another Evidence Based Practice Program that DBH has is the Assertive Community Treatment (ACT). These services are Medicaid Reimbursable at \$38.04/ 15 minutes. Its billing code is H0039.

Assertive Community Treatment (ACT) is an intensive, integrated, rehabilitative, treatment and community-based service provided by an interdisciplinary team to adults with serious and persistent mental illness. ACT services are provided to consumers in accordance with the Individual Recovery Plan (IRP). ACT Teams involve specific and dedicated staff to consumer ratios. Service coverage by the ACT team is required to have specific program hours but to be available for crisis services 24 hours per day, seven days per week. At least sixty percent (60%) of services are required to be provided to the consumer in non-office settings in the community.

Services offered by the ACT Team shall include:

- (a) Mental health-related medication prescription, administration, and monitoring
- (b) Crisis assessment and intervention
- (c) Symptom assessment, management and individual supportive therapy
- (d) Substance abuse treatment for consumers with co-occurring addictive disorder
- (e) Psychosocial rehabilitation and skill development
- (f) Interpersonal, social, and interpersonal skill training
- (g) Education, support and consultation to consumers' families and their support system which is directed exclusively to the well-being and benefit of the consumer.

Providers	Capacity	Current Enrollment
Pathways	320	304
Family Preservation	200	154
Green Door	200	202
Community Connection	700	646
Anchor	150	118
Capital Community Services	0	92
Hillcrest	300	189
Total	1870	1705

- As of January 15, 2016 there are 21 ACT Teams
- Capitol Community Services is scheduled to close in March 2016.
- The nineteen (19) remaining ACT Teams have the capacity to accept the ninety-two (92) individuals that are enrolled in Capital Community Services

Each fiscal year every ACT team has a Dartmouth Assertive Community Treatment Review (DACTS). The scale measures the treatment reliability of the teams.

Health Home

The Health Home Benefit Initiative is a service delivery model that focuses on providing individualized, person-centered and recovery-oriented case management and care coordination. A Health Home is the central point for coordinating, collaborating and ensuring communication amongst all relevant parties engaged in the delivery of each consumer’s care. The Health Home is responsible for achieving the District of Columbia’s Triple Aim Goals:

1. Improving the individual experience of assessing and receiving care;
2. Improving the health of its population; and
3. Reducing the per capita costs of care

Specifically, a Health Home is responsible for:

- Preventing avoidable hospital admissions and readmissions;
- Preventing unnecessary emergency room visits;
- Providing timely transitional follow-up; and
 - Decreasing the overall Medicaid cost for the consumers in the District who have serious mental illnesses (SMI).

Health Home has two Medicaid rates based on the individual’s level of need. The rates and the Medicaid codes are S0281-U1, \$481.00 Per Person Per Month and S0281-U2, \$349.00 Per Person Per Month. The chart below depicts the providers and their capacity. Please note this program began in January 2016 and the enrollment process is underway.

Providers	Capacity
McClendon Center	300
Community Connections	600
Hillcrest Children’s Center	300
Medstar Washington Hospital Center	300
Anchor Mental Health Association	300
Green Door	600
The Family Wellness Center, Inc.	300
Psychiatric Center Chartered, Inc	300
Mary’s Center	300
Contemporary Family Services	300
TOTAL	3600

Each provider will be evaluated annually to determine their compliance with the Centers for Medicare and Medicaid Services quality measures. DBH has released a second Request for Proposal and the Health Home capacity is estimated to increase to 4,500.

Q83. 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 measures that have been put into place to assess the program.

DBH Response:

- 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;

The Chart below represents a list of all the Evidence-Based Practices that are considered trauma-informed.

EBP and Provider	Medicaid Code/Rate		Capacity	FY16 Enrollment
Trauma Focused-Cognitive Behavior Therapy (TF-CBT)	H004ST	35.74	96	57
First Home Care			18	6
Community Connections			24	13
MD/DC Family Resources			15	21
Hillcrest Children and Family Center			22	15
Universal			17	2
Child Parent Psychotherapy for Family Violence (CPP-FV)	H004HT	35.74	35	35
DBH PIECE Program			25	33
Post Permanency Center of Adoptions Together			10	2
Trauma Systems Therapy (TST)	H0004	26.42	80	34
Contemporary Family Services			25	6
First Home Care			25	13
MD/DC Family Resources			20	13
PSI			10	2
Total			211	126

- e. Any quality assessment or outcome measures that have been put in place to assess the program.

The Chart below represents each quality assessments/or outcome measures utilized by each EBP.

Evidence-Base Practice	Quality Assessment/Outcome Measures
Trauma Focused-Cognitive Behavior Therapy	UCLA Post-Traumatic Stress Disorder Reaction Index (PTSD-RI) is an outcome measure completed before and after participation in TF-CBT. It measures PTSD Severity Score pre and post treatment. PTSD-RI evaluation component of this measure has 20 items that assess the frequency of occurrence of post-traumatic stress disorder symptoms during the prior month according to both child/youth self-reports and reports of their parents/caregivers (for children ages 4-18).
Child Parent Psychotherapy for Family Violence	CPP primarily utilizes the Trauma Symptom Checklist for Young Children (TSCYC) and the Child Behavior Checklist (CBCL) pre and post treatment among several other assessment tools available to this model.
Trauma Systems Therapy	TST utilizes the Child Stress Disorder Checklist of the District of Columbia (CSDC-DC) trauma assessment tool. The CSDC-DC tool gathers firsthand accounts of trauma history, current symptoms and exposures. The tool communicates the extent of the child's trauma history, the extent the trauma history is impacting the child's functioning, and some understanding of the areas in which a child is struggling to emotionally regulate so that specific trauma interventions and approaches can be developed to address the child's challenges. CSDC-DC is administered to children and adolescents ages 2 to 20 years old.

Q84: Please provide an update on the Department's efforts to work with DHCF to allow behavioral health providers to bill for collateral contacts.

DBH Response:

In May of 2013, DBH initiated a comprehensive rate setting review of Mental Health Rehabilitation Services (MHRS) to ensure that the costs associated with the delivery of service whether direct, indirect or costs unique to the provision of a specific service were covered adequately in the reimbursement rate. The total cost of provider staff and the time necessary to document and coordinate services (collateral) were included in the cost to build the rates. The review conducted over several months enlisted five MHRS providers to provide detailed financial materials which were matched against a full year of corresponding MHRS claims for those agencies. The providers were asked to join the review based on the comprehensiveness of their services, size and ability to complete a service sample that was significant to evaluate MHRS.

As a result of the review, it was recommended that a 14.8% improvement in rates overall be effected in order to cover the costs to deliver MHRS. Since the MHRS rates are covered under Medicaid, DHCF needed to approve the review's proposed rate structure in order for it to become effective. DHCF fully supported the recommendation and on December 30, 2013, the new rates recommended by the review went into effect.

In addition to building in the cost of collateral contacts in the base rate structure, in FY 2015 DBH reimbursed MHRS providers for community support collateral contacts totaling \$667,164.14.

Q85. 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?

DBH Response

In FY 15, 5,065 children ages 0-20 received a service through MHRS which is a slight increase over FY 14 when 5,037 children in this age range received an MHRS service.

- Q86. Please provide the following information regarding the Comprehensive Psychiatric Emergency Program (CPEP):
- 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).
 - What is the average length of stay for a patient at CPEP?
 - The number of individuals served at CPEP linked to substance abuse services during FY15? To date in FY16?

DBH Response:

- 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).

During FY 2015, the Comprehensive Psychiatric Emergency Program had 3,802 admissions and year to date for FY 2016 there have been 981 admissions for a total of 4,783. Of the total number 3,569 were transported by DC MPD and the remaining 1,214 presented via other sources (e.g. social worker, self -presentation.)

Comprehensive Psychiatric Emergency Program – Admission Numbers by Transport Type – FY15													
Transport Method	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	TOT
Other Transport	63	75	87	89	77	85	82	66	85	81	87	84	961
MPD Transport	262	232	197	218	213	251	240	237	208	273	267	243	2841
Total	325	307	284	307	290	336	322	303	293	354	354	327	3802

Comprehensive Psychiatric Emergency Program Admission Numbers by Transport Type – FY16					
Transport Method	OCT	NOV	DEC	JAN	TOT
Other Transport	81	71	91	10	253
MPD Transport	241	231	225	31	728
Total	322	302	316	41	981

- What is the average length of stay for a patient at CPEP?
The average length of stay for FY15 was 23 hours and year to day for FY16 is 25 hours.
- The number of individuals served at CPEP linked to substance abuse services during FY15? To date in FY16?
In FY 15, 32 consumers were discharged/linked to a drug treatment program. In FY16 to date, seven consumers were discharged/linked to a drug treatment program.

Q87. 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.

DBH Response:

DBH continues to strategically approach the process of serving co-occurring mental health and substance use disorder clients by first implementing a universal screening tool to identify clients that are experiencing needs in both areas. In FY15, DBH implemented activities at our access points including the Assessment and Referral Center (ARC), Urgent Care Clinic at Superior Court, Access Help Line, and several community partners to ensure all individuals entering into the DBH system are screened for co-occurring disorders by using an evidence based co-occurring screening tool called the Global Appraisal of Individual Needs- Short Screener (GAIN-SS). The GAIN-SS is a 20 question screening tool which combines four scales (Internalizing Disorder, Externalizing Disorder, Substance Disorder, and Crime/Violence). In addition, DBH issued a policy making the use of GAIN-SS mandatory throughout the entire DBH network.

The GAIN-SS is an effective means of gathering general behavioral health information on a large population across systems. DBH co-locates a staff at the Child and Family Services Agency (CFSA), to conduct the GAIN-SS assessment and refer individuals needing substance use treatment to the appropriate services. CFSA provides services and family stabilization resources to families and children alleged to be abused and/or neglected through the coordination of public and private partnerships. As a part of its collaboration with APRA around substance use issues, CFSA began screening key segments of its population, both youth and adults, using the GAIN-SS. This process allows CFSA to identify those who are in the greatest need of assessment and expedite those referrals to APRA intake sites.

During FY15, DBH administered 7,806 GAIN-SS to individuals who accessed the SUD system. To date in FY 16, DBH administered 757 GAIN-SS to individuals who accessed the SUD system, and provided treatment services to 3,629 individuals.

In FY15, DBH continued building the infrastructure with the assistance of a grant issued through the Substance Abuse and Mental Health Services Administration (SAMHSA) entitled The 12 Cities Minority AIDs Initiative. This program is built to identify clients who are HIV-positive or at-risk for HIV infection who also have co-occurring behavioral health issues. When a client presents at the Assessment and Referral Center or a mental health Core Service Agency the GAIN-SS is administered as part of the intake process. If a more in depth assessment is indicated on GAIN-SS, a referral to services can be initiated in the same visit, providing high quality service access and maximizing the opportunity for client engagement.

The Assessment and Referral Center has assisted in reconnecting clients to their mental health agencies through DBH's Access Helpline. Co-occurring clients are now able to receive appropriate treatment in a timely manner. The ARC provided Hepatitis C and HIV/AIDS and Hepatitis C education, testing and linkage into primary care.

The goals of this project are to ensure that individuals attempting to access the DBH system of care:

1. Receive HIV screening and testing
2. Receive co-occurring screenings
3. Receive linkages to treatment as appropriate
4. Receive follow-up and continuing care as appropriate
5. Receive immediate access and same day services for HIV positive and High Risk individuals.

The DBH access sites executed activities such as the colocation of client care services for behavioral health and primary care, ensuring that treatment providers have the ability to develop treatment plan(s) for behavioral health and primary care, and adding Clinical Care Coordination to the service menu, which in turn enhances coordinated care between Mental Health and Substance Use Disorder service providers.

In FY15, DBH added Clinical Care Coordination to the SUD service menu. One of the many purposes of this service is to enhance treatment services for individuals with co-occurring disorders (COD). Many individuals with CODs present with somatic medical conditions in addition to their comorbid SUD and mental health disorders. Clinical Care Coordination enhances treatment services by allowing the clinician to construct an integrated treatment plan which may include behavioral health needs, inclusive of somatic, mental and addictions needs.

In FY15, expansion of services included partnering with local hospitals – Psychiatric Institute of Washington, Washington Hospital Center, Providence Hospital and United Medical Hospital Center to conduct Substance Use Disorder (SUD) assessments and referral to the appropriate level of care post hospitalization/detoxification. These hospital are able to stabilize psychiatric symptoms, assess for SUD treatment and refer to DBH certified SUD providers. In addition, SUD partnered with Comprehensive Psychiatric Emergency Program (CPEP) and St. Elizabeth Hospitals so that acutely psychotic patients could obtain a comprehensive psychiatric assessments, stabilization, and hospitalization prior to admission into the SUD treatment services. SUD staff and mental health staff were cross-trained to recognize both SUD and mental health symptoms which expedited and facilitated the client receiving the necessary health care services.

Recovery starts when a District resident begins services through: peer support, recovery coaching, recovery support services, and referrals to recovery community based and faith based programs within the community. Through a small grant, the department developed an advocacy group DC Recovery Advisory Council (DC RAC) in 2013 to advocate and initiate community recovery conversations and drug free events. The council consists of persons in recovery from mental illnesses, substance use disorders, criminal justice re-entry, ex-sex workers, and members of the LGBTQI community. The department partners with Alcoholic Anonymous & Narcotic Anonymous, recovery student groups at local universities; peer run advocacy groups, recovery support services programs located within the District's 8 Wards, and provide funding for 277 housing slots within the local Oxford Houses.

During the 2015 National Recovery Month “Visible, Vocal, Valuable” sponsored by SAMHSA/CSAT the department sponsored over twenty five community events promoting recovery through community conversations with persons in recovery showing the “Anonymous People” and “Life Continued Defeating Depression” videos with panel discussions with persons in recovery including youth and young adults. The citywide community conversations discussed drug use in the community, how to develop prevention strategies, where are more services needed, and how everyone within the community can help. The department was a major partner for the Unite to Face Addiction Rally on the National Mall (October 2015). Over 1,200 consumers in recovery of mental health, substance use disorders and community advocates represented the District at this national event. The Department of Behavioral Health had the largest contingency of persons in recovery at the rally.

On 9/4/15, DBH published final regulations, New Certification Standards for Substance Use Disorder Treatment and Recovery Services, which contain two new levels of care (one outpatient and one residential) requiring that the SUD provider either also be certified by DBH as a mental health provider or have a psychiatrist on staff.

On 9/18/2015, DBH issued notice in the DC Register lifting our moratorium on accepting applications for certification as a mental health or substance use disorder treatment provider. The moratorium lift was designed specifically to elicit applications from providers who are currently providing one set of services so that they could be certified to deliver services in both areas. In other words, DBH is now accepting application from mental health providers who would like to begin adding SUD services, and vice versa. This is in addition to SUD programs that are currently certified under the old certification regulations (Chapter 23) who must apply to be certified under the new regulations (Chapter 63).

DBH has fully moved to using a streamlined application and certification process that improves our ability to certify providers, including those treating co-occurring disorders, in a timely fashion. We utilize a single application and process for all services that the Department certifies. This application removes duplicative requests and allows providers to expand or change the programs for which they are seeking certification simply by describing the program for which they are applying. DBH provided training on the new application and the application process to interested stakeholders in Q4 2015.

Q88. 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?

DBH Response:

The Minority Aids Initiative Targeted Capacity Expansion Project (MAI-TCE) Grant from Substance Abuse and Mental Health Services Administration (SAMSHA) was awarded to twelve cities across the nation. The specific outcomes are to (1) reduce HIV transmission; (2) increase the number of people receiving treatment for substance use disorder, mental health and/or co-occurring substance abuse and mental health disorders; (3) increase the number of people who, receive recovery support services post treatment; (4) increase the number of people who know their HIV status; and (5) increase case management services and referrals to primary HIV care for antiretroviral therapy, primary care and other services for individuals who test positive for HIV. The target populations are minority persons living with HIV or at high risk of HIV infection with co-occurring conditions of substance use disorder and/or serious persistent mental illness.

During the life of the grant, 16,000 individuals were offered the opportunity to be tested—14,446 or 90 per cent were tested. Of this number, 124 tested positive, 328 individuals self-identified that they were HIV positive, and 2,274 were considered high risk for contracting HIV as a result of self-reported risky behaviors. Both the positive and high-risk groups were offered substance use disorder, mental health, primary health, and community services

The SAMHSA grant expired on October 1, 2015. The Initiative will continue with local and other grant funds dedicated to the prevention, treatment of HIV and the reduction of high risk behaviors.

Q89. 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.

DBH Response:

The Department of Behavioral Health has developed partnerships with the Department of Health (DOH) and the Department of Human Services (DHS) to implement a network of integrated, behavioral health and primary care services for residents at risk for or living with HIV/AIDS with mental health, substance use disorder, or co-occurring disorders.

In FY 14, the Global Assessment of Individual Needs (GAIN-SS) GAIN-SS was piloted with two providers. The GAIN-SS is a screening tool designed to screen for possible psychiatric related disorders, substance related disorders as well as other maladaptive behavioral functioning. In FY 15, the use of this screening tool was expanded system wide.

In FY2015, nearly 19,000 GAIN-SS screenings were performed, and during the first quarter of FY 2016, more than 4,800 screenings have taken place.

Collaboration between CFSA and DBH: CFSA

DBH expanded its collaboration with the Child and Family Services Agency (CFSA) to address the substance use disorder needs of its clients. In FY 15, through the mobile assessor, DBH administered 67 assessments to mothers of CFSA clients, and 43 assessments to date in FY 16.

Collaboration between DBH and ICH

DBH is collaborating with the District's Interagency Council on Homelessness (ICH) to implement the Cooperative Agreement to Benefit Homeless Individuals (CABHI) grant. The District received \$3 million per year for three years, totaling a grant award amount of \$9 million. This grant will allow the District to enhance services for people who experience chronic homelessness. The program will target (1) people who experience chronic homelessness and who also have substance use disorders, serious mental illnesses (SMI), or co-occurring mental health and substance use disorders; and (2) veterans who experience homelessness or chronic homelessness and have substance use disorder(s), SMI, or co-occurring mental and substance use disorders. The target is 300 individuals each year for a total of 900.

Collaboration between DBH and FEMS

DBH collaborated with Fire and Emergency Medical Services (FEMS) to conduct a pilot study using Screening, Brief Intervention, and Referral to Treatment (SBIRT) for District residents in potential crisis from an opiate overdose. SBIRT is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. Information on individuals found to have overdosed responded positively to Narcan were referred to DBH. Within three to five days, DBH dispatched an outreach team comprised of health care and social work personnel only. Participation in the screening was voluntary and the

outreach team SBIRT engaged 84 individuals. DBH currently is reviewing options to sustain the program.

Collaboration between DBH and DOH: Heroin Task Force

The purpose of the Heroin Task Force is to decrease the morbidity and mortality from opioid use and addiction in the District of Columbia through a multi-disciplinary approach. This workgroup brings leaders together across both District and Federal agencies to make policies which will 1) decrease the number of overdoses from opiates in the District; 2) decrease the number of deaths due to opiate overdose in the District; 3) expand access to naloxone; and 4) increase participation in Medication Assisted Treatment. The task force meets monthly and is led by DBH and DOH.

Collaboration between DBH and DOH: Marijuana Task Force:

The Directors of the Departments of Behavioral Health and Health co-chair the Marijuana Task Force which oversaw the development of an educational campaign about Initiative 71 that focused on the health consequences of underage marijuana use and the link to physical and emotional well-being.

Q90: 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.

DBH Response:

In FY 15, one hundred and sixty seven (167) individuals enrolled in the public mental health system self-identified as veterans. Of those, 51 actively received treatment in FY14 and to date in FY15. The DBH services used by the veterans are community support, medication somatic service and Assertive Community Treatment (ACT) services, supported employment, crisis intervention services and transitional services from hospital care to community-based services.

DBH and its community providers continue to work closely with the Veterans Administration (VA) to ensure that veterans with active benefits are able to remain in the VA system and receive necessary mental health services. DBH also provides training for VA employees. Saint Elizabeths psychiatry residents rotate through the VA, and military residents rotate through the emergency psychiatric facility (CPEP). In addition, the DBH works with the Substance Abuse and Mental Health Administration (SAMHSA) Policy Academy on Working with Military and Veterans. The purpose of the academy is to develop strategies within the District and throughout the country to improve mental health and health care services, education, economic security and to decrease criminal justice involvement and homelessness among veterans.

DBH is collaborating with the District's Interagency Council on Homelessness (ICH) to implement a federal Cooperative Agreement to Benefit Homeless Individuals (CABHI) three – year, \$9 million grant. The targeted receiving population includes veterans who experience homelessness or chronic homelessness and have substance use disorders, mental illnesses or co-occurring mental and substance use disorders.

Oscar Morgan, Director of Adult Services, is responsible for this program.

Q91. 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.

DBH Response:

In FY15 to date, DBH provided a range of mental health Mental Health and Rehabilitative Services (MHRS) services for 903 individuals over the age of 65. In addition, a description of some other services provided to this population is as follows:

Pre-Admission Screening/Resident Review (PASSR). As the public mental health authority, DBH is responsible for the PASRR (Pre-Admission Screening/Resident Review) level II, which is required for any individual with mental illness entering or being discharged from a nursing facility or who is in a nursing facility and has a change in condition in either their mental health or functional abilities. Forty-one (41) PASSRs were conducted for individuals over the age of 65. Of those nine were for individuals discharged from nursing home level of care. From October 2014 to December 31, 2015, 18 PASSR have been completed; three were for individuals discharge from nursing homes level of care.

Responsible Staff: Chaka Curtis

On January 1, 2016 DBH in conjunction with the Department of Health Care Finance launched the Health Home Medicaid Benefit for persons with Serious Mental Illnesses. Individuals who are 65 years or older enrolled in this initiative will receive case management and care coordination of the behavioral health, physical health and social service needs. With an emphasis on physical health care, the expected outcomes are:

- Preventing avoidable hospital admissions and readmissions;
- Preventing unnecessary emergency room visits;
- Providing timely transitional follow-up; and
- Decreasing the overall Medicaid cost for the consumers in the District who have serious mental illnesses (SMI).

Another key element of this Initiative is the provision of educational training and consultation geared toward helping individuals establish and achieve healthy life-styles, actionable goals for illness management and recovery.

Responsible Staff: Tippi Hampton

Illness Management and Recovery (IMR) Pilot. In the fourth quarter of FY14, DBH launched a pilot program for elderly individuals with mental illness to assist them in developing self-management and recovery skills. Participants receive instruction based upon the IMR curriculum that is used to help people develop personal strategies for coping with mental illness and to move forward with their life. IMR has been identified as an evidence-based practice. It includes a combination of motivational, educational and cognitive behavioral techniques. It is

delivered in either an individual or group format. Each person involved in the program also receives a “Health Buddy” which is a telehealth device that collects and transmits health management information. The person is able to provide a nurse care manager with information about their physical and mental health condition on a daily basis from their home. The nurse can provide telephonic support or deploy a mental health worker to the person’s home if required to address any issues identified.

Responsible staff: Oscar Morgan

Green Door is the DBH contractor responsible for implementing this pilot program. The focus of this effort is on improving the health status of individuals who have SMI and who also may have one or more physical health conditions. Start-up activities were conducted during FY 14. In FY15, 85 individuals received services. The vendor that supplied the Health Buddy discontinued this device; therefore the pilot was not brought to scale in FY16. The IMR evidenced-based curriculum and skill development process can be implemented independently of the telehealth device. Consideration is being given to incorporating IMR as a Health Home practice.

Interagency Partnerships. DBH has developed a Memorandum of Agreement (MOA) with District of Columbia agencies including the DC Office on Aging (DCOA), and Department of Health Care Finance DHCF to move individuals, most of whom are elderly, out of nursing homes and community hospitals into the community. DBH’s role is to ensure that individuals enrolled in the mental health system receive appropriate transitional and ongoing services and supports that assist them in functioning effectively in the community. DBH mental health providers are responsible for coordinating all available community services and managing the delivery of care to individuals assigned to their agency. In addition, DBH’s Integrated Care Division monitors community placements for up to 120 days of step-down from a nursing home to assure services are provide timely.

The DBH participates as a member of the District’s Age Friendly Initiative which is chaired by the Deputy Major and the President of George Washington University. This Initiative is geared toward promoting active and healthy aging for District residents. The specific areas for which DBH are:

- Introduce or expand primary mental health screening programs for older adults
- Provide training on behavioral health for counselors and aides working in hospitals and home-based care units
- Expand number of peer counselling and support programs and increase the number of older adult peer counselors.

Responsible Staff: Oscar Morgan

Q92. 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?

DBH Response:

Illness Management and Recovery (IMR) Pilot. In the fourth quarter of FY14, DBH launched a pilot program for elderly individuals with mental illnesses to assist them in developing self-management and recovery skills. Participants receive instruction based upon the IMR curriculum that is used to help people develop personal strategies for coping with mental illness and to move forward with their lives. IMR has been identified as an evidence-based practice. It includes a combination of motivational, educational and cognitive behavioral techniques. It is delivered in either an individual or group format. Each person involved in the program also receives a “Health Buddy” which is a telehealth device that collects and transmits health management information. The person is able to provide a nurse care manager with information about their physical and mental health condition on a daily basis from their home. The nurse can provide telephonic support or deploy a mental health worker to the person’s home if required to address any issues identified.

Green Door was the DBH contractor responsible for implementing this pilot program. The focus of this effort is on improving the health status of individuals who have SMI and who also may have one or more physical health conditions. Start-up activities were conducted during FY 14. In FY15, 85 individuals received services. The vendor that supplied the Health Buddy discontinued this device; therefore the pilot was not brought to scale in FY16.

The IMR evidenced-based curriculum and skill development process implemented independently of the telehealth device. Consideration is being given to incorporating IMR as a Health Home practice.

Q93. What activities did DBH undertake in FY5 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.

DBH Response:

DBH serves residents who meet the income guidelines which is 200 per cent of the federal poverty level for adults and 300 percent for children. The majority qualify for Medicaid—those who do not are supported with all local dollars. In FY 15, about 23,400 individuals received at least one mental health service. To date, in FY16, we are on track to serve about the same number. All enrolled individuals based upon individualized needs are eligible to receive the full range of services and supports offered by DBH.

The employees responsible for coordinating these services are: Oscar Morgan, Director of Adult Services and Denise Dunbar, Director of Child, Youth and Family Services, and Marquitta Duvernay, PhD. Deputy Director, Addiction Prevention Recovery Administration.

Q94. 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.

DBH Response:

DBH supports and works with our community partner Helping Individual People Survive (HIPS) to provide recovery support services, advocacy and substance use disorders treatment referrals to the LGBTQI population. HIPS is a nonprofit community program located in Ward 6. HIPS mission is to assist female, male, and transgender individuals engaging in sex work lead healthy lives. Utilizing a harm reduction model, HIPS programs strive to address the impact that HIV/AIDS, STIs, discrimination, poverty, violence and drug use have on their lives. Three nights a week, from 9:00pm until 5:00am, HIPS staff and volunteers, provide education and counseling, and distribute safety materials, clothing and food to sex workers on the streets. HIPS also provides referrals, help for parents of persons engaged in sex work and emergency housing assistance.

The School Mental Health Program provides services and supports tailored to address the issues faced by LGBTQ youth. The following activities were conducted:

Too Good for Violence: During SY 14-15 the SMHP implemented the program in 29 schools and to date in SY 15-16 in 17 schools. Too Good for Violence is a Substance Abuse and Mental Health Services Administration (SAMHSA) approved, evidence-based violence prevention program is designed to reduce aggression and improve the behavior of elementary, middle and high school students. It emphasizes four areas: conflict resolution, anger management, respect for self and others, and effective communication.

Signs of Suicide: SOS is a depression awareness and suicide prevention program that teaches how to ACT (Acknowledge, Care and Tell) when a person or friend experiences symptoms of depression or suicide. It also includes information regarding the statistics of suicide among youth in the LGBTQ population. SOS was implemented in eight schools last school year and three schools to date in SY15-16.

Individual and Group Therapy – SMHP clinicians provide individual and group therapy to youth who identify as LGBTQ.

Work with School Climate Teams. At Jefferson Academy in honor of National Bullying Prevention Month facilitated classroom presentations entitled, "Recognizing and Reducing Bullying Behavior."; at Cardozo High School planned the annual Pride Day. Clinicians also have provided presentations to address bullying and cyber-bullying.

Co-facilitated Gay Straight Alliance (GSA) Meetings. Clinicians facilitated clubs and groups at four schools to support LGTBQ students.

Q95: 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 FY15;
- c. Number of discharges, by month, for FY15 and to date in FY16; and,
- d. Average length of stay.

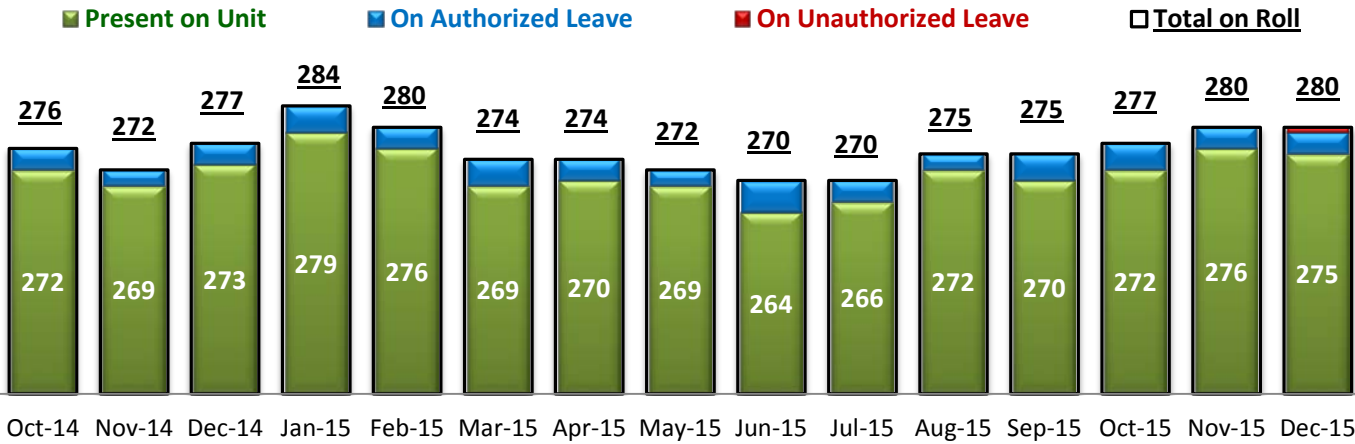
DBH Response:

1) Census (Oct-2014 ~ Dec-2015)

The census is affected by the number of admissions and discharges. Prior to FY13, the average daily census (ADC) at the Hospital declined consistently for several years accompanied by a steady decrease in the number of admissions. The declining trend of admissions, however, was reversed in FY13 and the number of admissions continued to increase in FY14 and FY15, contributing to a consistently high average daily census. This pattern continues to date in FY 16 resulting in a further increase in the average daily census during the first three months of FY16.

In January 2015, the ADC reached 284, the highest level since November 2011. The ADC then gradually decreased from January –July 2015, in part a result of the concerted efforts to discharge several long-term post trial residents who had been in care for over a decade. However, since August 2015, the Hospital began to experience significant challenges in discharging individuals in care to the community while the number of admissions remained high. (See #3 below for specific data on the decline in discharges) Consequently, the ADC gradually increased beginning in the summer 2015 and was hovering around 280 during the first quarter of FY16.

Number of Individuals Served on a Given Day (Oct-2014 ~ Dec-2015)



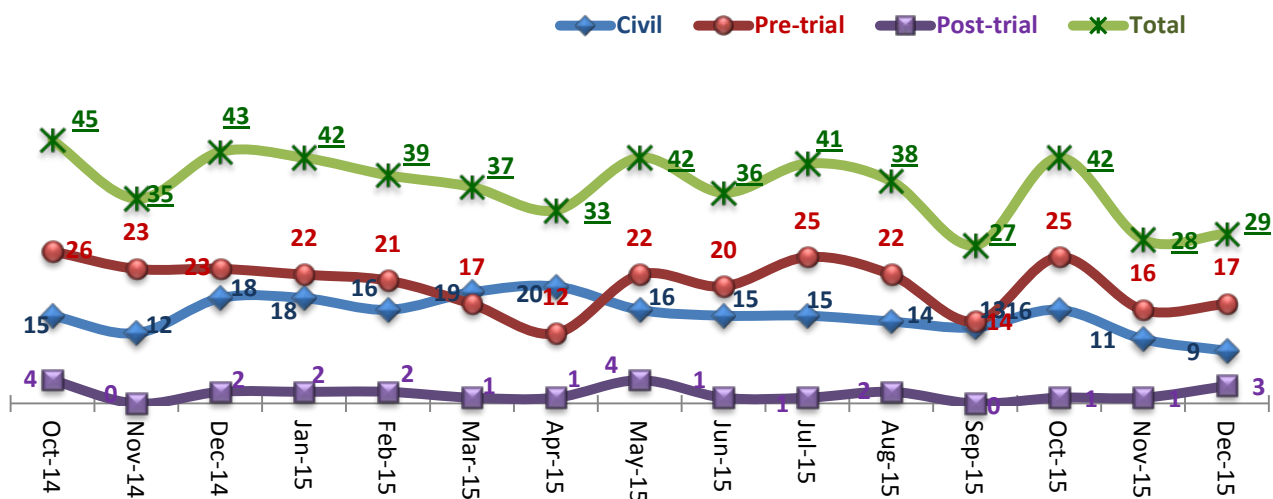
2) Admissions (Oct-2014 ~ Dec-2015)

The trend of a reduction in the number of monthly admissions that had continued for several years was reversed in FY13, and the number of monthly admissions continued to increase steadily in FY14 and FY15. The total number of admissions in FY12 was 400 (33 per month), increased to 423 (or 35 per month) in FY13, 434 (or 36 per month) in FY14, and 458 (or 38 per month) in FY15. This trend was reversed somewhat during the first quarter of FY16, however, as the number of admissions decreased to 33 per month. However, because there was an even greater decrease in the number of discharges during the first quarter of FY 16, census remains high.

This increase of admissions to the Hospital FY15 is driven primarily by an increase of forensic pre-trial admissions, those sent by the Superior Court for competency evaluation and/or restoration prior to stand trial on criminal charges. The monthly average number of pre-trial admissions during FY13 was 15. The number of pre-trial admissions started to increase in FY14 (19 per month) and increased further in FY15 (21 per month).

The number of pre-trial admissions marginally declined in the first quarter of FY16 (19 per month). It should be noted, however, that this decrease of admissions in the last few months is attributed more to the unavailability of bed space for pretrial individuals due to a continued high census at the Hospital. Throughout the first quarter of FY16, there was a waiting list for admissions every day during this period; had bed space been available, the number of admissions in the first quarter of FY 16 would have likely equaled or exceeded FY15 levels. It should also be noted that the time spent on the waiting list for admissions increased significantly in first quarter FY16 and this trend continues to date.

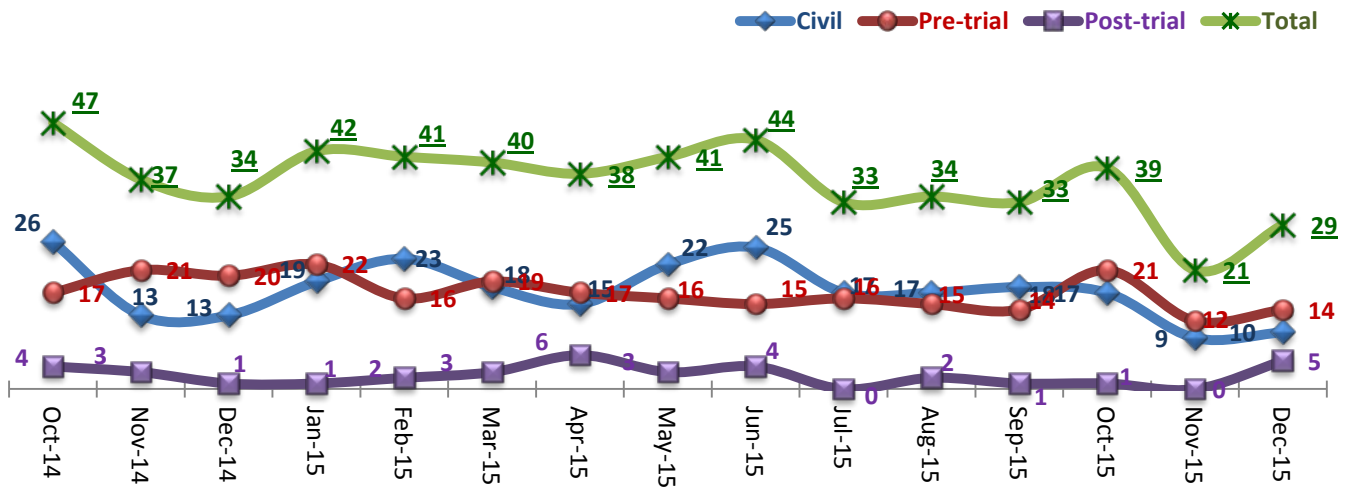
Number of Admissions during Month (Oct-2014 ~ Dec-2015)



3) Discharges (Oct-2014 ~ Dec-2015)

The number of discharges increased from a total of 429 (or 36 per month) in FY14 to a total of 464 (or 39 per month) in FY15. The number of FY15 discharges was slightly higher than the number of FY15 admissions (a total of 458). The number of discharges was high during the first three quarters of FY15 but discharges began to decrease noticeably during the last quarter of FY15 and the first quarter of FY16. This declining trend of discharges resulted in an increase of census in the last six months. The decrease in the number of civil discharges reached a significant low (9) in November 2015 and was only slightly better in December 2015.

Number of Discharges during Month (Oct-2014 ~ Dec-2015)



4) Length of Stay (LOS)

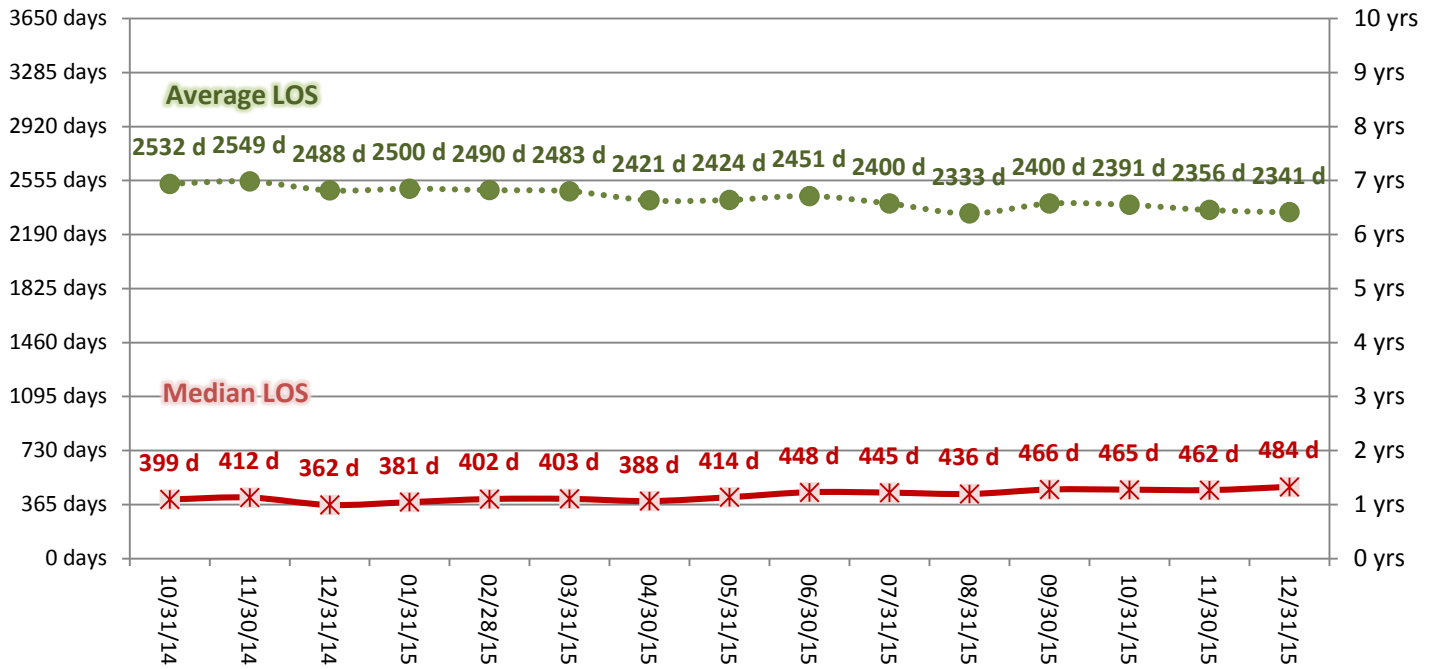
The average (mean) length of stay (LOS) at the Hospital has been always much longer than the median (midpoint) LOS¹. The average LOS can be easily skewed because it can be affected disproportionately by a few individuals who have been hospitalized for an extended period of time. While we always monitor and will present the average LOS data herein, we rely more often on the median LOS as it helps us to assess the central tendency more accurately.

Overall, the length of stay (both average and median) for individuals in the Hospital's care significantly shortened in FY14. The average LOS continued to decline during FY15 and the first quarter of FY16. However, the trend of the median LOS was reversed in FY15, gradually increasing, particularly over the past six (6) months. This trend reflects the census and discharge trend presented above: discharges of several long-term patients that occurred in the first half of 2015 resulted in a decrease of the 'average' LOS. However, a decrease of overall number and timeliness of discharges in the last six (6) months contributed to an increase of 'median' LOS. The median LOS for those remaining in care as of October 31, 2014 (15 months ago) was 399 days (approximately 13 months), meaning 50% of the individuals in care had been residing at the Hospital for longer than 13 months. Since the median LOS increased throughout the year in FY15 and to date in FY16, it reached its highest point since July 2014 at 484 days (approximately 16 months) on December 31, 2015.

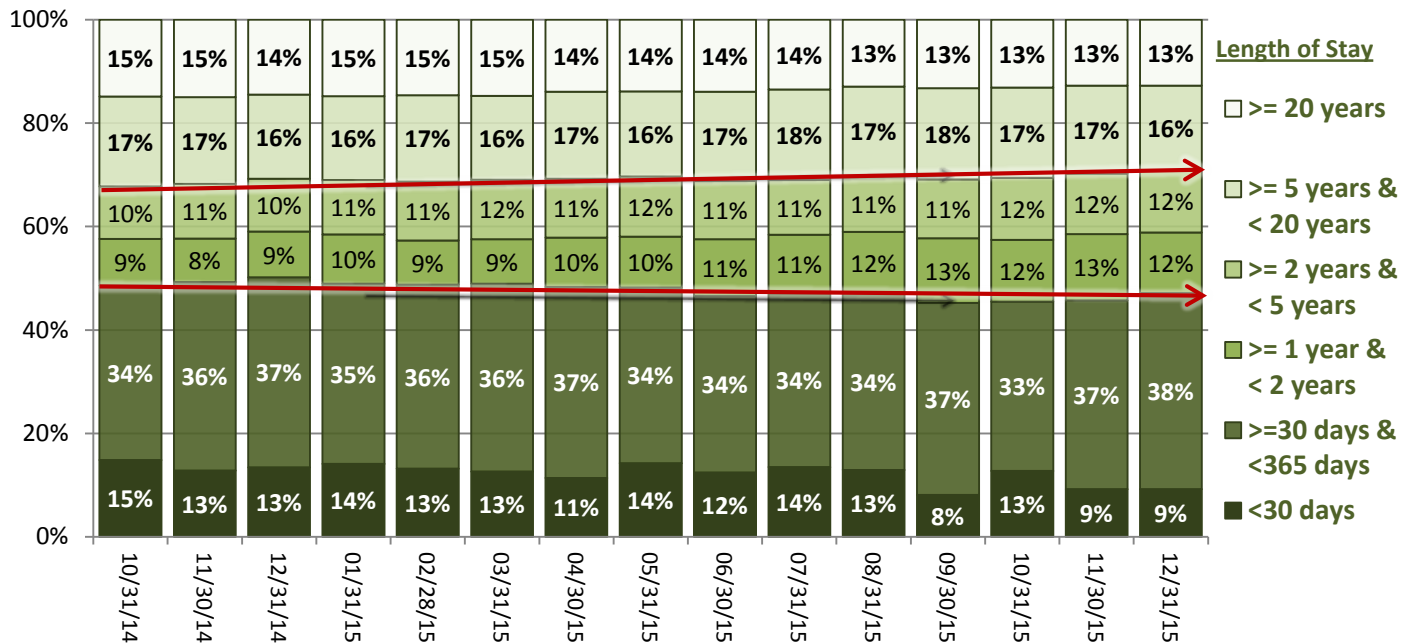
The trend of this increase in the median LOS along with the decrease in the average LOS is also demonstrated well in the length of stay distribution chart. The proportion of those who had been in care for five (5) years or longer decreased throughout the year, lowering the average LOS of the overall population. However, the percentage of those who had been in care for more than a year and less than five years noticeably increased, raising the mid-point (median) LOS.

¹ Median length of stay means that half the individuals' length of stay was less than those number of days, and the length of stay for the other half of individuals exceeded those number of days.

Length of Stay for Individuals Remaining in Care at End of Month (10/31/14 ~ 12/31/15)



Length of Stay Distribution for Individuals Remaining in Care (10/31/14 ~ 12/31/15)



Q96. 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?

DBH Response

In FY 15, there were 464 individuals who were discharged from Saint Elizabeths, with 138 of them receiving hospital discharge support from Adult Services. In FY 16, through December 31, 2015, there have been 89 individuals discharged, with 59 of those receiving discharge supports from Adult Services. As of December 3, 2015, there were 282 individuals in Saint Elizabeths Hospital, and 126 of whom were receiving discharge support. These individuals receiving discharge support are not necessarily clinically ready for discharge, but are those for whom the discharge planning process has been initiated due to clinical progress made or in anticipation of forensic (court ordered) discharge.

The most prominent barrier to discharge is the number of available SRR placements available. As of December 31, 2015 there were 27 individuals receiving hospital discharge support and will be prioritized for community placement. In February 2014, the Department launched the Clinical Review and Monitoring Step-Down Project, which assesses and moves consumers to more independent levels of housing. While this Project has moved 25 individuals to lower levels of housing, this has not kept pace with the number of SRR referrals during its existence.

Complex medical needs and mobility concerns are also barriers to discharge. The Department currently has an RFP out for 10 Intensive Residential (IR), which is a higher level of housing intended for consumers who meet an SRR level of placement but also have more complicated medical concerns than are typically managed in an SRR placement. The provider chosen will have placements that are wheelchair accessible or can address the needs of individuals with mobility concerns.

Administrative barriers to discharge have been addressed by updating discharge protocols and identifying additional staff to assist with the discharge process. Additionally, weekly meetings with providers have been initiated to ensure that our outpatient providers are performing their responsibilities in the discharge process.

Q97. Have you completed FY15 Provider Scorecards? If so, please attach. If not, please explain why Provider Scorecards were not completed.

DBH Response:

The annual Provider Scorecard is based on data from the prior fiscal year. DBH plans to publish the FY 15 Provider Scorecard in June 2016. The Office of Accountability (OA) is now collecting and analyzing data. After completion of the scoring, OA will meet with each provider to discuss the Scorecard process and review the final score. The FY 14 Scorecard was published in FY 15 and is posted on the DBH website. The Scorecard is attached.

See Attachment. FY 14 Provider Scorecard

Q98. Please attach the FY15 Community Service Review results of the children/youth. Please explain when the targeted review of adults will be conducted. In addition, please describe the process for substance use disorder services.

DBH Response

During FY15, a Community Service Review (CSR) was conducted with 85 children and youth between January and July. Eighty were completed by DBH, two were completed with the Child Family Services Agency (CFSA), and three were completed by CFSA. This was the first system-wide review using the new protocol developed with CFSA, which enables both agencies to share the data collected. The CSR review protocol was revised substantially to reflect best clinical practices. For example, several indicators were broken out to get measures of how well the individuals that made up the whole family system were served.

A target review of Adult Services was conducted during July and August 2015 which focused on adults aged 65 and older who participate in day rehabilitation services. Eight reviews were completed. This population was chosen because this demographic group consistently utilizes the most units of day services. The purpose of the review was to explore the needs of this group and examine what role day services plays in their treatment to guide future service planning for this group. The overall practice performance scored 75% acceptable. The qualitative data reported that participation in day treatment services appears to be the only significant source of social interaction and social support for most of the consumers reviewed. Many consumers appeared to have few natural supports and limited opportunities to develop social relationships beyond their participation in day treatment activities. This review suggests that day treatment is meeting an important need for this population and it needs to be better integrated with other supports and treatments received by an individual.

A workgroup was established to develop qualitative evaluations of substance use disorder services. The process includes integrating the measurement of service quality into the discussion of adapting services to a Medicaid fee-for-service model. Also, the person-centered treatment model will be the basis for the protocol to measure the quality of substance use disorder services. Because of the focus on developing and implementing the new Chapter 63 regulations for substance use disorder providers and trainings for providers to prepare for certification, the workgroup was slowed. DBH projects the written protocol and evaluation process will be developed by September 30, 2016, and pilot evaluations will begin in the new fiscal year.

See Attachment. Child/Youth FY 15 CSR

Q99. 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.

DBH Response

On November 1, 2014, DBH implemented the use of the Child and Adolescent Functional Assessment Scale (CAFAS) and the Preschool and Early Childhood Functional Assessment Scale (PECFAS) across all child-serving mental health providers. CAFAS/PECFAS is a standardized assessment tool for assessing children and youth day-to-day functioning and for tracking changes in functioning over time. The tool is completed by a practitioner based on information from routine clinical evaluation providing a comprehensive and objective assessment focusing on observable behaviors. The CAFAS/PECFAS is backed by over 20 years of research supporting its validity and sensitivity to detecting change in behaviors. It is widely used to inform decisions about type and intensity of treatment, level of care, placement and need for referral.

On December, 1, 2015 the CAFAS was also implemented for the adolescent substance use disorder treatment providers (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.

Q100. Please provide an update on the work DBH's Integrated Care Division in discharge planning efforts at Saint Elizabeths. Elaborate on any new projects that were undertaken in FY15 and to date in FY16.

DBH Response

In FY15 care coordination services provided by the DBH Integrated Care Division focused on providing timely community-based services to adults following discharge from a psychiatric facility. Four hundred and sixty-four (464) individuals were discharged from Saint Elizabeths Hospital with 138 receiving discharge support from the DBH Integrated Care Division during the fiscal year. In FY 16, through December 31, 2015, there have been 89 individuals discharged, with 59 of those receiving discharge supports from Adult Services.

The Integrated Care division tracks individuals leaving a psychiatric inpatient unit after an involuntary admission or being discharged from Saint Elizabeths. The Integrated Care Division strives to assist individuals who are discharged with obtaining appointments with Core Service Agencies within seven (7) days of discharge. The Integrated Care Division also follows to see if the same individuals are seen a second time within thirty days of being discharged. Sixty two percent (62%) received a service within seven (7) days and seventy four percent (74%) received a service within 30 days.

In FY16 DBH will procure 10 beds for individuals who have physical health conditions that exceed the clinical care capacity of existing residential providers but whose conditions are not appropriate for nursing home level care.

Q101. Please provide an update on the New Direction Program which focuses on community re-integration efforts for long-term SEH patients. How many individuals were served by this program in FY 15 and to date in FY 16?

DBH Response

The New Directions Program is currently operated by Anchor Mental Health Association and is also referred to as the Integrated Community Care Project (ICCP). The ICCP continues to provide comprehensive care to individuals with serious and persistent mental illnesses who have had long-term hospitalizations at Saint Elizabeths Hospital (SEH). Intensive clinical and social rehabilitation services are provided to individuals leaving the hospital and re-entering the community from long-term and often recurrent, hospitalizations. The goal is to support community integration and maintenance of community tenure. The specific objectives established for the program are to:

- Reduce recidivism and length of stay within institutional settings such as psychiatric hospitals, correctional facilities and nursing homes;
- Increase community tenure;
- Establish social support networks and natural supports to assist individuals with serious and persistent mental illness to live successfully within the community;
- Assist individuals in developing the functional and social skills necessary to live in the least restrictive environment; and to
- Effectively manage their mental illness and other co-occurring conditions.

The ICCP served 30 individuals in FY 15. At the end of the first quarter of FY 16, twenty-nine (29) individuals were enrolled in the ICCP. Of the twenty-nine, nineteen (19) have had no readmissions to Saint Elizabeths Hospital during calendar year of January 2015 – December 2015. Ten individuals had fourteen separate readmissions during the same time period but were able to return to the community following hospitalization.

The DBH Integrated Care Division meets bi-monthly with representatives from SEH and Anchor to assess individuals residing in the hospital potential for participating in this program as well as to review the progress of those enrolled.

Q102. 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.

DBH Response

Please see the chart below which provides the number of currently licensed Mental Health Community Residence Facilities in each ward.

Ward	CRFs
1	6
2	0
3	2
4	14
5	16
6	12
7	26
8	33
Grand Total	109

Q103. 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.

DBH Response

See Attachment. Strategic Housing Planning Appendix A Updates

Q104: Please describe the adequacy of DBH's existing supportive housing capacity to meet the needs of adults with severe and persistent mental illness.

DBH Response:

The District of Columbia is a national leader in providing supported housing for individuals with mental illnesses. In FY15, a total of 2,820 people were in supported housing including supported residences, and rental subsidies. In FY 16, fifty new and renovated affordable housing units will be added. In addition, through its collaboration with the D.C. Department of Housing and Community Development (DHCD), DBH is providing capital funds to support housing set asides in new developments for people with mental illnesses. Currently, 152 units are in the various stages of development, including 17 under construction, 99 units from the 2013 Consolidated NOFA, and 36 units from the 2014 Consolidated NOFA. Despite this growth, demand continues to exceed availability. DBH prioritizes support to individuals who are homeless, moving from Saint Elizabeths Hospital, or relocating to a more independent living environment.

Q105. Please identify the unduplicated number of clients served by each provider organization certified by APRA for the drug treatment for FY2015 and FY16 to date.

DBH Response

Agency Name	UNDUPLICATED COUNT FOR FY2015	UNDUPLICATED COUNT FOR FY2016
Access Housing Inc.	54	3
Andromeda	597	198
Angels and Associates, Inc	252	108
APRA Intake Agency(Internal)	5,844	1,646
Calvary Healthcare Inc	124	20
Child and Family Services Agency(Int)	74	0
Clean and Sober Streets	310	106
Community Connections	52	12
DC Recovery Community Alliance	715	101
Department of Behavioral Health(Internal)	576	54
Family & Medical Counseling Service	586	90
Federal City Recovery	982	255
Found. for Contemporary Drug Abuse	165	32
Good Hope Institute	115	48
Hillcrest Children & Family Center	189	55
Holy Comforter St. Cyprian	717	186
LaClinica Del Pueblo	64	17
Latin American Youth Ctr.	46	11
LIFE STRIDE	65	20
Maryland Treatment Center	50	11
Pilgrim Rest	18	9
Providence Hospital	584	169
Psychiatric Institute of Washington	1,055	335
Riverside Treatment	48	15
Safe Haven Outreach Ministry	217	63
Salvation Army	598	129
Samaritan Inns	256	106
So Others Might Eat (SOME)	345	91
TOTAL FAMILY CARE COALITION	79	0
United Planning Organization	181	44