DC Council Committee on Health
Councilmember Christina Henderson, Chair
Fiscal Year 2022 Performance Oversight Pre-Hearing Questions
Department of Behavioral Health

Organization and Performance

1. Please provide the current organizational chart for the agency, with 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 FY 2022 and FY 2023, to date.

DBH Response

In FY 22, Disaster Behavioral Health and Support Services was transferred from the Chief Clinical Officer to the newly established position of Chief, Crisis Services to consolidate all crisis services activities and programs.

See Attachment. FY 23 Organizational Chart.

2. Please describe the agency's procedures for investigating allegations of sexual harassment or misconduct committed by or against its employees. List and describe any allegations received by the agency in FY 2022 and FY 2023, to date, and whether those allegations were resolved.

DBH Response

Mayor Muriel Bowser issued a Mayor's Order on sexual harassment on December 18, 2017, that addresses the definition of sexual harassment, reporting procedures, and the various protections provided to employees who are the subject of a sexual harassment complaint. It also included mandatory training for all employees. The Department of Behavioral Health (DBH) is committed to providing a workplace that is free from sexual harassment and takes the necessary steps to ensure that such matters are promptly investigated and addressed as outlined in Mayoral Order 2017.33.

The Equal Employment Manager for a District agency serves as the Sexual Harassment Officer (SHO) and is the primary point of contact for questions or concerns regarding sexual harassment.

Employees who know of incidents of sexual harassment, as well as behavior that may create an intimidating, hostile or offensive work environment, or who are victims of sexual harassment or inappropriate conduct, should report the sexual harassment or inappropriate conduct to the SHO.

The SHO has responsibility for investigating or overseeing investigations of alleged sexual harassment in accordance with the Mayoral Order and guidance from the Office on Human Rights. Any allegation of sexual harassment also is reported to the Mayor's Office of Legal Counsel.

Per the Mayor's Order, DBH follows the procedures for investigating allegations of sexual harassment or misconduct committed by or against its employees upon receipt of a complaint:

1. The SHO reviews and recommends immediate action whether to separate the parties involved, (such as temporary employee reassignments, temporary telework schedule, etc.) or whether to involve law enforcement, pending the investigation as warranted.

2. The SHO determines the scope of investigation, speaks with all relevant parties, collects documents and records all information received to prepare a written report.

3. The SHO conducts a meeting with the Complainant which could include a third-party witness or an individual to whom the allegation was reported. More thorough interviews of these individuals occur as the investigation progresses. The investigation includes verifying the allegations by conducting interviews (if possible, record all interviews) and gathering documents and other evidence. The SHO evaluates the evidence and prepares the written report of findings and recommendations for the Director including what the investigation entailed and what details or information were confirmed (or not confirmed) by the evidence. The final report is shared with General Counsel and findings and actions are shared with the Mayor's Office of Legal Counsel.

Below is a list of allegations of sexual harassment and misconduct cases received by DBH in FY 2022 and FY 2023 to date.

Type of Case	**Sexual Harassment**	**Fiscal Year**	**Outcome**
Sexual Harassment	Sexual Orientation	FY 22	Dismissed
Sexual Harassment	Unwelcome Advances	FY22	Substantiated. Disciplinary action took place
Sexual Harassment	Inappropriate Behavior/Touch	FY 22	Substantiated. Employee terminated
Sexual Harassment	Sexual Orientation	FY22	Unsubstantiated
Sexual Harassment	Unwelcome Advances	FY22	Unsubstantiated
Misconduct	Inappropriate/language	FY 22	Substantiated. Employee resigned
Misconduct	Unprofessional Behavior	FY22	Unsubstantiated

Sexual Harassment	Unwelcome advances	FY22/FY23	Pending-investigation still in progress

3. How many performance evaluations did the agency complete in FY 2022? How many performance improvement plans were issued in FY 2022? How many employees have submitted SMART Goals or other relevant workplans in FY 2023? For each question, provide the total number and the percentage of total employees.

DBH Response

For the FY 22 performance appraisal period October 1, 2022, through December 23, 2022, a total of 956 performance evaluations were completed. This represents 83 percent of the total workforce of 1,147 employees. In FY 22, there were no performance improvement plans issued. To date in FY 23, 976 performance plans have been completed. This represents 81 percent of the workforce of 1,203 employees.

4. Please provide the following budget information, in Microsoft Excel, for the agency, including the amount budgeted and spent for FY 2022 and FY 2023, to date. In addition, please describe any variance between the amount budgeted and spent.
    a. At the agency level, please provide information broken out by source of funds and by Comptroller Source Group and Comptroller Object;
    b. At the program level, please provide the information broken out by source of funds and by Comptroller Source Group and Comptroller Object; and
    c. At the activity level, please provide the information broken out by source of funds and by Comptroller Source Group.

DBH Response:

Please see Attachments:
FY 22 Oversight Question 4 Attachment 1 of 3. Agency Level
FY 22 Oversight Question 4 Attachment 2 of 3. Program Level
FY 22 Oversight Question 4 Attachment 3 of 3. Activity Level

5. Please provide a complete accounting of all intra-district transfers received by or transferred from the agency during FY 2022 and all interagency budget processes for FY 2023, to date, where the agency is a buyer and seller. For each, please provide a narrative description as to the purpose of the intra-district transfer and interagency budget process,

and which programs, activities, and services within the agency the intra-district transfer and interagency budget process affected.

DBH Response

Please see Attachment 1 of 1. Intra-district transfers

6. Please provide a complete accounting of all reprogrammings received by or transferred from the agency in FY 2022 and FY 2023, to date. For each, please provide a narrative description as to the purpose of the transfer and which programs, activities, and services within the agency the reprogramming affected.

DBH Response:

Please see attached document titled, "FY22 Oversight Question 6 Attachment 1 of 1. Reprogramming".

7. Please provide the following information for grants/sub-grants awarded to and by the agency in FY 2022 and FY 2023, to date, broken down by 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. Organization or agency that received the grant;
    g. Grant amount;
    h. Grant deliverables;
    i. Grant outcomes, including grantee/subgrantee performance;
    j. Any corrective actions taken or technical assistance provided;
    k. Agency program and activity supported by the grant; and
    l. Agency employee responsible for grant deliverables.

DBH Response

Please FY22 Oversight Question 7. Attachment 1 of 2. FY22-23 Grants, and FY22 Oversight Question 7. Attachment 2 of 2. FY22 SubGrants

8. Please provide the following information for all contracts, including modifications, active during FY 2022 and FY 2023, to date, broken down by program and activity:
    a. Contract number;

b. Approved Budget Authority;
c. Funding source;
d. Expenditures (including encumbrances and pre-encumbrances);
e. Purpose of the contract;
f. Name of the vendor;
g. Original contract value;
h. Modified contract value (if applicable);
i. Whether it was competitively bid or sole sourced;
j. Final deliverables for completed contracts;
k. Any corrective actions taken or technical assistance provided; and
l. Agency employee(s) serving as Contract Administrator.

DBH Response:

Please see FY22 Oversight Question 8A Attachment 1 of 1. Contracts

8. Please provide a list of all Department of General Services work orders submitted in FY 2022 and FY 2023, to date, for facilities operated by the agency. Please include the date the work order was submitted, whether the work order is completed or still open, and the date of completion (if completed).

DBH Response:

Please see Attachment 1 of 1. DGS

9. Please provide a complete accounting of all DBH's Special Purpose Revenue Funds for FY 2022 and FY 2023, to date. 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 FY 2022 and in FY 2023, to date;
   d. DBH activity that the revenue in each special purpose revenue source fund supports; and
   e. The FY 2022 and FY 2023, to date, expenditure of funds, including purpose of expenditure.

DBH Response:

Please see FY22 Oversight Question 9 Attachment 1 of 1. Special Purpose Revenue

10. Please provide copies of any investigations, reviews or program/fiscal audits completed on programs and activities within DBH during FY 2022 and FY 2023, to date. 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 a chart with the following:

a. Name of the provider;
b. Date complaint was received;
c. Type of complaint;
d. Referral source;
e. Type of report;
f. Summary or complaint or allegations;
g. Conclusion(s);
h. Recommended outcomes or actions; and
i. Date completed.

DBH Response:

The Office of the Inspector General
During FY 22, the Office of the Inspector General (OIG) did not complete any audits on DBH programs and activities. The OIG began an audit of nine agencies' overtime usage that includes DBH that is continuing in FY 23. According to the OIG, the objectives of this engagement are to assess: (1) overtime usage by District agencies; (2) adherence to District overtime policies; and (3) the effect overtime usage has on District operations.

The DC Auditor
During FY 22, the DC Auditor issued one report related to DBH: "NEAR Act Violence Prevention and Interruption Efforts: Opportunities to Strengthen New Program Models." Enacted by the Council in 2016, the Neighborhood Engagement Achieves Results (NEAR) Act was a comprehensive blueprint for a public health approach to criminal justice reform in the District. The ODCA reviewed the implantation and impacts of the NEAR Act to see if the law was implemented as intended and what impacts could be demonstrated from its first five years. As it relates to DBH, the report made the following recommendation:

Recommendation #12. The Metropolitan Police Department should comply with the law by establishing the Community Crime Prevention Team program, in partnership with the Department of Behavioral Health and the Department of Human Services.

The response of the Office of the Deputy Mayor for Public Safety and Justice (DMPSJ) to the recommendation is copied below and can be found on pages 94-95.

DMPSJ Response: Disagree. ODCA's finding that MPD, DBH, and the Department of Human Services (DHS) failed to implement the provision on the Community Crime Prevention Team (CCPT) is contrary to Council action on that provision. As part of her FY 2018 Budget, Mayor Bowser proposed that Council accept the plans for the Pre-Arrest Diversion Pilot in lieu of the CCPT. DBH, with the support of MPD and DHS, presented the proposal to the Committee on the Judiciary and Public Safety staff. The Committee accepted the plan and chose to fund it. Per the

"Report and Recommendations of the Committee on the Judiciary and Public Safety on the Fiscal Year 2018 Budget for Agencies under Its Purview" (May 18, 2017, pp. 138-139): The budget provides $970,544 to launch a new arrest diversion program to support individuals in crisis due to problems associated with substance abuse, mental health, or homelessness.

As Chief Newsham noted during the Department's budget oversight hearing: "Comprehensive harm reduction strategies can help to move some of the issues from the law enforcement arena to the public health and services realm where they belong." The program is intended to satisfy the requirements of Section 105 of the NEAR Act – the Community Crime Prevention Team Program – although its structure is different. . . . It is the Executive's intention to develop intervention strategies by service agencies with expertise in these areas, and the Mayor's Errata Letter recommends transferring the funds to the Department of Behavioral Health ("DBH"). . . . The Committee supports the intent of this proposal . . . The Executive recommends ODCA mirror its recommendation #8 that Council should amend the NEAR Act to reflect what it has already agreed to as embodied in the Committee report and as accepted at oversight hearings. The recommendation would appropriately lodge responsibility for developing and reporting on behavioral health diversion programs with DBH rather than MPD.

In addition, the DMPSJ made the following comments:

Before responding to the audit's specific recommendations, we provide some general comments. Overall, the report went into great detail on a few of the NEAR Act provisions, such as the successful security camera rebate program, yet it glossed over other programs, like the MPD/Department of Behavioral Health (DBH) partnerships. DBH and MPD are actively working on several projects to best meet the needs of community members. These new efforts include the 911 Alternative Response Program, enhanced training for MPD members, a Sobering Center, and initial work on a "familiar faces" protocol. The agencies also will be reviewing various co-response and other models to see how they can best be used and tailored to the unique needs of District residents. DMPSJ is also involved in coordinating these efforts.

In the section entitled "The Metropolitan Police Department, the Department of Behavioral Health, and the Department of Human Services did not establish the Community Crime Prevention Team program required by the NEAR Act," the ODCA theorizes that DBH would have less input into training needs with MPD than it would have had under the original plan envisioned in the NEAR Act. However, this speculation is incorrect. DBH provides Crisis Intervention Officer (CIO) training to MPD and, in FY 2022, DBH began providing Mental Health First Aid for First Responders (MHFA). By the end of the 2023 training season, all MPD officers will have had either CIO or MHFA training. Both trainings are based on comprehensive national or international models. This year, MPD hired a Behavioral Health Partnerships Coordinator to continue to strengthen the department's work to serve individuals with behavioral health needs and the communities in which they live. The new MPD staff member previously worked for DBH and is a Licensed Professional Counselor. She has experience working with individuals diagnosed with severe and persistent mental illness or who are in need of immediate crisis intervention. Her research focus is on trauma and Post Traumatic Stress Disorder in underserved populations. That said, the majority of the work to develop programs to support

individuals with behavioral health needs will continue to rest with DBH, which has the most expertise in this area. For example, DBH conducted the research and determined the Law Enforcement Assisted Diversion (LEAD) model recommended in a 2017 Committee on the Judiciary and Public Safety report would not be appropriate for the District.

In addition to the work that MPD and DBH have already done together, the Deputy Mayor for Public Safety and Justice (DMPSJ) is bringing together MPD, DBH, and the Fire and Emergency Medical Services Department (FEMS) to discuss a larger, more comprehensive approach to mental health preventative care in lieu of arrest or hospitalization at the point of crisis.

The DBH Accountability Administration
The DBH Accountability Administration conducts the following program/fiscal audits:

- Claims Audits

The Accountability Administration conducts audits of paid claims for each fiscal year for certified providers. The auditing process is retrospective and generally crosses fiscal years. Audits are conducted annually for Mental Health Rehabilitation Services (MHRS), Adult Substance Abuse Rehabilitative Services (ASARS) and Free Standing Mental Health Clinics (FSMHC) providers on a sample universe which includes all paid claims. All audit samples are random, statistically valid, and generated using RAT-STATS, a tool developed for this purpose by the Federal government. In addition, focused audits are conducted for a variety of reasons and the sample universe may be tailored to the reason for the audit. Focused audit samples may be generated using methods appropriate to the purpose of the audit. The corrective action plan section below explains what happens in response to audits and reviews by the Accountability Administration.

In FY 22 and to date in FY 23, the following audits and audit activities were conducted:

- 33 focused and annual audits for FY 22 MHRS claims
- 20 focused audits for FY 21 and FY 22 SUD claims
- 8 annual audits for FY 21 Free Standing Mental Health claims
- 5 audits for FY 21 Supported Employment claims

Audits for FY 22 Supported Employment claims are scheduled for April 2023. Preliminary audit results are anticipated to be completed by the end of September 2022. Audits are continuing for FY 22 MHRS claims.

Providers have an opportunity to contest claims audit findings. A Claims Review Committee (CRC) that includes providers is set up to as needed to review and evaluate failed claims about which the provider and DBH disagree. During FY 22, six Claims Review Committees reviewed 77 claims.

Based on the audit findings, a provider may be required to repay the amount of the failed claims. Below is the recoupment amount for FY 21 and FY 22 to date Medicaid and local funds.

Medicaid $61,121.00

Local	$9,181.77
Total	$70,302.77

Appeals for FY22 Recoupments:
No appeals have been submitted to date.

- **Investigations**

Investigatory reports may include recommendations for policy changes, training, corrective action plans, or disciplinary action when allegations are substantiated. All corrective action plans are considered during the licensure and re-certification process.
See Attachment 1. Investigatory reports

The Accountability Administration requires providers to submit Corrective Action Plans (CAPs) for compliance and quality deficiencies identified during claim audits or during other routine monitoring. Statements of Deficiencies (SOD) are issued to Mental Health Community Residence Facility (MHCRF) operators for failure to comply with licensure regulations. SODs also are issued for failure to comply with DBH certification regulations. Each provider is assigned a primary Accountability Administration contact who collaboratively monitor CAPs and SODs. In addition, the Accountability Administration provides training on compliance planning and proper claiming. Information from audits and other reviews is used to inform the overall technical assistance plan for each provider.

11. Did DBH meet the objectives set forth in the performance plan for FY 2022? Please provide a narrative description of what actions DBH undertook to meet the key performance indicators. For any performance indicators that were not met please provide a narrative description for why they were not met, and any remedial actions taken. In addition, please provide a narrative description of the performance objectives for FY 2023 and what actions DBH has undertaken to meet them to date.

DBH Response

Please see Attachment 1 of 2. FY 22 Performance Plan KPI Report and Attachment 2 of 2. FY 23 KPI Report.

12. Please provide DBH's capital budgets for FY 2022 and FY 2023, including amount budgeted and actual dollars spent. In addition, please provide an update on all capital projects undertaken in FY 2022 and in FY 2023, to date.

DBH Response:

Please see attached document titled, "FY22 Oversight Question 12 Attachment 1 of 1. Capital Projects".

Project updates:

Project HC990C. The Facility Upgrade project at St Elizabeths Hospital. The Automatic Transfer Switch (ATS) for the kitchen electrical upgrade has been affected by supply chain delays. The vendor is expecting to receive the parts needed to complete the ATS build by early February. Subsequently, they are projecting the build to be complete by the end of February and ready to ship in early March; arriving at Saint Elizabeths by the middle to end of March. Additionally, a change order to update a breaker in the electrical cabinet to complete the connections is being issued.

Project HX995C. The Systems Transformation project is divided into four components: Integrated Technology Engine (ITE), iCAMS reconfiguration, grants management system, and credentialing/certification database.

The ITE project is in its second year (Phase 2). DBH works closely with vendor, IdeaCrew, to design and implement a data repository to enable DBH to use client level data to manage Whole Person Care/population health in support of the agency's system transformation goals. DBH is working with DHCF, ESA, MPD, OUC, CRISP DC as well as other governmental agencies to receive a rich data to monitor and shape a District behavioral health model. The ITE will interface with DBH's eHRs, grants management system, and certification database. Phase 2 of the project is scheduled to be completed by mid-summer.

ICAMS reconfiguration project has finished the scope of work and requirements. The vendor, QualiFacts, will begin to work with the Office of Contracting and Procurement to finalize a contract. The project will support the system of care at the DBH practice management system/electric health record. The project is scheduled to be completed in late summer.

Currently, grants are managed using a SharePoint site. The grants management system project currently underway will the utilize a SalesForce database to build a comprehensive grants management system. The project will be implemented in conjunction with OCTO. The project is scheduled to be completed by September 30, 2023.

DBH through the same arrangement with OCTO will utilize a SalesForce database to implement a credentialing/certification database. The database will be the repository for documents and data used to certify behavioral health providers in the District. In addition, the database will house documents to credential DBH employees as MCO and other health care payer providers.

Project HX999C. The server replacement and database hub configuration project is being developed in consultation with OCTO. DBH is exploring all feasible options including site based and cloud-based models with vendors.

13. For each Mayoral Board, Commission, or Council overseen by DBH, please provide an updated list of members, including when their terms started and end, and their contact information. Please indicate any vacant positions.

DBH Response

The Department of Behavioral Health (DBH) does not oversee any Mayoral Board, Commission or Council.

14. Please provide an update on the upgrade of the provider electronic health record (EHD) systems including the selection of the vendor that will offer technical assistance to providers and the consultant that will assist DBH in developing the data sets (encounter file) that providers will produce monthly through their EHRs.

DBH Response:
DBH collaborated with the Department of Health Care Finance (DHCF) Home and Community Based Services (HCBS) Digital Health Technical Assistance (TA) Grant Program to develop the scope of work for behavioral health providers to receive technical assistance and funding to procure an electronic health record (EHR). The HCBS TA program will incentivize DBH-contracted providers to meet milestones for adopting and implementing a Certified Electronic Health Record Technology (CEHRT) system and connecting to the DC Health Information Exchange (DC HIE) by September 30, 2023.

Currently, 67 eligible behavioral health providers are participating in the HCBS TA grant program. The program provides tailored TA and training to HCBS providers including assessing provider readiness to select and adopt a new Health IT system; support system implementation and ensure connectivity to and use of the DC HIE. The HCBS Digital Health TA Team under the direction of DHCF is led by DC Primary Care Association (DCPCA). DC PCA has partnered with Clinovations, Zane Networks and CRISP DC to support behavioral health providers.

DBH selected IdeaCrew to support the development of the Behavioral Health Supplemental Data (BHSD) extract. BHSD is client level information on clients receiving behavioral health services. DBH along with IdeaCrew has produced a companion guide that serves as instruction and validation rules to assist providers in the successful submission of a monthly extract to DBH. BHSD extract from DBH contracted providers together with DHCF claims data will allow DBH to meet federal funding reporting requirements and state reporting needs. BHSD extract will provide necessary data to

DBH to support the transition to Whole Person Care (WPC) service delivery, outcome-based care and population behavioral health.

15. Please provide a list of all FTE positions detailed **to** DBH, broken down by program and activity for FY 2022 and FY 2023, to date. Include a narrative on specific role the detailed staff took at DBH during their detail. In addition, please provide which agency the detailee originated from and how long they were detailed to DBH.

DBH Response

There were no FTE positions detailed to DBH in FY 22 and to date in FY 23.

16. Please provide a list of all FTE positions detailed **from** DBH to another agency in FY 2022 and in FY 2023, to date. In addition, please provide which agency the employee was detailed to, what work they took on, and for how long.

DBH Response

There are no FTE positions detailed from DBH to another agency in FY 22 and to date in FY 23.

17. Please provide the following information for grants (regardless of source) awarded to DBH during FY 2022 and FY 2023, to date, 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;
    j. Organizations or agencies that received the grants; and
    k. DBH employee responsible for grant deliverables.

DBH Response

Please see FY22 Oversight Question 17. Attachment 1 of 1. FY22-23 Grants Awarded

18. 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 FY 2020 to FY 2021 or FY 2022 to FY 2023 and a detailed explanation as to why it occurred.

a. Please provide an update on the District of Columbia Opioid Response grant where there was a grant lapse due to underspending in Contractual and Sub grants.

DBH Response

Please see FY22 Oversight Hearing Question 18. Attachment 1 of 1. Grant Lapse Report

Providers, Core Service Agencies (CSAs), & Agency Partnerships

19. Please provide a comprehensive list, in Microsoft Excel, of all DBH providers and Core Service Agencies (CSAs) that serve children, youth, and adults. Include the following information:
    a. Name of provider;
    b. Location(s) (including ward) where services are provided;
    c. Types of services (indicate whether virtual, in-person, or hybrid);
    d. Populations served (ages, LGBTQ+, seniors, justice involved, experiencing homelessness, newly arrived migrants, returning citizens, etc.); and
    e. How many consumers were served in FY 2021, FY 2022, and in FY 2023, to
    f. date.

DBH Response

See Attachment 1 of 3 FY 22 DBH Certified Providers
Attachment 2 of 3 Certified Agencies by Ward
Attachment 3 of 3 Consumers Served

20. Please provide any updates on how DBH ensures the quality of behavioral health services within its provider network.

DBH Response

Quality of services is measured in numerous ways such as claims audits, medical reviews, fidelity reviews, and consumer interviews. These are practices used by the Centers for Medicare and Medicaid Services, National Committee on Quality Assurance, and the Joint Commission.

To measure the quality of the children and youth services provider network, DBH utilizes several methods to measure quality of services. DBH contracts with model developers and

purveyors to complete annual fidelity reviews to assess each provider's adherence to Evidence- Based Practice models. Community-Based Intervention or (CBI), DBH's most intensive outpatient service, utilizes a third-party consultant, the Center for Innovative Practices at Case Western Reserve University, to assess fidelity by reviewing each agency's compliance with model components including: intensity of service, crisis response and availability, safety planning, and team composition. DBH also reviews all Evidence-Based Practice (EBP) outcomes for child and youth evidence- based programs on a monthly basis to assess the impact of services on the youth served. The outcome measurement utilized is the number of successful discharges. Each model also utilizes an assessment tool that rates behaviors and symptoms in the beginning of treatment and end of treatment.

In addition, DBH utilizes the Child & Adolescent Functional Assessment Scale (CAFAS) and the Pre-school & Early Childhood Functional Assessment Scale (PECFAS) to determine level of care and track functioning throughout treatment. CAFAS was also identified as the Key Performance Indicator (KPI) to measure the performance of cases. DBH contracts with the developer to provide system access for completion of the tool for all DBH-Certified child and youth behavioral health providers and School-Based Behavioral Health (SBBH) providers. Providers may access an individualized report to guide treatment planning. DBH analyzes reports to monitor provider performance as well as how children and youth are improving over their course of treatment.

Results of the fidelity reviews and system performance on the CAFAS/PECFAS outcomes are shared with DBH and the providers. DBH uses the results to inform areas such as policy, training, and technical assistance plans.

DBH also uses fidelity reviews of Evidence Based Practices for Supported Employment and Assertive Community Treatment (ACT). Supported Employment providers are evaluated annually for fidelity to the model. DBH utilizes these practices to ensure quality in our behavioral health provider network in addition to offering training and technical assistance.

DBH also conducts consumer satisfaction surveys of consumers receiving mental health and substance use services from community providers, as well as individuals in care at Saint Elizabeths Hospital. If there are significant adverse findings of consumer satisfaction that rise to the level of concern, DBH refers these to the DBH Ombudsman, the Accountability Administration, or both depending on the nature of the report. This information is also used to improve service delivery at the systems level.

DBH uses data produced by the annual claims audit to plan and hold specific training and clinical technical assistance to address identified challenges. DBH provides quality and compliance trainings and provided technical assistance to providers (particularly to new providers) based on review of provider service documentation. DBH also provides ongoing technical assistance to new and existing providers to address clinical practice.

The DBH Training Institute examines trends to find areas where providers are not performing well and develops training to address these areas. In addition, the DBH Training

Institute supports quality service through classroom training and eLearning in a wide range of best-practice mental health and substance use areas targeting direct service practitioners, clinical supervisors/managers, consumers, and leaders of the provider network.

21. Please share the specific steps DBH continues to take to ensure consumers living in DBH supported housing have been protected from contracting COVID?

DBH Response

The Accountability Administration Division of Licensure expanded its COVID-19 mitigation efforts by continuing vaccine booster efforts, partnering with The Project First Line Task Force and utilizing grant funds to decrease the spread of COVID-19 in our Mental Health Community Residence Facilities (MHCRF).

DBH partnered with DC Health's Project First Line Task Force in January 2022 to provide training materials, job aids/infographics, and other resources to MHCRF operators to help prevent the spread of COVID-19. This partnership provided the opportunity for our Licensing Inspectors to receive training required to become a Project First Line facilitator. As facilitators, our Licensing Inspector present training materials and resources to MHCRF staff and operators during quarterly trainings. DC Health continues to provide updated materials and information weekly to the Licensure Team in efforts the reduce the spread of COVID-19 within our MHCRF community.

DBH was awarded $125,000 from the Mental Health Block Grant (MHBG) Supplemental Funding for COVID Mitigation for use during the FY22 fiscal year. These grant funds were used to provide Personal Protective Equipment, rapid COVID testing, technical assistance on implementing rapid COVID test, and training on how to develop onsite testing confidentiality policies. DBH distributed COVID mitigation supplies to ninety-three (93) MHCRFs. COVID mitigation supplies were also provided to five (5) residential substance use disorder treatment programs.

In addition to the PPE supplies and test kits the Department was able to provide two (2) virtual trainings. The trainings focused on instructing staff on how to safely assist MHCRF residents with self-administering At-Home COVID-19 Testing.

The Division of Licensure continues to work collaboratively with the owners, operator and staff members of the MHCRFs. Next to education, vaccination remains one of best tools we have against COVID-19. Building on the progress of FY21, DBH Licensure Division partnered with Ascension Health of the Providence Health System to provide in-home booster shots to an additional 123 MHCRF residents. At the conclusion of our efforts 71% of residents who received the initial vaccine in FY21, were fully vaccinated and boosted by May of 2022. In comparison to a year prior when 20% of the residents who received their first vaccine had also received their booster shot.

22. How many grievances were filed against DBH providers and DBH during FY 2022 and FY 2023, to date? How many external reviews were filed in FY 2022 and in FY 2023, to date? How many external reviews found in favor of the consumer? How many of those external review determinations in favor of the consumer were approved by the DBH Director?

DBH Response

During FY 22, DBH received a total of 52 grievances, of which 32 were filed against DBH and 20 against certified community providers. Two external reviews were held, of which one was found in favor of the consumer and approved by the DBH Director.

During FY 23 to date, DBH received a total of 18 grievances, of which 15 were filed against DBH and three against certified community providers. One external review has been requested.

23. Please provide a list and narrative description of any DBH partnerships with District agencies in FY 2022 and FY 2023, to date, to address employment for DBH consumers. Please include the following:
    a. The number of individuals served, the types of employment placements available, and the employee(s) responsible for coordinating the partnership;
    b. The number of participants who entered post-secondary or occupation training program, apprenticeships, or District employment programs; and
    a. For DBH's partnership with Rehabilitation Services Administration (RSA) please provide the names of any organizations or agencies providing services through the Evidence-Based Support Employment program for FY 2022 and FY 2023, to date. Include a breakdown of how many participants were hired and where they were employed. Indicate whether any of the placements were in subsidized or temporary positions.

DBH Response

The Evidence-Based Supported Employment program serves adult consumers with a serious mental illness or substance use disorder for whom competitive employment has been interrupted or intermittent as a result of significant mental health or substance use challenges.
Evidence-Based Supported Employment strives to help enrollees obtain part-time or full-time employment. The consumer receives supports in a competitive employment setting that pays at least the minimum wage. The program offers intake, assessment, job development, treatment team coordination, disclosure counseling, benefits counseling and follow-along supports for all participants enrolled in the program.

DBH provides this program in partnership with Department of Disabilities Services (DDS), and Rehabilitation Services Administration (RSA) through a memorandum of understanding (MOU). As stipulated in the MOU, RSA provides funding to six DBH-certified Evidence-Based Supported Employment programs using a "pay for performance" methodology. Providers receive payment for meeting specified milestones for the following services: job development, job placement, and job stabilization for shared consumers.

a. *The number of individuals served, the types of employment placements available, and the employee(s) responsible for coordinating the partnership;*

DBH's Supported Employment programs served a total of 381 consumers in FY 22 and 41 to date in FY 23. In FY 22, 199 consumers received job placement and retention services, while 18 consumers received job placement services to date in FY23.

Employees responsible for coordinating the partnership:
Melody Crutchfield - DBH Supported Employment Program Manager
Catherine Pitts - DBH Supported Employment Program Analyst

b. *The number of participants who entered post-secondary or occupation training program, apprenticeships, or District employment programs:*

Although the goal of DBH's Supported Employment programs is rapid placement into competitive employment, we also placed individuals in training and education programs. Please see Table 1 for the number of individuals placed in training and education programs in FY 2022 and FY 2023.

Table 1. Support Employment: Training and Education

	FY22	To Date FY23
Participants Entered Post-Secondary Education Programs	16	1
Occupational Training Programs	2	0
Participated in Apprenticeships	0	0
Entered District Employment Programs	0	0

c. *For DBH's partnership with Rehabilitation Services Administration (RSA) please provide the names of any organizations or agencies providing services through the Evidence-Based Support Employment program for FY 2022 and FY 2023, to date. Include a breakdown of how many participants were hired and where they were employed. Indicate whether any of the placements were in subsidized or temporary positions.*

The partnership with RSA supports six DBH certified Supported Employment programs. Please see Table 2 for the number of consumers placed by each of the Supported Employment providers.

Table 2. DBH Evidence-Based Support Employment FY 22		
Name of Agency	Number of Placements	Subsidized or Temporary
Anchor	61	0
Community Connections (CC)	13	0
MBI	25	0
PCC	44	0
PSI	15	0
Hillcrest	41	0

DBH Evidence-Based Support Employment FY 23		
Name of Agency	Number of Placements	Subsidized or Temporary
Anchor	4	0
Community Connections (CC)	0	0
MBI	4	0
PCC	3	0
PSI	2	0
Hillcrest	5	0

Please see Attachment 1 of 1. Placements Report which lists the number and types of placements made by each agency during FY 22 and FY 23.

DBH has partnerships with the following District agencies to help residents with behavioral health challenges obtain and keep employment with ongoing support.

Department of Employment Services (DOES)
DBH partners with the Department of Employment Services (DOES) to provide onsite behavioral health support, screening and referral for DC residents who participate in DOES' Job Readiness Programs, specifically DC Career Connections and Project Empowerment. This partnership promotes behavioral health wellness and prepares participants to have a comprehensive and well-rounded experience leading to long term employment success and economic stability. During FY22, there were two (2) DBH onsite clinicians who screened and referred 591 residents to behavioral health resources and services. In FY23 to date, DBH has screened and referred 240 DC residents.

Office of the Deputy Mayor for Planning and Economic Development (DMPED) New Communities Initiatives

DBH partners with the Office of the Deputy Mayor for Planning and Economic Development (DMPED) New Communities Initiatives (NCI) to support the behavioral

health needs of residents living in the following four NCI neighborhoods: Barry Farm, Park Morton, Lincoln Heights/Richardson Dwelling, and Northwest One. DBH provides two onsite Mental Health Clinical Specialists (MHCS) to provide behavioral health support, screenings/assessments, and linkage to supports and services.

During FY22, the two DBH Mental Health Clinical Specialists were co-located at the four NCI Neighborhood designated sites and provided behavioral health support to 54 residents via screening, referral, care coordination and solution focused sessions. They also provided 137 consultations to the case managers and partners working directly with residents impacted by unaddressed behavioral health needs. The MHCS also conducted 14 behavioral health workshops which yielded a total participation of 237 residents who live in NCI neighborhoods.

In FY23 to date, the Mental Health Clinical Specialists have provided behavioral health support to 18 residents via screening, referral care coordination and brief solution focused sessions. The DBH MHCS provided 11 behavioral health consultations to case managers and partners working with residents of the NCI neighborhoods. During FY23 to date, four workshops have been conducted serving 18 residents of NCI neighborhoods.

The employee responsible for coordinating the partnerships with the Department of Employment Services (DOES), and Office of the Deputy Mayor for Planning and Economic Development (DMPED) is Kim Ray

24. 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 FY 2022 and in FY 2023, to date?

DBH Response

DBH continues its partnership with the Department of Human Services (DHS), Economic Security Administration (ESA) to better assist TANF customers who may face behavioral health challenges. In FY 22, three hundred and sixty-one (361) TANF customers were screened and referred to providers for ongoing behavioral health services. In FY23 to date, one hundred and eleven (111) individuals have been screened and referred for ongoing behavioral services.

25. Please provide the list of services currently available as part of the Mental Health Rehabilitation Services (MHRS) system. Specifically, please provide a description of

each service and indicate whether it is available as part of the Medicaid MHRS program, the non-MHRS program, or both. In addition, please provide the FY 2022 and FY 2023 reimbursement rates for each service.

DBH Response:

Please FY22 Oversight Question 25 Attachment 1 of 1. MHRS Funding Medicaid Local Both
In the attachment, if a service is paid by Medicaid and local funds, there is a "Y" (Yes) in the column for "Medicaid". If a service is paid by local funds only, there is a "N" (No) in the column for "Medicaid".

26. Please provide the monthly MHRS utilization data for FY 2022 and to FY 2023, to date. Please include:
    a. A breakdown of Medicaid MHRS vs. non-Medicaid MHRS;
    b. For Medicaid MHRS, provide a breakdown by managed care vs. fee-for-service (and include a breakdown by specific managed care organization); and
    c. For non-Medicaid MHRS enrollees, indicate whether the individual had coverage via the DC Healthcare Alliance or was uninsured.

DBH Response

Please FY22 Oversight Question 26 Attachment 1 of 1. MHRS Utilization FY22_FY23

DBH currently is not able to link the insurer information (MCO, Alliance) to an individual client. With the implementation of the Integrated Technology Engine (ITE), DBH will be able to link Economic Security Administration (ESA) insurance coverage to individual clients. DBH anticipates that this feature for the ITE will be available in late summer.

27. Please provide, for FY 2021, FY 2022, and FY 2023, to date, the name of all certified MHRS providers. For each provider, please indicate whether or not the provider utilizes the Medicaid MHRS program, the locally-funded MHRS program, or both.

DBH Response:

Please see Attachment 1 of 1. Certified MHRS Providers by Funding Source FY21-FY22-FY23".

28. Are there any services provided through CSAs or other mental health providers that are not currently reimbursed by Medicaid? If so, please indicate whether these services will be

reimbursed under DC's approved 1115 waiver or could be reimbursed under a 1915(i) state plan option, a waiver, or a demonstration project.

DBH Response:

Please see document attached titled, "FY22 Oversight Question 28 Attachment 1 of 1. MHRS Services Not Reimbursable by Medicaid".

From this list, Transition Planning Services is included in the 1915i expansion of the State Plan Amendment. In addition, Transportation for medical appointments currently is a Medicaid benefit.

29. Please provide a description of all housing programs administered by DBH. For each, please provide the following information:
    a. Name of the program, services provided, and eligibility requirements;
    b. Number of individuals served in FY 2022 and FY 2023, to date;
    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 experiencing homelessness or in other housing programs.

DBH Response

DC Local Rent Supplement Program (LRSP)
The LRSP is administered by the D.C. Housing Authority (DCHA). The program follows the eligibility requirements and rules and regulations of DCHA's federally funded voucher program. DBH makes referrals for initial occupancy and backfill of vacancies for LRSP vouchers attached to newly renovated or developed units funded with DBH capital dollars for 25 years. The LRSP vouchers are attached to single-room occupancy (SRO) units and to apartments.

Home First Housing Voucher Program
The locally funded Home First Program provides housing rental vouchers for individuals and families who live in the apartment or home of their choice and sign their own rental leases. Consumers pay thirty percent (30%) of their household income to the landlord toward their rent and the Home First Program subsidizes the balance of the rental amount.

Supported Residences (Licensed Mental Health Community Residential Facilities)

- Intensive Rehabilitative Residence (IRR)

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

- Supportive Rehabilitative Residence (SRR)
  A SRR CRF provides 24-hour, structured housing support for consumers with severe and persistent mental illness who need an intense level of support to live within the community. 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 one-to-one 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)
  A SR CRF provides 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, implementation, and follow-up.

Number of Individuals Served in FY22 and FY23-1Q and *Capacity of the program*
In FY 22, the capacity of the supported housing program increased by 78 rental housing vouchers and 10 placements in supported residences.

Table 1.	**Housing Capacity and Consumers Served**			
Supported Housing Program	FY22 Capacity	Consumers Served FY22	FY23 Capacity	Consumers Served FY23 Q1
Site-based Vouchers				
DBH Capital-Funded Housing (LRSP Vouchers)	210	214	210	210
Rental Vouchers				
Home First (Vouchers)	878	828	878	780
Mental Health Community Residential Facilities (MHCRFs)				
Intensive Residence (IR)	8	8	8	8
Supportive Rehabilitative Residence (SRR)	188	191	204	183
Supportive Residence (SR)	445	424	429	376

Total Supported Housing	**1,729**	**1,665**	**1,729**	**1,557**

Performance measures and associated outcomes for each program

Table 2. Housing Program Performance Measures and Outcomes

Quality Domain	Performance Measure	Outcome
Housing Tenure/Stability	75% of consumers will maintain community tenure in independent housing for 12 months or longer	92% in FY22
Housing Occupancy	DBH will maintain an 80% or greater occupancy rate within its subsidized housing program	FY22 : 94% FY23-Q1: 92%
Availability of Housing Services/Supports	80% of consumers in subsidized housing will enroll with a Core Service Agency to receive mental health services and supports	83% enrollment
CRF Placement Stability	90% of consumers who remained in the CRF placement for at least 90 days from move-in date, with no psychiatric hospitalizations, incarcerations, crisis bed placements, or involuntary discharges.	86%

Name and title of the DBH employee responsible for administering the program
Brandi Gladden, Director – Housing Development Division, is the DBH employee responsible for administering the DBH housing programs.

The average wait time for a consumer to access housing through the program
The average time between referral and placement is four to six weeks.

The number of individuals on waiting lists for the program
DBH does not maintain a waiting list for housing. DBH requires certified providers to assess housing needs at the time of intake and for consumers to indicate if they want to be considered for housing resources when they become available. Individuals who request a rental housing voucher self-report whether they are homeless, living on the streets or in a shelter, living temporarily with families or friends, or living place to place. They also can report if they are rent burdened, at risk of eviction, or living in substandard housing. This information is entered into the consumer's electronic medical record. This process has been commonly referred to as a "waiting list" but it is a self-report of housing needs. When a rental housing voucher becomes available, DBH notifies providers and works with them to determine eligibility of current consumers. Since interest far exceeds available vouchers, consumers experiencing homelessness who are living on the streets or in a shelter are prioritized. This process does not apply to supported residences where placement is determined by level of need.

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

As indicated above, at the time of intake, individuals self-report their living situation. Individuals who request a rental housing voucher often seek support from other available housing programs as well.

30. DBH regulations provide that DBH conduct targeted compliance reviews of CSAs supported housing assessments and report the results to each CSA under review. DBH policies also require that DBH monitor certified providers to ensure compliance with DBH's housing procedures and programs, and that DBH utilize routine oversight and monitoring activities to determine whether CSAs are meeting their supported housing objectives. How does DBH conduct targeted compliance reviews and monitor certified providers to ensure compliance with its housing procedures and programs? What type of oversight and monitoring does DBH conduct to determine whether CSAs are meeting their supported housing objectives?

DBH Response

DBH monitors the performance of Core Service Agencies (CSAs) and operators through established protocols to ensure their compliance with Housing Program regulations and procedures. DBH Housing staff schedule regular, bi-monthly meetings with all CSA Housing Liaisons to review their protocols and their eligibility for available DBH housing resources. In addition, DBH Housing staff are in constant communication via e-mail and phone calls with CSA Housing Liaisons and Community Support Workers (CSWs) to provide technical assistance, answer questions and reinforce housing protocols and policies. When a consumer in housing is reported to be in crisis or experiencing behavioral challenges, DBH Housing staff immediately engage CSA Housing Liaisons to offer guidance and direction to ensure the consumer can successfully maintain their housing. The DBH Ombudsman and the Accountability Administration are also engaged as necessary to address situations where a CSA is not in compliance with DBH housing protocols and policies.

31. Please provide any updates regarding wheelchair accessibility of Mental Health Community Residential Facilities (MHCRF) and Supported Independent Living (SIL) providers within the DBH system?

DBH Response

Seven of 92 licensed MHCRFs are wheelchair accessible. DBH no longer contracts with Supported Independent Living (SIL) providers. All providers are expected to provide functions that support independent living that are Medicaid reimbursable.

32. What is the average wait time for consumers to become a resident in an accessible MHCRF from the date of the application or request? What is the same average wait time for SIL?

DBH Response

An application for a MHCRF requires the completion of a Level of Care assessment to determine the most appropriate placement in supportive housing. The assessment includes a determination of whether an MHCRF is required and available at the time. Typically this process can take 90+ days between the time the Level of Care assessment is completed and approved, and the consumer moves into an accessible MHCRF bed.

In FY 21, DBH ended contracts funded with local dollars to provide Supported Independent Living services with providers who operate congregate living settings as these supports are Medicaid reimbursable. All DBH certified providers are expected to provide services to support consumers maintain independent living that are Medicaid reimbursable.

33. Of the total number of consumers that DBH serves, what is the number of consumers who are experiencing homelessness? Please provide the number and ages of those consumers under the age of 21. How is this data collected and compiled? How does DBH coordinate with housing and homeless service providers to serve these consumers and populations?

DBH Response

During intake, an individual is asked about their living situation. An individual may self-identify as "homeless" if they are living with family or friends, in a shelter, or living on the street. The numbers below are based on claims data. Please note that DBH identifies 18 years old as the age break between children/youth and adults receiving mental health services and 20 as the age break between children/youth and adults receiving substance use disorder services.

FY 22	Total Utilization	Self-identify as "homeless"	Under the age of 18
Mental Health Services	41,560	7,435 (18%)	33
Substance Use Disorder Services	5,265	1,269 (24%)	1

During FY 22, DBH was engaged in several initiatives with the Interagency Council on Homelessness (ICH), the Department of Human Services (DHS), and the Department of Health (DC Health) to coordinate our efforts in supporting individuals in the District who identified as not having a stable living arrangement. DBH partnered with DHS to address the needs of people living in the encampments at 21st and E St, 25th and VA St, NOMA, and New Jersey and O St to assess consumers with behavioral health needs, connect them to care when appropriate, and to facilitate transitions into permanent housing.

DBH also partnered with the DC Health and ICH to provide services and care coordination within the District's PEP-V sites and shelters to support residents with behavioral health needs. Through our contracted vendor, MBI, DBH delivered on site behavioral health assessments to PEP-V consumers and provided necessary support. In addition, DBH deployed our Intensive Care Coordination teams to engage PEP-V and shelter residents who were no longer connected to an on-going behavioral health provider to facilitate getting those individuals reconnected to care.

34. In FY 2022 and in FY 2023, to date, what array of services and support did DBH provide to homeless consumers? What were DBH's outcomes? How many DBH consumers in FY 2022 and FY2023, to date, who were homeless, were placed in housing?

DBH Response

DBH sees stable housing as a primary factor in overall recovery. DBH-certified providers are required to assess for housing needs, include housing needs on treatment plans, make referrals, and take steps as appropriate to address the housing needs of their consumers.

Consumers who self-report as experiencing homelessness—defined as those without a stable living arrangement, living temporarily with family or friends, living in shelters or living on the streets—receive the full array of behavioral health services as well as priority housing placement. DBH's 24-hour Community Response Team (CRT) regularly engages such individuals through street outreach to build relationships and encourage treatment. The CRT provides on the spot psychiatric assessments, in person counseling and crisis support. The team also assists with obtaining vital documents such as a birth certificate required to engage in services and provides transportation to appointments. In addition, the team conducts outreach and education regarding opioids and other substance use disorder services and distributes life-saving naloxone. During inclement weather or cold emergency alerts, the CRT supports the Department of Human Services (DHS) in outreach and connection to emergency resources.

With respect to children and youth, supports include the community and school-based prevention, early intervention, and treatment services. The school-based teams also partner with the Homeless Outreach Coordinators within the public schools whenever necessary to coordinate behavioral health services and supports. DBH has also partnered with the Youth Economic Justice and Housing Coalition to discuss available behavioral health supports for youth and how to strengthen the partnership between DBH and homeless service providers.

Community Connections and MBI (DBH certified providers) partnered with District youth shelters to link individuals to behavioral health services and refer Transition Age Youth (TAY) to housing at DBH's Transitional Living Facility, Wayne Place. Wayne Place allots a minimum of four slots for young adults who are not able to locate housing at the Department of Human

Services (DHS) facilities because of space and the restriction of the environment. Additionally, the TAY team participates in meetings related to youth homelessness which includes the District's Interagency Council on Homelessness and Community Partnership.

During FY22, DBH provided the following *targeted services* and supports to consumers who are homeless:

- *Projects for Assistance in Transition from Homelessness (PATH)* - is a SAMHSA funded initiative designed to identify, engage, and support people who are experiencing homelessness and help them connect to behavioral health care and permanent housing. PATH targeted activities include: outreach, BH screening and diagnostic treatment, habilitation and rehabilitation, mental health and substance use treatment, referrals for primary care, job training, educational services, and housing.
- *Intensive Care Coordination (ICC)* – DBH's ICC Teams provide care coordination and case management services in PEP-V sites, encampments, and shelters with the goal of helping people select a CSA/provider and ensuring that meaningful connections to care are made before closing a case.
- *Assertive Community Treatment (ACT) services* – Through our provider network, DBH provides behavioral health and crisis services and supports to consumers who are experiencing homelessness including: diagnostic assessment, counseling, medication management, and community support. People who qualify for Assertive Community Treatment also receive this service irrespective of where they are in the community.

Outcomes during FY 22:

- In collaboration with DHS, 105 consumers previously in encampments on DHS' "By Name" lists received case management and 95 of these individuals were permanently housed.
- DBH's ICC Team engaged 404 consumers and a total of 44 were housed during that period of engagement.
- PATH and ICC engaged 264 consumers in PEP-V sites providing care coordination, case management and support.
- 48 consumers who identified as homeless were housed in DBH Community Residence Facilities.
- 15 consumers who identified as homeless were housed with a DBH housing subsidy.
- 17 youths obtained secure housing through the school based homeless program.

35. In FY 2022 and in FY 2023, to date, what range of services and support did DBH provide to consumers who identify as LGBTQ+? Please indicate what services are for children and youth.

DBH Response

DBH requires all our certified providers to offer services (within their scope of practice) to anyone seeking care or to appropriately refer such individuals to a qualified provider, whether an individual identifies as LGBTQ+ or not. DBH repeatedly emphasizes this mandate in our monthly provider meetings to ensure that that those who identify as LGBTQ+ do not experience any barriers to accessing necessary care. In addition, DBH has provided specialized grants focused on *Expanding Access and Retention in Care for Opioid and/or Stimulant Use Disorder Treatment* to Whitman Walker and HIPS targeting especially the LGBTQ population.

This initiative seeks to bring local providers together to: implement strategies that reduce barriers to accessing treatment for targeted individuals with Opioid Use Disorder or Stimulant Use Disorder; re-engage consumers who have unexpectedly or prematurely discontinued treatment; and support current consumers to promote retention, and whole-person care. By addressing the known barriers to care, this initiative seeks to reduce health disparities within this underserved community by improving access to needed behavioral health care services.

During FY22 and FY23 to date, DBH has especially focused on providing a range of services to children, youth and adults who identify as LGBTQ+. Our School Behavioral Health Program (SBHP) clinicians provide prevention, early intervention, and treatment services to children and youth in schools, some of whom identify as LGBTQ+. For example, an SBHP clinician facilitated a prevention group that focused on LGBTQ+ topics within her building. In addition to providing services, DBH also supported training and professional development regarding the needs of this population. In April 2022, the DC School Behavioral Health Community of Practice, through a contract with George Washington University, hosted a training titled "Supporting LGBTQ+ Youth and Clinical Competencies". Behavioral health providers, DBH team members, team coordinators attended the session. This training focused on the following areas: 1) identifying challenges facing LGBTQ+ youth, 2) means by which schools and clinicians can collaborate and leverage the resilience of the youth to promote safety and well-being, and 3) identifying resources to support schools in promoting the safety and well-being of LGBTQ+ youth.

Across various DBH social media pages and platforms targeting Transitional Aged Youth (such as Twitter, Instagram and Facebook), DBH has posted imagery and language promoting inclusion. In June 2022, our Transitional Age Youth (TAY) social media pages highlighted gay pride month by showcasing both globally famous and local individuals who identify as LGBTQ+ who are successfully managing their behavioral health concerns and navigating adulthood. Additionally, our TAY social media pages promoted activities and trainings available throughout the city to LGBTQ+ youth and young adults. In addition, TAY social media pages highlighted the work of "Supporting and Mentoring Youth Advocates and Leaders" (SMYAL), an organization committed to providing queer and trans youth ages 6-24 with safe spaces to express themselves, enhance their coping skills and build community. Many of DBH's behavioral health

providers partner with SMYAL to ensure clients receive the full continuum of services to support their mental health.

To strengthen services for those who identify as LGBTQ+, DBH plans to host a forum in the coming months to hear directly from consumers, family members, providers and community stakeholders on what additional services and trainings are needed to increase access, support and services to those who identify as LGBTQ+.

Children and Youth Services (Non-School Based Behavioral Health)

36. Please provide an update on the work of the children mobile crisis teams. What services are provided? In what languages are Children and Adolescent Mobile Psychiatric Service (ChAMPS) services provided? How many individuals were served in FY 2022 and in FY 2023, to date? Please include the following:

    a. The process for determining what calls are deployable and non-deployable;
    b. The response time for deployable calls including the longest and shortest response times that occurred in FY 2022 and FY 2023, to date, as well as the average;
    c. The number of mobile crisis teams;
    d. How are calls triaged to ensure that a team is available upon request;
    e. The relationships and coordination between the 911 call-takers, Access Helpline, and ChAMPS teams; and
    f. The findings of any review or evaluation of these services.

DBH Response

The Department of Behavioral Health contracts through the Office of Contracts and Procurement for emergency mobile psychiatric services for children and youth. The current contractor is Anchor Mental Health, and the program is called Children and Adolescent Mobile Psychiatric Service (ChAMPS). The ChAMPs program operates 24 hours a day, seven days per week and helps children and youth between six to 17 years of age manage extreme emotional behavior and supports families wherever possible to prevent behavior from resulting in the child needing to be removed from the home or a psychiatric hospitalization. In the cases where a child or youth does require hospitalization, ChAMPs facilitates the referral for both voluntary and involuntary hospitalizations. ChAMPS services also include screening for mental health and substance use needs, crisis stabilization, referral to appropriate resources, including longer-term mental health or substance use services. ChAMPs also provides information dissemination, consultation to parents and service providers and outreach to the community regarding their services.

Services are provided in the community, schools, or in homes for District residents and children living in Maryland in the care and custody of the DC Child and Family Services

Agency. After a family is involved with an emergency crisis intervention service, ChAMPS follows up with them within 24 hours to check on the child's well-being and provides support for up to 30 days post-intervention. The team links children and families to a behavioral health provider for ongoing support. For children already enrolled with a provider, the team communicates the child's status and recommendations based on the intervention. ChAMPS also offers Family Peer Specialist services to support families in the stabilization of their child's behavior and to promote a culture that recognizes, understands, and respects the family's views and preferences.

ChAMPS can provide services in the following languages with support of the Jeenie App: Akateko, Albanian, American Sign Language (ASL), Amharic, Arabic (Algerian Moroccan & Tunisian), Arabic (Egyptian or Sudanese), Arabic (Gulf), Arabic (Iraqi), Arabic (Levantine), Arabic (Modern Standard), Armenian, Bengali, Bosnian, Cape Verdean Creole, Chinese (Cantonese), Chinese (Mandarin), Dari (Persian), Farsi (Persian), French, Greek, Gujarati, Haitian Creole, Hebrew, Hindi, Hmong, Hungarian, Indonesian, Italian, Japanese, K'iche', Karen, Kinyarwanda, Korean, Lao (Laotian), Mam, Nebaj Ixil, Nepali, Oromo, Pashto, Polish, Portuguese, Portuguese (Brazil), Punjabi, Q'anjob'al / Kanjobal ,Q'eqchi, Romanian, Russian, Serbian, Somali, Spanish, Swahili, Sylheti, Tagalog (Filipi), Thai, Tigrinya, Turkish, and Vietnamese. CHAMPS also has one Spanish speaking licensed clinician who can provide services and supports.

The table below shows the total number of calls to ChAMPs for FY22 and FY23 Quarter 1.

Total Served:

Fiscal Year	Total Calls	Individual Number of Children and Youth Served
FY22	1555	607
FY23 Q1	417	161

a. Each call that is routed into ChAMPS is received by a Licensed Clinical Manager who is trained and equipped to make a clinical determination on how to manage crisis calls. In making their clinical determination, the Licensed Clinical Manager considers the following: whether there is an active mental health or behavioral crisis; the current safety concerns; whether or not there is a mental health clinician present; whether the client has an ongoing mental health provider; whether there are any current concerns that may require immediate medical attention; and whether the client is under the influence of any illegal substance. All calls involving children and youth in psychiatric crisis are deployable calls which result in an onsite response by a clinical team. ChAMPS also provides telephone clinical consultation to child serving agencies seeking support for concerns such as family conflict, oppositional defiant behavior, and emotional dysregulation of children and or youth. A non-deployable call includes requests for information about program services or resources only or instances in which a caregiver

declines an on-site assessment. The table below shows the data with respect to response to calls:

Service	FY22	FY23 Quarter 1
Deployments	356	67
Deployments – No intervention	64	10
Cancelled Calls	141	30
Clinical Consultations	786	200
Information Only	208	109
Total Deployments	420	77
Total Calls Not Deployable	1135	339
Total Calls	1555	416

b. In FY 22, ChAMPS reported that the average deployment time was 44 minutes. The longest response time was 1 hours and 28 minutes. The shortest time was under a minute due to crisis team already being on site for another crisis call. In FY 23 to date, the average deployment time is 41 minutes. The longest response time was 1 hours, 21 minutes. The shortest time was 9 minutes. The requirement is to arrive to all deployments within one hour or less during the week and within 2 hours for overnight on call shifts and weekend on call shifts.
c. Contractually, ChAMPS was required to have seven teams available in FY22 and FY23 Q1. However due to workforce challenges they were understaffed, often with the Clinical Manager completing deployments as well. Currently, ChAMPS has four teams available.

d. ChAMPS teams are deployed in pairs. Staff are scheduled in a staggered manner to maximize coverage and the number of crisis teams available. Calls are triaged according to imminent risk and prioritized by the level of danger a child poses to self or to others. Additional considerations are the availability of a mental health clinician, and whether an MPD or a Crisis Intervention Officer is needed at the deployment site. The Clinical Manager maintains contact with the caller until the crisis team arrives at the scene. There have been times when a ChAMPS crisis team has not been available due to other deployments or staffing issues however, an independent licensed social worker is always available via telephone to provide clinical consultations, recommendations, assist in connecting a client to ongoing mental health service, and contacting a service provider from the family's Care Service Agency (CSA). Also, if there is an instance of eminent danger or safety concerns a Crisis Intervention Officer (CIO) officer can be deployed to assist them immediately.

e. ChAMPS has a working relationship with 911, MPD, Access Helpline (AHL) and other District entities. Most calls for Crisis Services are made directly to ChAMPS however in FY22, 9 calls were transferred from the AHL in FY22 and one in the first quarter of FY23. ChAMPS often joins the parent or guardian on a call with AHL to link the youth and family to services. ChAMPS does receive calls from MPD for support addressing psychiatric needs of children and youth. In addition, when a child or youth is aggressive, ChAMPS will rely on MPD for support and transportation when FD-12 is required. In addition, ChAMPS conducts information sessions about crisis services and advertises the program throughout the community, encouraging the public and private sector to use these services when needed.

f. ChAMPS conducts monthly surveys regarding the quality of care received by contacting the parents of child or youth after the case has been discharged. ChAMPS created and uses a Likert Scale survey that asks if they were satisfied with the services provided, did they and/or child feel they were treated with dignity and respect and were the services received in a manner that demonstrated consideration for their beliefs, values, and cultural background. Of the surveys received, 98% of the participants reported that they were satisfied with the services that were provided by ChAMPS.

37. For individuals served by ChAMPS, how many times did receipt of service result in psychiatric hospitalization in FY 2022 and in FY 2023, to date? Of the individuals who were hospitalized, how many of those hospitalizations were involuntary (FD-12) and what agency, if any, had custody? Of the individuals who were hospitalized, how many had a diagnosis of "serious emotional disturbance" Please provide the same information for any other Youth Mobile Crisis provider.

DBH Response

The goal of emergency crisis support is to stabilize children and youth experiencing a behavioral health crisis and avoid inpatient hospitalization or placement disruptions in the case of children and youth in the care and custody of the child welfare system. Of the 420 deployments in FY22, the clinician on the scene initiated an FD-12 process for involuntary treatment in 69 instances. Of that number, 23 children/youth required inpatient hospitalization. In Q1 of FY23, of the 77 deployments, an FD-12 was initiated in 16 instances and of those, 11 children/youth required hospitalization.

ChAMPS is the only youth mobile crisis provider under contract with DBH.

38. During FY 2021, FY 2022, and FY 2023, to date, how many calls to ChAMPS were initiated by MDP? How many calls were initiated by DCPS or a public charter school? How many calls were initiated by family members? How many calls were

initiated by the child or youth? How many were initiated by others? How do the totals from FY 2022 compare with FY 2021? Please provide the same information for any other Youth Mobile Crisis provider.

DBH Response

The chart below reflects calls received in FY21, FY22 and Quarter 1 of FY23 that were initiated by MPD, schools, family members, child/youth, and others. The data reflect that schools and family remain the highest referral sources for mobile crisis services for children and youth. The volume of family calls has remained consistent since the onset of the pandemic in March of 2020 while school calls have increased from FY21 as schools fully re-opened in FY21.

Table 1

Fiscal Year	MPD	School	Family	Child/Youth	Other
FY 21	102	173	589	23	178
FY 22	123	474	604	36	191
FY 23 Q1	26	142	172	9	31

ChAMPS is the only youth mobile crisis provider contracted by DBH.

39. How long does it take for families or children who are enrolled in DBH either by calling the Access Helpline or by walking into a community provider office seeking mental health services to receive the treatment they need? Please provide the following information for FY 2021, FY 2022, and FY 2023, to date:
    a. The number of days, on average, between when a family or child calls the Access Helpline and when they are referred to a Core Service Agency;
    b. The number days, on average, between when a family or child is enrolled and their intake appointment with a Core Service Agency;
    c. When is a child or family considered "enrolled" in services;
    d. The number of days, on average, between when a family or child is enrolled and when they receive a diagnostic needs assessment;
    e. The number of days, on average, between when a family or child is enrolled and when they receive their first service as part of a treatment plan; and

DBH Response

a. DBH's Access Helpline is one of the ways families and children are connected to services provided by the Department and its certified providers. Callers to the Access Helpline are referred to a provider during the call. DBH collects data to track the number of days from when a family or child is referred and their intake appointment; and the number of days between when a family or child is enrolled and when they receive a diagnostic needs assessment.

b. In FY21, the average time between a referral to an intake appointment was 24 days. In FY 22, the average time was 23 days. DBH has continued to work closely with providers to streamline processes to complete intake appointments via virtual platforms as well as in person. In FY23 YTD the average number of days has decreased to10 days.

Table 1. Average Number of Days from Referral to Intake Appointment (Enrollment)			
FY	2021	2022	2023 Q1
Avg days	24	23	10

c. The AHL refers children and families to providers for services. A child or family is considered enrolled in services when an intake appointment is completed.

d. In FY21, the average time between an intake to a diagnostic assessment appointment is 29 days. In FY 22, the average number of days was 34 days. Several providers had staff turnover both on the leadership and clinician level which impacted capacity. To support providers, DBH has provided technical assistance to streamline their intake process. In addition, data has been shared with providers on an annual basis to guide protocols and procedures. In FY 23 YTD, the average time decreased to eight days. DBH will continue to work with providers to utilize flexible scheduling, streamlined processes and telehealth platforms to reduce the time period from referral to an intake appointment and from the intake appointment to the diagnostic assessment appointment.

Table 2. Average Number of Days from Intake Appointment (Enrollment) to Diagnostic Assessment			
FY	2021	2022	2023Q1
Avg days	29	34	8

e. DBH does not collect data on the number of days from enrollment/ intake appointment and the first service as part of a treatment plan based on the diagnostic assessment.

40. Please explain the work DBH is doing with Child and Family Services Agency to better serve the mental health needs of foster children and their families in the District. Please provide the following information for FY 2021, FY 2022, and FY 2023, to date:
    a. The number of children/youth in out-of-home placements DBH served;
    b. The number of children/youth in in-home care DBH served;
    c. The percentage of children/youth who were screened within 30 days of entering or re-entering care;
    d. The services DBH provides to parents and guardians whose children are being served through in-home or out-of-home care;
    e. The number parents and guardians that received services;
    f. The services DBH provides to resource providers; and
    g. The number of resource providers who received services from DBH.

DBH Response

In FY22, DBH and CFSA have continued to collaborate to better serve the mental health needs of foster children in the District. DBH continued to have a staff member co-located at CFSA to support the linkage, enrollment and follow up of behavioral health services to children, youth and families needing services. CFSA continued support of the expansion of Functional Family Therapy (FFT) utilizing the Community Based Child Abuse Prevention (CBCAP) funding to provide intensive therapeutic interventions to families to prevent or reduce child abuse and neglect. FFT is an evidenced-based practice that targets families with children between the ages of 11-18 with behavioral or emotional problems such as conduct disorder, violent acting out, and substance use disorders. CFSA funding was used to maintain the certification of FFT providers and supported continued training in the model.

a. and b. The tables below show the numbers of CFSA youth in FY21, FY22, and FY23 Q1 in DBH services.

FY21		
Placement	**DBH Services**	**CFSA Cases**
Foster Care	355	502
In-Home	391	621
Total	**746**	1123

FY22		
Placement	**DBH Services**	**CFSA Cases**
Foster Care	267	508
In-Home	285	814

Total	**552**	1322

FY23		
Placement	**DBH services**	**CFSA Cases**
Foster Care	**147**	511
In-Home	**79**	632
Total	**226**	1143

c. DBH is no longer providing screening for children and youth who enter or re-enter care within CFSA. This ended in FY20, when CFSA launched their Mental Health Redesign, which included the onboarding of three mental health clinicians to administer mental health screenings and to provide direct therapeutic interventions.

d, e, f, g. Services are provided to parents, guardians and resource parents of children and youth involved in the child welfare system, but this data is not aggregated in our database system. The adults have access to services available in the DBH network to address their own needs in addition to psychoeducation and behavior management strategies that will support parenting and family dynamics.

41. Please provide an update on DBH's early childhood mental health projects, including any studies or reports. Please include a list of providers for these services.
    a. For the Parent Child Infant Early Childhood Enhancement Program, please include a description of the services provided, the type of clinicians employed, their capacity, and the number of children served, and how the cases ended (e.g. successful completion, closure for lack of attendance, etc.) in FY 2022 and in FY 2023, to date.
    b. For the Early Childhood Mental Health Consultation Project, Healthy Futures, list the childcare centers, homes, and schools that are participating, the services they have received and provide any progress/outcome measure available. Please provide updates on hiring for Healthy Futures. Please share any obstacles to expanding Healthy Futures to all subsidized child development centers and home providers. For FY 2021, FY 2022, and FY 2023, to date, please provide the amount budgeted and spent on Healthy futures, including a cost breakdown. Include a breakdown of the amount of local, federal, provide, and special revenue funding across all sites.
    c. Please provide an update on the DC MAP contract.

DBH Response

a. For the Parent Child Infant Early Childhood Enhancement Program, please include a description of the services provided, the type of clinicians employed, their capacity, and the number of children served, and how the cases ended (e.g. successful completion, closure for lack of attendance, etc.) in FY 2022 and in FY 2023, to date.

The Parent Infant Early Childhood Enhancement Program (PIECE) was established based on the findings from the 2007 Washington D.C. Early Childhood Mental Health White Paper, which identified the lack of existing mental health services in the District of Columbia for children under the age of five. The PIECE Program recognizes early childhood intervention programs have the potential to address cognitive, emotional and behavioral challenges in the lives of young children. The PIECE Program is certified by DBH to provide early intervention and treatment to young children and their families from birth to seven years old. The goal of the program is to intervene early with comprehensive services designed to prevent social emotional/behavioral challenges, reduce stressors within the parent-child relationship and family that might adversely affect the developing child. The program provides family focused behavior management, individual and family therapy/counseling, art and play therapy, developmental screenings, diagnostic assessments, psychiatric/medication management, home/school visitation, and mental health services for prenatal and postpartum women. The PIECE program continues to utilize a hybrid approach developed during the pandemic, which offers both virtual and in person clinic sessions.

The staff of the PIECE Program are trained and certified to provide several early childhood evidence-based practices for children and their families. The following is a list of these programs and a brief description of each of them.

Parent Child Interaction Therapy (PCIT) is a parent coaching program that teaches caregivers skills and techniques to improve their child's disruptive and non-compliant behavior. In PCIT caregivers are coached in specific skills by the therapist through an earpiece while the therapist observes the caregiver and child playing together in a separate room.

PCIT with Toddlers (PCIT-T) is an adaptation of PCIT, that combines attachment theory, play therapy, family systems, and cognitive-behavioral approaches with nurturing and sensitive caregiving. PCIT-T is an in-vivo coaching approach utilized with parents of children ages 12 months to three years to address disruptive behaviors and as a prevention model for caregivers experiencing stress.

Child Parent Psychotherapy (CPP) is a therapy for parents with infants, toddlers and preschoolers who have experienced trauma(s). CPP is also offered in a hybrid manner including the use of on-line stories art making via white board virtual adaptations and other telehealth applications in addition to in-person sessions.

Attachment & Biobehavioral Catch-up (ABC) is offered to parents and caregivers of babies who are between six and 24 months old. ABC strengthens the parent child

relationship while helping the child to learn to regulate behaviors and emotions. The ABC approach helps parents/caregivers identify and respond to their baby's signals. As a result, the parent's relationship with their child is supported to address stress and early challenges.

The PIECE Program has the capacity to provide services to 130 children and families. The staff include a clinical psychologist, and five clinicians. The credentials of the clinicians are as follows, 3 Licensed Independent Clinical Social Workers, 1 Licensed Graduate Social Worker, and 1 PhD with multiple credentials as a Licensed Professional Counselor, Licensed Marriage and Family Therapist, and is also a board-certified art therapist. In addition, two Board Certified Child Psychiatrists provide evaluation, and medication management services to children and adolescents for both the PIECE Program and the Urgent Care Clinic.

During FY 22 the PIECE Program provided services to 454 families. To date in FY 23, 1st Quarter the PIECE Program has provided services to 140 families. During FY 22 the program discharged 52 families, of which 25 were successful and 27 were unsuccessful due to a lack of attendance, referrals to CFSA's Office of Well-being and changes in jurisdiction. To date in FY 23, 1st quarter, the program has discharged 22 client families, of which 10 were successful and 12 were unsuccessful. A successful discharge is determined when the child and family has met their individualized treatment goals, as evidenced by pre/post assessments, and there is improvement in the social/emotional/behavioral symptoms reported at referral.

b. For the Early Childhood Mental Health Consultation Project, Healthy Futures, list the childcare centers, homes, and schools that are participating, the services they have received and provide any progress/outcome measure available. Please provide updates on hiring for Healthy Futures. Please share any obstacles to expanding Healthy Futures to all subsidized child development centers and home providers. For FY 2021, FY 2022, and FY 2023, to date, please provide the amount budgeted and spent on Healthy futures, including a cost breakdown. Include a breakdown of the amount of local, federal, provide, and special revenue funding across all sites.

The Healthy Futures program provides consultation services to Child Development Centers (CDCs) and home childcare providers as well as directly to children and families. These services are provided by a mental health professional. The goals of the program are: (1) building professional skills and capacity of caregivers to promote social emotional development and prevent escalation of challenging behaviors (2) reducing the number of early childhood expulsions and (3) increasing appropriate referrals for additional assessments and services to support child and family functioning. See Attachment 1 for the list of Healthy Futures child development facilities.

During FY 22, DBH continued to expand Healthy Futures. Funding for FY 23 currently supports 26 early childhood clinical specialists, three supervisors, and a Program Manager. All

leadership positions are currently filled and 16 of the 26 early childhood clinical specialist positions are filled. DBH is recruiting for the remaining clinical specialists.

During FY 22 the Healthy Futures program provided services in 85 child development centers and 17 home providers for a total of 102 locations. When fully staffed, Healthy Futures will have a maximum capacity of 182 CDCs.

While most CDCs reopened in FY22, some centers continued to struggle to stay open consistently. Many centers have closed intermittently due to continued COVID-19 concerns. The early childhood clinical specialists worked with child development centers and homes virtually and in person to provide as many services as possible.

The early childhood mental health specialists served 7,571 children across 102 facilities. Healthy Futures specialists provided 65 parent workshops, 384 parent consultations and 1,354 director consultations. Centers referred 132 children to Healthy Futures for child-specific support and 116 of those children's families signed consent to allow individual observations and interventions. The Devereux Early Childhood Assessment (DECA) was completed for children who received child-specific consultation services. Of the 116 children whose family signed consent 116 received an initial DECA and 70 received a post DECA. Of those children with follow-up DECAs, all showed improvement in at least one area of concern (attachment, initiative, and self-regulation).

Healthy Futures continues to provide consultation and education to early childhood directors on the positive impact of working with children that exhibit challenging behaviors rather than expelling them from their programs. Through Healthy Futures, CDC staff developed policies, skills and resources that help minimize expulsion as an option for children with challenging behaviors. In FY 22, there were zero expulsions of the 7,571 children served from child development facilities where the Healthy Futures Program was implemented; no children have been expelled from a child development center in FY 23 to date. See Attachment 2 for additional utilization data.

Healthy Futures has continued its collaboration with the Office of the State Superintendent Office's (OSSE) Quality Improvement Network (QIN) and Pre-K Enhancement program (PKEEP). Through this collaboration with OSSE and the QIN Hubs (UPO and Easter Seals) the Healthy Futures consultants provide self-care and trauma informed practices workshops to the staff of the participating child development centers and homes.

During FY21, the Healthy Futures received $2,518,348 in local funds and $831,007 intra-district funds from the Office of State Superintendent of Education (OSSE). All the intra-district funds and most of the local funds were for personnel services. Of the local funds, $81,000 was budgeted for contracts, $54,000 for equipment, and $1,527 for supplies.

In FY22, DBH received $2,700,767 in local funds, $831,007 in intra-district funds, and $480,412 from the American Rescue Plan Act (ARPA). The ARPA funds were allocated for the Healthy Futures Treatment Pilot. In FY 22, all the intra-district funds and most of the local funds were

for personnel services. Of the local funds, $171,000 was budgeted for contracts, $54,000 for equipment, and $1,527 for supplies.

In FY 23, DBH received $3,136,166 in local funds, $864,668 in intra-district funds, and $480,412 in ARPA funds. Again, most of the local funds and all the intra-district funds were allocated for personnel services. Of the remaining local funds, $171,000 was budgeted for contracts, $54,000 for equipment, and $1,527 for supplies. Nearly $700,000 was placed in an incorrect category (i.e., non-personnel categories– maintenance of persons and subsidies) and must be reprogrammed into the personnel category.

FY 21-FY 23 Healthy Futures Budget			
	FY 21	FY 22	FY 23
Local Dollars - Personnel	$ 2,381,821	$ 2,474,240	$ 2,209,174
Local Dollars - Non-Personnel	136,527	226,527	926,992
Intra-District - Personnel	831,007	831,007	864,668
ARPA - Personnel	0	228,412	228,412
ARPA Funds - Non-Personnel	0	252,000	252,000
Total	$ 3,349,355	$ 4,082,186	$ 4,481,246

c. Please provide an update on the DC MAP contract.

After a competitive procurement process through the Office of Contract and Procurement, Paving the Way Multi Service Institute was awarded the contract to deliver DC MAP services on October 14, 2021. After a transition period, they began providing services in November 2021. DC MAP offers primary pediatric care providers (PPCPs) telephone consultation (Monday-Friday, 9am-5pm) from a team of mental health professionals, including psychiatrists, psychologists, social workers, and care coordinators. In addition to answering mental health-related inquiries about specific children (e.g., questions about community resources that would be appropriate for the family, medication questions), the DC MAP team also provides education and technical assistance for PPCPs to identify and address mental health issues in primary care.

DC Health is providing funding through its HRSA grant to support the DC MAP initiative. This includes funding to expand training opportunities for PPCPs on the use of telehealth and cultural competency; to establish a regional consortium of telehealth practices that includes the Virginia Mental Health Access Program (VMAP) and the Maryland Behavioral Health Integration in Primary Care Program (BHIPP); to create new data entry fields in the software platform managed by DC MAP which will allow the collection of information on every patient served and track connections to care and referrals; develop a referral system to school-based mental health for patients identified as needed behavioral health services and supports; and develop

partnership and be a telehealth resource that addresses the needs of children, birth through five years of age with DC Health Help Me Grow. To meet the requirements of DC Health's HRSA grant, Paving the Way continues its collaborations with other MAP programs and with local community partnerships including the DC Collaborative for Integration of Mental Health in Pediatric Primary Care.

Another aspect of the HRSA grant is for grant recipients to provide training on behavioral health topics to pediatric primary care providers and to produce a PPCP telehealth manual. Paving the Way is working in collaboration with Concert Health, as stipulated in their joint agreement, to provide this service. In FY 23, Concert Health will also focus on the provision of technical assistance to local practices for integrating behavioral health into primary care and continued primary care provider education. Paving the Way will pilot partnership and referral process to support School Based Health Centers capacity to meet the medical and behavioral needs of children and youth with identified behavioral health concerns.

In FY 22, 176 providers were enrolled in DCMAP and received a total of 271 consultations. As of first quarter FY23, there are a total of 182 pediatric primary care providers enrolled in DC MAP. The DC MAP Pediatric Primary Care Mental Health team continued to see an increase in the utilization of referrals and care coordination. For the first quarter of FY23, there were183 consultation requests which is a 105% increase from first quarter FY22 which had a total of 81 consults.

See
Attachment 1 of 2. List of Healthy Futures Child Development Centers
Attachment 2 of 2. Healthy Futures Utilization Data

42. Please describe what substance abuse services are offered to children and youth, the process for obtaining these services, and detail how DBH partners with District schools (DCPS, charters, and private schools) to provide services and education to children and youth on the dangers and harm of substance abuse. Please describe how DBH uses data from the DC Youth Risk Behaviors and Academic Achievement Report (YRBS) to inform the work and better serve District youth. Please include:
    a. The total number of children and youth who received substance abuse services in FY 2022 and FY 2023, to date. Please breakdown by consumer age, consumer home ward, ward where services took place, how many were in-person/virtual/hybrid, and the types of services;
    b. The total number of agencies or organizations that provided substance abuse services to children and youth. Please provide (via Excel spreadsheet) a list of the agencies and organizations that provide substance abuse services to children and youth. Include their location, Ward, how many children and youth they served in FY 2022 and FY 2023, to date, the format of their services (virtual/in-person/hybrid), what services they provided, and contact information (staff contact, email address, phone number, and website);
    c. Where there are gaps and if there are plans in FY 2023 to fill these gaps or expand the types of substance abuse services offered to children and youth; and

d. The number children and youth who received services through the Adolescent Community Reinforcement Approach (A-CRA) in FY 2022 and FY 2023, to date.

DBH Response

The substance use services offered to children and youth within the District of Columbia include substance use disorder (SUD) prevention services, treatment, and recovery support services (RSS). SUD prevention services are delivered primarily through DBH's four (4) DC Prevention Centers (DCPCs) and the youth treatment and recovery support services are made available through DBH's two (2) Adolescent Substance use Treatment Expansion Program (ASTEP) providers. During FY2022, there were three (3) ASTEP providers. One provider, Federal City Recovery Services, terminated their youth treatment program on August 15, 2022. With the closing of its program, Federal City Recovery Services worked with the two (2) remaining ASTEP providers, Hillcrest Children and Family Center and Latin American Youth Center (LAYC) to ensure the seamless transition of youth enrolled in their program to other treatment services.

DBH has been able to provide sub-grants to both its prevention and youth treatment providers through the federal funding received from the Substance Abuse and Mental Health Services Administration (SAMHSA). The DC Prevention Centers focus specifically on educating residents about the dangers and harms of substance use in order to prevent and/or delay the onset of alcohol, tobacco, and other drug use. The ASTEP providers, through the Federal SAMHSA grant, DC Changing and Improving Treatment for our Youth (DC-CITY), offer non-Medicaid billable services such as outreach and engagement for youth referred to SUD treatment and Recovery Support Services (RSS).

The SUD prevention services provided by the four Prevention Centers include workshops and trainings on SAMHSA's Strategic Prevention Framework (SPF) – an approach for developing strategies aimed at addressing and preventing substance use among District youth, engaging and conducting outreach to residents through community events such as health fairs, and fostering the leadership skills of youth via the respective Youth Prevention Leadership Corps (YPLCs). The DCPCs have also worked to create formal partnerships with local middle and high schools within their wards to promote the prevention of substance use. The Centers have been able to work directly with the Community Based Organizations (CBOs) and School Based Clinicians to expand their efforts to include a focus of substance use prevention. This includes conducting presentations in classrooms and school assemblies on the harms and dangers of substance use, the adoption of curricula aimed at preventing drug use "Too Good for Drugs," and establishing school specific YPLC.

The two ASTEP providers, Hillcrest Children and Family Center and LAYC, provide both mental health and substance use services to youth within schools. Both providers have created a mechanism for making internal referrals to youth SUD treatment and recovery support services for those students who may be in need. In FY2022, school referrals made up 15% of the total

number of referrals made to the ASTEP providers for service. The ASTEP providers also receive referrals from individuals making self-referrals, agencies such as the DC Department of Youth Rehabilitation Services (DYRS) and the Child and Family Services Agency (CFSA), and from other youth serving entities. Once referrals are made, the ASTEP providers conduct outreach and engagement, assess the youth to determine the appropriate level of care, and then enroll youth into the services that can best address their substance use needs.

The Youth Risk Behavior Survey (YRBS) data which as compiled and analyzed by the Office of the State Superintendent for Education (OSSE) is critical to DBH's SUD efforts. One of the ways in which these data have been used is in the development and targeting of social marketing strategies. For example, one key data variable in the YRBS reports is the age of marijuana and alcohol use. In determining what content or graphics would resonate the most, DBH looks at the age of on-set as reported by middle school and high school students. The data is compared across years where the survey was administered to observe whether the age of first use is trending upwards or downward. This data was also used as a guide in purchasing the "Too Good for Drugs" curricula for the grade levels likely to have the greatest impact in preventing and/or delaying the on-set of drug use. In addition, the YRBS data presents a picture of substance use frequency, particularly past 30-day use. DBH uses this trend data to identify the substances that are most popular among youth, and then prioritizes these substances for the programs and social marketing strategies that are selected, developed, and/or implemented.

a. DBH has a full continuum of substance use services for youth which includes prevention, treatment, and recovery. Regarding prevention services rendered, *Table A* below shows that during FY2022, the DC Prevention Centers (DCPCs) served a total of 6,266 individuals aged 24 and younger through information dissemination, social marketing engagement, and Youth Prevention Leadership Corps (YPLC) activities. During the first quarter of FY2023, a total of 763 individuals have been served. Historically, broader reaching events have taken place in the spring and summer months, thus we anticipate that the number of children and youth reached will increase significantly during the third and fourth quarters of FY2023.

Table A

Substance Use Prevention Services Offered to Children and Youth in FY2022			
Number of Youth	Service Wards	Delivery Method	Types of Services
6,266	Wards 1&2 = 775	Hybrid (combination of virtual and in person sessions)	Information dissemination, social marketing engagement, and YPLC activities
	Wards 3&4 = 1,357		
	Wards 5&6 = 3,257		
	Wards 7&8 = 877		
Substance Use Prevention Services Offered to Children and Youth in FY2023			
Number of Youth	Service Wards	Delivery Method	Types of Services
763	Wards 1&2 = 60	Hybrid (combination of	Information dissemination, social
	Wards 3&4 = 76		
	Wards 5&6 = 513		

	Wards 7&8 = 114	virtual and in person sessions)	marketing engagement, and YPLC activities

As it pertains to youth treatment and Recovery Support Services (RSS), DBH has experienced a steady increase in the number of youths enrolling into SUD treatment and RSS in FY22. As noted in the table below (*Table B*), in FY2022, a total of 119 youth enrolled in services. This is a significant increase compared to the 74 who were served in FY2021. In the first quarter of FY2023, 31 additional youth enrolled in services. A unique identifier is used to identify the youth who receive services from the ASTEP providers. Only the location of the agency that rendered the service is recorded. As a result, the addresses for clients is not captured in this data. . The wards corresponding with where the ASTEP providers physical buildings are located and the subsequent services that were rendered are included in the table. It should be noted that ASTEP providers see youth from all Wards , in schools and through telehealth applications.

Table B

Substance Use Treatment and Recovery Support Services Offered to Children and Youth in FY2022					
Number of Clients	Age		Service Wards	Delivery Method	Types of Services
119	11 y/o = 1	17 y/o = 23	Wards 1, 2, and 8 (location of provider offices)	Hybrid (combination of virtual and in person sessions)	Individual Counseling, Group Counseling, A-CRA, RSS
	12 y/o = 1	18 y/o = 19			
	13 y/o = 5	19 y/o = 14			
	14 y/o = 10	20 y/o = 8			
	15 y/o = 23	21 y/o = 4			
	16 y/o = 11				
Substance Use Treatment and Recovery Support Services Offered to Children and Youth in FY2023					
Number of Clients	Age		Service Wards	Delivery Method	Types of Services
31	13 y/o = 6	18 y/o = 2	Wards 1, 2, and 8	Hybrid (combination of virtual and in person sessions)	Individual Counseling, Group Counseling, A-CRA, RSS MET/CBT
	14 y/o = 7	19 y/o = 2			
	13 y/o = 4	20 y/o = 2			
	16 y/o = 2	21 y/o = 1			
	17 y/o = 4	22 y/o = 1			

b. To provide substance use disorder (SUD) prevention, youth treatment, and recovery support services, DBH works with a number of partners. This includes four DBH funded Prevention Centers (DCPCs) which are strategically located throughout the District of Columbia and provide services to all eight (8) wards. DBH provides supplemental funding to the Adolescent Substance use Treatment Expansion Program (ASTEP) providers to support SUD treatment and

recovery support services for youth. In FY2022, DBH had three (3) ASTEP providers. One (1) of the providers closed their youth program in August of 2022, and there are currently two (2) ASTEP providers serving youth through treatment and recovery support services in FY2023.

As requested, information for the organizations providing SUD services for children and youth is included in Attachment 1.

c. DBH through its work with youth, families and the community have identified some gaps within the continuum of substance use disorder services for youth. DBH will implement the following strategies to address identified gaps:

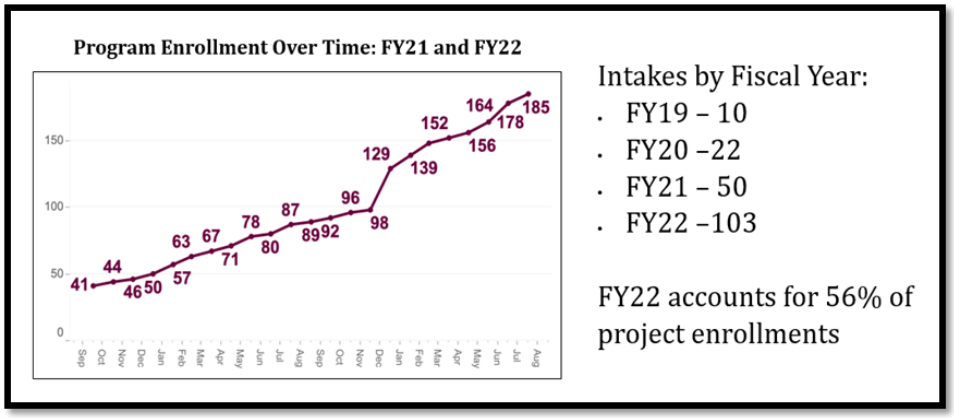
1. **Addressing Opioid Use Disorders:** As more youth are potentially at risk of experiencing Opioid Use Disorders, DBH has sought to expand the options available for youth requiring more intensive SUD treatment services. To that end, during FY2022, DBH began working with Dr. Sivabalaji Kaliamurthy who is an Attending Psychiatrist at Children's National Medical Center, specializing in treating youth with Opioid Use Disorders. In the establishing of this relationship, DBH and its ASTEP providers now have a local intensive outpatient option for youth struggling with opioids and needing support beyond the care that the ASTEP providers are providing. In addition, in FY2023 DBH began engaging a regional partner, the Fairfax County Community Services Board in Northern Virginia. This group is also focused on addressing Opioid Use Disorders among youth and identifying resources for treatment. DBH is working with them to explore and exchange ideas on how to best serve this population.

2. **Limited Evidence Based Interventions and Providers:** In an effort to respond to the diverse needs of youth requiring SUD treatment, DBH has sought to train the ASTEP providers in a variety of evidence-based interventions that have proven to be effective in reducing participants' dependence on drugs. There are currently a limited number of providers trained in and/or providing the Adolescent Community Reinforcement Approach (A-CRA) as a model for treating youth. In March of 2023, DBH is slated to facilitate an A-CRA training for providers to increase the number that are certified to deliver this evidence-based program. Certified staff will be able to train other staff within their organizations using a "train the trainer" model. This certification is critical as it will allow new staff to be trained quickly and will reduce training costs that otherwise would be paid to the national trainer of the program. Additionally, DBH provided training in Motivational Enhancement Therapy (MET)/ Cognitive Behavioral Therapy (CBT) for the ASTEP providers in August of 2022. As a part of its sustainability plan for the DC CITY grant, DBH will facilitate another MET/CBT training for ASTEP providers in FY2023 for new hires.

3. **Access to Treatment:** There are challenges which impact youth accessing SUD treatment. These challenges include whether youth know about the services that exist, how these services can be accessed, and the stigma associated with participating in youth SUD treatment. To address these challenges, non- reimbursable activities such as outreach and engagement are necessary. Through the five (5) year DC Changing and

Improving Treatment for our Youth (DC-CITY) grant that DBH received at the beginning of FY2019, the Agency has been able to provide sub-grants to the youth SUD treatment providers. As the DC CITY grant is focused on the expansion and enhancement of youth SUD treatment services, the ability to assist the ASTEP providers with conducting non-Medicaid billable activities such as outreach engagement has been invaluable to reaching more youth. More specifically, the numbers of youth enrolling in youth SUD treatment and RSS via the DC CITY grant after the providers received funding increased exponentially. The expanded access to treatment contributed to an uptick in enrollment. The table below (*Table C*) displays enrollment numbers the year prior to receiving funding for outreach and engagement (FY2019) in comparison to the years that follow where funding was allocated (FY2020, FY2021, and FY2022).

Table C



With the data showing a positive correlation between outreach and engagement activities and increased numbers of youth enrolling into SUD services, DBH has built into its sustainability plan, assisting the ASTEP providers with additional funding to support outreach and engagement staff once the grant expires.

d. In FY2022, a total of 17 individuals received services through the Adolescent Community Reinforcement Approach (A-CRA). While this number seems relatively low, it should be noted that A-CRA is only one of the services provided by the ASTEP providers. Additionally, during this period, there were only two (2) A-CRA trained staff across the three (3) provider organizations.
To date, in FY2023, no children or youth have received A-CRA services because there are currently a limited number of A-CRA providers. DBH is slated to offer an A-CRA training for current provider staff during March of 2023.

43. Please provide an update on DBH's pilot treatment services for the eight child development centers in the areas of the District most impacted by the COVID-19

pandemic. Please include the FY 2022 and FY 2023, to date, budget and expenditures and provide outcomes for the same period.

DBH Response

During FY 22, DBH began a treatment pilot for young children and families in child development centers. Clinicians will be trained in early childhood evidence-based treatments and the program has the capacity to service up to 75 young children and families. Services will be provided in eight child development centers in communities most impacted by the COVID-19 pandemic. DBH collaborated with OSSE to identify the eight centers. Because DBH is still recruiting two clinicians for the pilot, Healthy Futures clinicians already on staff have been assigned to begin providing treatment services in four centers in early 2023. Center directors now are identifying children who need support and working with the Healthy Futures clinicians to screen and connect with parents.

See Attachment 1 of 2. List of Child Development Centers.

During FY 22 and FY 23, DBH received $480,412 of American Rescue Plan Act (ARPA) funds to support the treatment pilot. In FY 22, no PS funds were spent as DBH was unable to hire the early childhood treatment clinicians. DBH spent $150,000 to train the clinicians assigned to the centers on Attachment Biobehavioral Therapy (ABC), an evidence-based program that supports young children and their families. No supplies or equipment were purchased in FY22. In FY 23 to date, an evaluation contract was awarded to Georgetown University to assess the implementation and the effectiveness of the treatment program. $85,000 supports the evaluation contract and $2,212 purchased equipment for the ABC program. DBH continues to recruit two clinicians and will contract to provide additional early childhood training for the clinicians. Supplies and equipment will be purchased to ensure clinicians have the necessary materials to implement services and supports.

See Attachment 2 of 2 for complete budget information.

44. Please provide an update on the online behavioral health training program for child development facilities and public schools that was launched in FY 2015. How many teachers and other personnel completed the online training in FY 2022 and FY 2023, to date?

DBH Response

The Department of Behavioral Health (DBH) continues to provide the online behavioral health training through the portal: http://www.supportdcyouth.com and all DC administrators and teachers are required to complete the mandated training modules on the same two-year cycle.

All District public and public charter school teachers and principals must complete three DC Youth Behavioral Health Program courses once every two years to be compliant with the legislative mandate. Additionally, it is highly recommended for educators to take the *Step In Speak Out* course for challenges and concerns related to LGBTQ students. This is an additional module that is available within the portal. Early childhood educators, child development center staff, and child development center administrators, must complete *At-Risk for Early Childhood Educators.* This simulation is for those administrators, staff, and educators who work with young children and builds understanding, knowledge, and skills in mental health and behavior management. The Division of Early Learning within the Office of the State Superintendent of Education (OSSE) has the completion of the *At-Risk for Early Childhood Educators* module as part of the yearly health and safety requirements, and all educators must complete their health and safety requirements by September 30, each year.

In FY22, 2,954 DC Public Charter Schools (DCPCS) teachers and other personnel completed the online training and 9,151 have completed the trainings in FY23 to date. For DC Public Schools (DCPS), 614 teachers and other personnel completed the training in FY22 and 16,525 have completed the training in FY23 to date.

In FY22, there were 237 DC Child Development Center Administrators and staff who completed the on-line training. And, in FY23 to date, 361 Administrators and staff have completed the training. The attached documents provide information on the number of DC Public Charter School, DC Public School, and DC Child Development Center teachers and other personnel who have completed the online training in FY22 and FY23 to date.

Q44. Attachment 1 of 3. DC Public Charter School Completions FY22 and FY23 to date
Q44. Attachment 2 of 3. DC Public School Completions FY22 and FY23 to date
Q44. Attachment 3 of 3. DC Child Development Center Completions FY22 and FY23 to date

45. Please provide an update on the High-Fidelity Wraparound program. Please include the following:
    a. Current capacity;
    b. Description of services currently being provided;
    c. Description of how individuals can access these services;
    d. How many individuals were serviced in FY 2022 and FY 2023, to date;
    e. Since MBI was awarded the Care Management Entity (CME) contract in 2017 with a reduced capacity to serve 94 youth in the community, the number of youth who were served in FY 2022 and FY 2023, to date;
    f. Short-term or long-term plans to increase available flexible funding available per youth;
    g. An update on DBH's efforts to transition high fidelity wraparound from a locally-funded pilot program to a Medicaid-funded permanent MHRS service. Share any steps that have been taken to date;

h. The number of children who diverted from PRTF placements. Please provide a breakdown for the school and community-based programs; and
i. Any outcome evaluations or reports of the program from the past two years.

DBH Response

a. The current capacity for High Fidelity Wraparound in FY22 and in FY23 Q1 at any given time is 85 youth.

b. High Fidelity Wraparound is a strength-based, evidence- informed process, led by a Care Coordinator who is responsible for collaborating a team-based planning process where representatives of multiple systems come together with a child, youth, and their family to create a highly individualized plan to address the complex emotional needs of a child or youth. The individualized plan of care is designed to prevent out-of-home placement and juvenile involvement with the courts. The plan of care is monitored by the Wraparound Coordinator several times per week to ensure that the family is receiving the required services including the incorporation of informal and natural support for the family. The average length of stay of youth and families enrolled in wraparound in FY22 was 9.5 months.

c. Children and youth are referred by a DBH-certified provider, the Juvenile Behavioral Diversion Program (JBDP), the Office of the Attorney General (OAG), Here Opportunities Prepare You for Excellence (HOPE) Court or the child or youth's family. A referral can be made through the program's website, wraparound.cftm@dc.gov. Referrals can also be made by contacting MBI or DBH directly to initiate the referral process. Once a referral is received, DBH's Wraparound Committee reviews the case presentation. Children and youth who are involved in multiple systems and are at-risk of out-of-home placement are accepted into the program. Children who meet the criteria for wraparound support are connected to DBH's contracted service provider, MBI. MBI is required to contact the family within 24 hours to begin the wraparound process.

d. and e. MBI provided High Fidelity Wraparound to 76 youth in FY22 and 52 youth in FY23 Q1. The capacity of 85 was not met during FY22 due to incomplete referrals and families not willing to engage in Wraparound.

f. Flexible funding is allocated to provide non-reimbursable services required to stabilize the family. These services may include but are not limited to academic tutoring, community mentorship, financial literacy, entrepreneurship internships, rental and utility assistance, behavior modification programming, recreational activities or connection to specialty behavioral health services not covered by Medicaid such as dialectical behavioral therapy. The average amount available for these nontraditional supports is $1,000.00 per family. Some youth may need more than the average while others may need far less. In addition, MBI is expected to identify and maximize both private and public community-based resources to meet each family's basic needs

such as shelter, food, clothing, and income maintenance. There are no plans to increase the current flex spending amount per youth involved in the program.

g. DBH explored the utilization of Medicaid funding for High-Fidelity Wraparound with the Department of Healthcare Finance as part of our behavioral health system transformation efforts. After review of other State Intensive Care Coordination rates and billing structures, DBH and DHCF have advocated that High Fidelity Wraparound be part of the Medicaid State Plan as a reimbursable service under the title of "Intensive Care Coordination (ICC). DBH and DHCF are finalizing regulations, rate, and billing codes for ICC to be a Medicaid billable service the second half of FY23 or the beginning of FY24.

h. One hundred percent of youth involved in Wraparound in FY22 were diverted from treatment in a PRTF. Currently there is not a Wraparound program available in schools, however funding through ESSER-II and Council has allowed for expansion of Wraparound in twelve schools. DBH, through the completion of the contract and procurement process, will contract with two vendors to provide High Fidelity Wraparound in the twelve identified schools and have secured training and coaching through the National Wraparound Implementation Center to support the initiative and fidelity of model. DBH anticipates that the school wraparound program will begin in Spring of 2023.

i. The outcomes for children and youth while they were enrolled in High-Fidelity Wraparound were reported by MBI for FY22 were as follows:

- Ninety-four percent of youth did not receive any additional juvenile charge.
- Eighty-five percent of youth maintained their living placement at time of referral.
- Seventy-one percent of youth showed an improvement in school attendance.

Sixty-eight percent of youth showed a decreased in detention and school suspensions.

School Based Behavioral Health

46. What type of assessments are in place for screening students? Does DBH use the Adverse Childhood Experiences assessment? How many students were assessed in FY 2021, FY 2022, and FY 2023, to date?

    DBH Response

    While DBH clinicians do not consistently use the Adverse Childhood Experiences assessment as a screener, DBH understands the importance of screening for events or circumstances that may be traumatic to students, and often uses screeners to guide treatment. School Based Behavioral Health (SBBH) clinicians use a wide range of screeners and assessments to gather information and data regarding student's strengths, weaknesses, and level of functioning. The specific screener or assessment tool is based on the need and the development age of the student. For example, young children who attend Child Development Centers are often assessed using the Ages and Stages

Questionnaire. Healthy Futures consultants who provide early childhood mental health consultation services support the centers in administering the screener and help to link the children and families to appropriate services when necessary. Children also are referred to the consultant for child-specific consultation services or to a behavioral health provider in the community.

Young students are also screened if they attend a school participating with Primary Project. Primary Project is an evidence-based, early intervention and prevention program for young children in pre-Kindergarten/4 through third grade who have been identified with mild adjustment issues in the classroom. Through one-to-one, non-directive play sessions, the program reduces social, emotional and school adjustment difficulties to improve school-related competencies in task orientation, behavior control, assertiveness, and peer social skills. During SY 22-23 Primary Project services are being offered in 9 DC public and DC charter schools. Four to six weeks after school starts, teachers assess the level of functioning and adjustment of each child in their classroom using the Teacher-Child Rating Scale-Short Form (TCRS-SF). Based on the results of the screening, children with mild adjustments concerns are referred to Primary Project, and children with more significant concerns are referred to a behavioral health clinician in the school. During FY 21, Primary Project was not implemented due to the COVID-19 pandemic and all students were learning virtually. During FY 22, 826 students were screened and in FY 23 to date 1,220 students have been screened using the TCRS-SF.

All clinicians complete a diagnostic assessment (DA) for all students participating in treatment services. When completing the DA clinicians gather information (i.e., presenting problem, developmental history, family history, history of abuse, social functioning, and trauma history etc.) from the student and parent/guardian. In addition to the DA, clinicians sometimes complete additional screeners to gather information about a specific topic or concern. For example, clinicians may use a specific screener to assess anxiety, depression, substance use, or attention difficulties. The screener helps to provide additional information which aids in creating a comprehensive and effective treatment plan. In addition, clinicians use screeners for students participating in specific treatment programs (e.g., Bounce Back or Cognitive Behavioral Intervention for Trauma in Schools (CBITS) to assess appropriateness for the program.

47. Please provide an update on DBH's School Behavioral Health Program including a list of all schools that have DBH clinicians, CBO clinicians, or both. Please provide:
    a. How much clinician time has been spent on Tier 1, Tier 2, and Tier 3 services;
    b. How many and what percentage of schools have one or more CBO or DBH clinician currently in place;
    c. How many schools do not have an active DBH or CBO clinician;

d. How many schools have not been matched with a CBO (Please identify schools without a CBO clinician and provide the reason why one has not been hired);
e. How many schools in each cohort that have a School Behavioral Health Coordinator;
f. A list of all of the schools in each cohort;
g. How many schools in each cohort have completed the School Strengthening Tool;
h. How many schools in each cohort have completed the Work Plan;
i. What obstacles or barriers to completing the School Strengthening Tool and Work Plan and identifying the School Behavioral Health Coordinator; and how these documents can be accessed by members of school communities including whether this information can be found on the DBH website, MySchoolDC website, or other website.

DBH Response

Please see Attachment 1 of 7 which provides a list of all schools that have a DBH, CBO, or both a DBH and CBO provider.

a. In August 2022, the DBH School-Based Behavioral Health Program transitioned to a new data tracking system. This data tracking system utilizes a QuickBase platform and is called the School Behavioral Health Program (SBHP) Activity Tracker App. The SBHP Activity Tracker App allows us to track the amount of time clinicians spend on Tier 1 and Tier 2 services. Prior to the current school year (SY2022-2023), we were not able to capture time spent. See Attachment 2 of 7 for the number of hours spent on Tier 1 and Tier 2 services. We do not have the ability to track the number of hours clinicians spent on Tier 3 services.

b. Currently, 155 or 61% of the DC Public and Public Charter Schools are staffed with a CBO and/or DBH provider.

c. Currently, 98 Public and Public Charter schools do not have an active DBH or CBO provider. Two of these schools are not participating in the program as the leaders have determined they have sufficient resources to support the behavioral health needs of their students. Of the remaining 96 schools, 71 schools have a partnership with a DBH clinician and are matched with a CBO and are recruiting for a clinician.

d. Twenty-one schools have not been matched with DBH and/or CBO and four schools are seeking new partnerships. In addition, nine schools have a DBH clinician but have not been matched with a CBO clinician. Four schools are seeking new partnerships.

Please see Attachment 3 of 7. List of Schools Not Matched.

A total of 86 CBO matched schools are currently vacant. Of these 86 schools, 26 currently have a partnership with DBH. While CBO partners are actively recruiting to staff these vacancies, workforce shortages and resignations have impacted the ability to hire and retain providers. At the beginning of the current school year (SY2022-2023) there has been an increase in hiring and strategies around workforce development are being explored to increase recruitment and retention.

Please see Attachment 4 of 7 for a list of CBO matched schools with a vacancy.

e. Currently there are 247 DC Public and Public Charter Schools that have an identified School Behavioral Health Coordinator. The number of schools by cohort is provided in Attachment 5 of 7.

f. Attachment 6 of 7 provides a list of schools in each cohort.

g. Modules from the School Health Index which comprise the School Strengthening Tool are no longer the prescribed sole data source for the school-centric assessment conducted annually by school behavioral health teams. This allows schools flexibility to identify and utilize existing school level data sources to complete the annual school-centric assessment and data-driven work plan. In completing the School Strengthening Work Plan, school behavioral health teams identify the data sources and metrics that are informing the work plan. Attachment 7 of 7 provides the number of schools in each cohort with completed annual school-centric assessments. The denominator used reflects the total number of schools per cohort regardless of whether a CBO clinician is in place or not.

h. Attachment 7 of 7 provides the number of schools in each cohort with a completed work plan. The denominator used reflects the total number of schools per cohort regardless of whether a CBO clinician is in place or not.

i. Obstacles and barriers to completing the School Strengthening Tool or school-centric assessment and work plan include the limited capacity of those professionals identified as School Behavioral Health Coordinators to manage often various assigned auxiliary roles. Additionally, the School Behavioral Health Coordinator is a role rather than a position. Given the workforce shortage, professionals with a behavioral health background, who are the recommended professionals to serve as School Behavioral Health Coordinators, are reported to already be stretched to fulfill various mandatory responsibilities within their job positions. Additionally, there is often a challenge to having protected time to conduct and participate in the teaming necessary to conduct the annual school-centric assessment and complete and periodically revisit the workplan goals and components throughout the school year. Relying on prescribed modules for the School Strengthening Tool was also noted as a barrier given the desire to have the opportunity to have options and flexibility to use relevant school level data that is already available for use by the school's behavioral health team.

Neither the school-centric assessments nor completed workplans are available on the DBH website, MySchoolDC, or other websites. DBH and its school partners recommend that the individual schools manage and engage the members of their school community on the assessment and workplan goals and how members of the school behavioral health team operationally support the school's priorities for the school year.

Q47. Attachment 1 of 7. List of Schools with DBH, CBO, or Both Providers
Q47. Attachment 2 of 7. Time Spent on Tiers of Services
Q47. Attachment 3 of 7. Schools Not Matched with a CBO
Q47. Attachment 4 of 7. CBO Matched Schools with Vacancy
Q47. Attachment 5 of 7. Schools with a SBHC by Cohort
Q47. Attachment 6 of 7. List of Schools by Cohort
Q47. Attachment 7 of 7. School-Centric Assessment/School Strengthening Tool and Workplan

48. Individual School Breakdown: For each school with a DBH or CBO clinician in place during FY 2021, FY 2022, and FY 2023, to date, please detail the services via an Excel spreadsheet that includes the following:
    a. The number of students who met with a clinician;
    b. The number of students who were referred to care;
    c. The student to clinician ratio for the school;
    d. The most common diagnosis;
    e. The referral source (walk-in, teacher, parent, etc.);
    f. The prevention programs and services that were offered in FY 2022 and FY 2023, to date;
    g. The number of students participating in prevention programs;
    h. Name and contact information for their clinician(s) and School Behavioral Health Coordinator;
    i. Relevant links for clinician websites, social media pages, or other materials;
    j. Plans to expand the prevention program and barriers to expansion; and
    k. A list of current programs that are meeting the existing need for services, and if not, what is being done to meet the total need.

DBH Response

a. The cost study mandated in the FY2023 Budget Support Act is currently underway. A rate study on school-based behavioral health services is being carried out by the Public Consulting Group (PCG). The PCG team has created a survey to directly collect information from all the Community Based Organization school providers. The survey will be used to better understand the current state of the overall services being provided, the reimbursement level for treatment services within the school-based behavioral health program and identify any challenges providers are facing with regards to providing all three tiers of the model. The study will ultimately determine if the current level of local funding and third- party reimbursement for treatment services covers the full cost of implementing the full model of services in each school.

The data collected from the providers will be analyzed to help DBH determine the true financial cost of the services provided within the school based behavioral health program.
A Comprehensive Cost Survey was sent to all CBOs to collect data on staffing, costs, and revenue. The data collection period runs from October 1, 2022, to December 31, 2022. The deadline for PCG responses is January 31, 2023. In addition, DBH contracted with Child Trends, an evaluation vendor to gather additional information needed to better understand the cost of implementing school behavioral health services. All information will be included in a report that is expected to be completed for review by DBH by February 28, 2023. Once completed the findings will be shared with Council, members of the Coordinating Council on School Behavioral Health, and at the DBH monthly provider meeting with the Department of Health Care Finance.

b. DBH and the Community Based Organizations (CBOs) who are providing the services through the school based behavioral health expansion initiatives have contracts with the Managed Care Organizations (MCOs) and the clinicians are billing for treatment services. Some CBOs have been successful with contracting with private insurances; however, barriers continue to exist. Based on location of the services, some private insurers have refused to panel clinicians. DBH is working to alleviate some of these barriers, by working with the District's Insurance Commissioner. Currently, clinicians bill for treatment services for all Medicaid clients. Prevention and early intervention services are not reimbursable in the current State Medicaid plan. The cost of these services is supported with funding from the DBH local budget allocation.

c. The findings and recommendations from the cost study will help to inform any necessary shifts or revisions to the funding structure within the School Based Behavioral Health Program. DBH will incorporate these findings to determine the future financial model in collaboration with the Department of Health Care Finance and the provider community.

49. Please provide an update on the implementation of the SBBH funding model that includes the following:
    a. The status of the cost study mandated in the FY 2023 Budget Support Act, the timeline for publication, and how the findings will be shared;
    b. An update on the extent to which CBO and DBH clinicians have been able to bill their services to Medicaid, private insurance, or other sources of funds outside of local dollars. Please also discuss plans to bill additional services in the future; and
    c. Plans for the financial model being re-evaluated or revised and the data DBH will use to make decisions.

DBH Response

The DC CoP advances the District's Comprehensive Expansion of School-based Behavioral Health Services by inviting School Behavioral Health Coordinators (SBHCs), Community Based Organization (CBO) and DC Department of Behavioral Health (DBH) clinicians, along with other members of the school-based teams, to participate in a peer learning environment aimed at building capacity to implement high-quality school-based behavioral health practices that supports a comprehensive school behavioral health system.

a. The following structural adjustments were made to the DC CoP based on emerging needs of community members and shifting funding priorities:

- Monthly CoP meetings now alternate between mornings and afternoons (e.g., January 3:00 - 5:00 pm; February 9:00 - 11:00 am) to accommodate different schedules of the CoP members.
- The Youth-Adult Partnerships Working Group grew out of youth engagement efforts. The Workgroup is focused on: amplifying the voice of students to address behavioral health and wellness issues that are most important to them; providing opportunities to work on shared messages and activities with adults; and building capacity of students to support their peers.
- A Primary Care and School Behavioral Health Collaboration Working Group was formed to explore ways the DC CoP can support better coordination between pediatric providers and school behavioral health teams to ensure continuity of care for children and families.
- New facilitators were recruited to support the Teacher Wellness Work group and Positive School Climate/Social and Emotional Learning Implementation Practice Group.
- The Crisis Response and Intervention Practice Group merged with the Suicide Prevention Working Group, which was formed last year in response to systemwide data showing the critical need to address suicide ideation and attempts, as a part of their ongoing work.
- The School Leadership and Clinical Supervision Practice Group was dissolved in 2021. This group was integrated into DBH's bi-weekly supervisor's meeting.

The CoP plans for FY23 include:

1. Continue to reach new members through promoting CoP learning spaces and resources.
2. Continue to increase the number of school teams (2+ individuals working in the same school) who attend DC CoP events regularly.
3. Continue to promote the application of Tier 1, Tier 2, and Tier 3 practices within a multi-tiered system of supports (MTSS) framework to achieve the goals of the School Strengthening Work Plan (SSWP).
4. Expand foundational trainings (e.g., MTSS, grief and loss) and promote the practical applications of interventions.
5. Improve communication around services available and how to access them, especially for caregivers and youth. Continue to increase access to resources developed/shared through the CoP (e.g., increase use of padlet, including links to CoP resources in the CoP newsletter).
6. Continue providing Social Work and Psychology CEUs for the CoP meetings.
7. Collaborate with the CoP and Core Team Members to identify strategies for sustaining the effective components of the CoP in the future.

b. and c. The attachment provides FY 2021, FY 2022, and FY 2023 to date information on b) implemented and c) planned events, trainings, meetings, and information informed by what is of the interest of the DC CoP members at the current point and time.

d. The timeline for fully establishing the processes and protocols needed to support the DC CoP is approximately 18 to 24 months. Although the Expansion does not define the term "fully established," the DC CoP uses five stages of a CoP (Wenger, McDermott, and Snyder, 2002) to measure community development. The DC CoP has consistently met the milestones each year and has advanced through four of the five stages of development since school year (SY) 2019-2020. The DC CoP is currently in the Self-sustaining and Stewardship phase. The CoP fully matured in terms of key leaders, structures, processes, and protocols; and many aspects of the community are now self-sustaining (e.g., practice groups), and outreach continues. The DC CoP is working towards the last stage, Legacy, or Transformation, which is the phase where DC CoP members report applying what they have learned from the CoP meetings to improve SBH access and quality.

e. Child Trends has surveyed School Behavioral Health Coordinators (SBHCs) for the past two school years. As a part of that survey, they asked SBHCs to share their experiences with eight different types of resources: DC CoP; tip sheets and best practice guides; training related to the use of planning tools; training related to the use of data; other professional development (i.e., trainings, etc. provided outside of the DC CoP); technical assistance; CQI data provided by DBH and partners; support from community partners. They asked respondents to classify each resource using the following categories: (1) useful, (2) not useful, (3) have not used the resource, and (4) not familiar with the resource.

In 2021, when ranked by the percentage of respondents that classified resources as helpful, the top three resources were:

1. Other professional development (70.8%)
2. DC Community of Practice (68.8%)
3. Technical assistance (64.1%)

In 2022, when ranked by the percentage of respondents that classified resources as helpful, the top three resources were:

1. Other professional development (49.5%)
2. Tip sheets and best practice guides (47.6%)
3. DC Community of Practice (46.4%%)

Every resource in 2022 had a smaller proportion of respondents classifying it as helpful when compared to the previous year. Notably, the proportion of "have not used" responses for both other professional development and DC Community of Practice were much higher in 2022 compared to 2021 (30.1% vs 11.7% for other professional development and 33.7% vs 11.7% for the DC CoP). This trend was consistent across nearly all the resources Child Trends asked about in the survey.

Data from a separate survey of school staff (e.g., behavioral health clinicians) offers context for understanding the increase in the proportion of SBHCs that did not use resources. The proportion of staff responding they frequently or almost always felt exhausted (62% vs 48%) or stressed (54% vs 38%) was higher in 2022 compared to 2021. These data suggest that many staff were overwhelmed in SY 2022-2023 and may have had limited capacity to engage with available resources.

With respect to plans for evaluating the DC CoP, Child Trends plans to continue with the plan that has been in place for the past year:

1. Child Trends will continue to survey SBHC, clinicians, staff, families and students to learn more about the effectiveness of the DC CoP
2. Child Trends will continue to request that the DC CoP collect information through their pre-registration survey and evaluation survey on whether participants have applied skills/knowledge gained through participation in the DC CoP in their work.

DBH believes that the combination of data from SBHCs, clinicians, school staff, families and students (which will capture both participants and non-participants of the DC CoP) is likely the most efficient way to understand the role of the DC CoP in building the capacity of school teams to address the behavioral health needs of students, families, and staff and to measure the effectiveness of the Community of Practice.

Q50. Attachment 1 of 2. CoP Event Meetings Planned and Actual Participants
Q50. Attachment 2 of 2. CoP Event Meetings Planned Participants

50. Please provide an update on the status of the community of practice for school-based behavioral health. Please include the following information:
    a. Changes to the current organization structure and plans for the future;
    b. List of events, trainings, or other convenings with brief summaries of the purpose of each event, target audience, planned number of participants, and actual number of participants in FY 2021, FY 2022, and FY 2023 to date;
    c. List of planned events, training, regular meetings, or other convenings with brief summaries of the purpose of each event, target audience, and planned number of participants in FY 2021, FY 2022, and FY 2023, to date;
    d. Estimated timeline for fully establishing the community of practice; and
    e. Plans for assessing the effectiveness and utilization rate for the community of practice.

Adult Substance Abuse Services

51. Please provide a detailed narrative on DBH's work to promote access to a continuum of quality substance abuse prevention, treatment, and recovery support services. Please include the following:

a. An update on the implementation of DBH's outpatient methadone maintenance treatment programs and clinics. Please include a list of providers providing these services;
b. An update on the Prescription Drug Monitoring Program;
c. An update on the Safe Syringe Exchange program;
d. An update on DBH's Peer Support Specialist program and the Peer-Operated Centers; and
e. The number of Peer Support Specialist for FY 2021, FY 2022, and FY 2023, to date.

DBH Response

In partnership with its grantees and community partners, DBH continues to lead the effort to promote and enhance access to the full continuum of quality substance use prevention, treatment, and recovery support services in the District. We utilize the following pathways / strategies to achieve these goals:

Web based Resources
A key component of our strategy to increase access to community services aggressive promotion of the DBH sponsored web site. This site provides information about accessing prevention, treatment, and recovery support services. Prevention information and resources about the DC Prevention Centers can be accessed via https://dbh.dc.gov/node/109292; information about accessing treatment through the DBH Assessment and Referral Center and DBH-certified treatment provider network can be found at https://dbh.dc.gov/page/substance-use-disorder-services; youth specific treatment information is available at https://dbh.dc.gov/node/107042; and recovery resources are available at https://dbh.dc.gov/node/109902. DBH also partners with DC Health through its MyRecoveryDC initiative to provide updated, ward level information and resources, as well as access to individuals with lived experience for support. DBH also participates in the Network of Care, another web based resource which provides information about local behavioral health resources. Lastly, through Twitter and other web based platforms, DBH pushes daily messages about accessing services and supports, as well as highlighting the important work of community providers and partners.

Social Marketing
In FY22, DBH launched the *"Hope" Campaign* ("This Time It is Different"), which targets individuals who need to be engaged or re-engaged in treatment by promoting the District's treatment, recovery services and supports. As part of this campaign, by texting *"Ready"* to 888-811, an individual receives a list of treatment providers who are open and available at the particular time of the text. In addition, all DBH promotional materials list the number for the Access Helpline (24/7 Hotline, discussed below) staffed by behavioral clinicians who can address emergent issues at the time of the call or refer the individual to community providers for on-going care.

Outreach and Community Engagement
In FY 22, DBH hired a Public Engagement Director to coordinate outreach efforts and community engagement, leveraging both DBH resources as well as teams within community organizations. These outreach teams provide support, training, distribute educational materials at community and pop-up events, and conduct community outreach in specified neighborhoods with the highest needs, engaging our most vulnerable citizens.

In the Spring of 2023, through the State Opioid Response (SOR) grant, DBH plans to launch an Opioid Ambassador's training, which will give community stakeholders an in depth overview of DBH's services and supports to enable them to spread the word throughout their communities regarding how those in need can best access services and supports.

Access HelpLine
Through the above pathways, we emphasize to community partners and those seeking care that our Access HelpLine at 1(888)7WE-HELP or 1-888-793-4357 is the most expedient and efficient means to connect to a DBH or certified, community behavioral health provider. This 24-hour, seven-day-a-week telephone hot line, staffed by licensed and trained, behavioral health professionals, serves as our Crisis and Triage hub: providing crisis management, counseling, information regarding community services, authorization for care and referrals to emergent services, as well as routine care in the community. The AccessHelpLine also receives calls from the "988" National Suicide Prevention Life Line emanating from the District.

a. In December 2022, the three community Opioid Treatment Programs (OTPs) (listed below) had 1,292 individuals enrolled. The majority of the individuals served were on Medicaid (718) and Medicare (319), while 126 were supported by local funds, and the remainder were self-pay (75) or commercial insurance (54). Since the COVID-19 public health emergency, the OTPs have been challenged by workforce shortages, which has forced them to limit or discontinue weekend hours. Fortunately, during this period, the Federal government has loosened regulations around take-home medication, which has allowed for increased take-home doses for all patients, including newly enrolled or "less stable" patients.

During the public health emergency, the OTP clinics provided care through virtual means (including group therapy, one on one sessions, and educational forums). Since many of these consumers have limited incomes and have no cell phones or computers, they have difficulty engaging in treatment via telehealth. In response to this potential barrier to care, DBH plans to launch a Telehealth Expansion Initiative this year to provide at risk individuals not consistently engaged in outpatient care a smart phone in order to connect to their provider via telehealth and ensure their continued engagement in care.

In addition, a number of community based Telehealth stations will also be distributed throughout the community to enhance access and connectivity to providers across a number of underserved communities. At the same time, the OTP clinics are also working to increase in-person attendance through a number of incentives for consumers (through food, small perks, etc.) in order to increase in person attendance in spite of the lingering

effects of COVID.

The three current community based OTPs are listed below. In addition, OTPs are also located at the DC Jail and the Veterans Administration:

Behavioral Health Group (BHG)
1320 Good Hope Road SE
Washington, DC 20020

Medmark (Formerly Foundation for Contemporary Mental Health - Partners in Drug Abuse Rehabilitation and Counseling [PIDARC])
2112 F Street NW
Suite 102
Washington, DC 20037

United Planning Organization (UPO)
1900 Massachusetts Avenue SE
Bldg. 13
Washington, DC 20003

b. The DC Prescription Drug Monitoring Program (PDMP) was implemented in 2016 by DC Health. Since the program was launched, annual PDMP queries have increased from roughly 85,000 in 2016 to over 300,000 in 2021 (the DC Health 2022 report has not been released.) In April 2019, the Opioid Overdose Treatment and Prevention Omnibus Act of 2018 became effective, which required that all practitioners authorized to prescribe or dispense in the District are registered with the DC PDMP. Most recently in March 2021, the Prescription Drug Monitoring Program Query and Omnibus Health Amendments Act of 2020 became effective, which required both prescribers and dispensers to query the PDMP prior to prescribing or dispensing an opioid or benzodiazepine medication for greater than a 7-day supply, and every 90 days thereafter during the course of treatment. The DC PDMP currently exchanges data with 27 jurisdictions through interstate interoperability agreements. Other services offered through the program include PDMP-EHR integration, quarterly 'Prescriber Reports,' and provider training sessions. DBH participates on the PDMP Advisory Committee, which meets several times each year to review data and implementation progress.

c. The District currently has four sanctioned syringe service programs (SSPs). Bread For The City provides syringe services out of their NW and SE primary care clinics. The three mobile SSPs are operated by Family and Medical Counseling Services, Inc. (FMCS), HIPS, and Us Helping Us / People Into Living Inc. (UHUPIL). Prior to FY23, DBH provided SOR funding to DC Health's HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA) for mobile SSP operations at FMCS and HIPS. In FY22, HAHSTA reported that the four SSPs provided services to 12,583 clients and exchanged a total of 864,914 syringes.

In August 2022, DBH competed a $2.3 million annual grant to support mobile SSP services as one of our key SOR initiatives. FMCS, HIPS and UHUPIL successfully competed and were awarded a base grant in FY23 with four option years, contingent on continued funding. In addition, DBH is providing an additional $140,000.00 of local funding in FY23 for the purchase of syringes due to a Federal law prohibiting the purchase of syringes with Federal grant funds. The SSP grant will formally kick off on January 27, 2023. Required grant deliverables include: syringe exchange, naloxone and fentanyl test strip distribution, overdose prevention education, responding to overdose spikes / clusters, and facilitating access to medication for opioid use disorder for individuals experiencing access barriers to traditional office-based treatment settings. This grant will also support additional staff positions to expand weekend and evening hours.

d. Due to the pandemic, the Peer Specialist Certification Training Program resumed in person training in July 22. The training program builds on the experience of people in recovery with training in foundational competencies required by anyone who provides peer support in behavioral health services. To date in FY 23, ten peers have been certified. DBH is also continuing to recertify peers who meet the requirements.

   The DBH Peer Support Specialist Certification Training Program is currently accepting applications for three six week classes scheduled on the following dates:

   - February 13-March 21
   - March 27-April 27
   - June 5-July 10

   Also, in an effort to increase peers in the District of Columbia, the program is offering waiver testing for individuals who have a current certification from another state or jurisdiction and are in good standing.

   There are currently four peer-operated centers (POCs). During FY 22, POCs offered naloxone training, recovery plan support, and support groups on a variety of topics such as harm reduction and wellness. They connected people to services and resources to support individual recovery plans and personal needs, such as acquiring supplemental food sources. POCs will continue this work in FY 23 by evaluating community needs and trends in order to tailor supports to meet real-time demands.

e. The total number of Certified Peer Support Specialists was 141 for FY 21, 128 for FY 22, and 144 for FY 23 to date.

52. Please provide a narrative on DBH's strategy for addressing the District's opioid crisis including an update on the Lifelong DC strategic plan. Please include the following:
    a. The number of DBH staff dedicated to opioid prevention and response;

b. An update on the Opioid Fatality Review board including a list of board members and participating organizations;
c. A list of locations (including ward) where the public can get Naloxone;
d. The number of Naloxone that was distributed in FY 2021, FY 2022, and FY 2023, to date. If possible, provide a list of the locations and the number of Naloxone that was distributed at each location;
e. The number of Naloxone trainings conducted in FY 2021, FY 2022, and FY 2023, to date;
f. A spreadsheet listing the 23 faith-based institutions detailing their work in FY 2021, FY 2022, and FY 2023, to date. Please include the types of services provided and the grant amounts each institution received;
g. The number of clinicians and other staff conducing assessments at the Assessment and Referral Center (ARC) in FY 2021, FY 2022 and FY 2023, to date;
h. How many assessments were done through the ARC in FY 2021, FY 2022, FY 2023, to date;
i. An overview of the assessment and referral process at the ARC; and
j. How many calls the Access Helpline received related to opioid addiction in FY 2021, FY 2022, in FY 2023, to date.

DBH Response

DBH certifies a network of community-based providers to render the following substance use disorder (SUD) treatment services which are based on the following levels of care established by the American Society of Addiction Medicine (ASAM):
Level 1 Outpatient, Level 2.1 Intensive Outpatient Program, Level 2.5 Day Treatment, Level 3.1 Clinically Managed Low-Intensity, Level 3.3 Clinically Managed High-Intensity, Level 3.5 Clinically Managed High Intensity Adult or Medium Intensity Youth, Level 3.7 Medically Monitored Intensive Inpatient Withdrawal Management.

DBH also provides a range of prevention and recovery services. Many adults with a substance use disorder (SUD) also have a co-occurring mental health disorder. DBH supports integrated care with screening, diagnosis and treatment for both mental and substance use disorders to treat the whole person for the best health outcomes.

SUD providers are located across the District **and** listed at: https://dbh.dc.gov/page/substance-use-disorder-services**.**

a. *The total number (via spreadsheet) of adults who received substance abuse services in FY 2022 and FY 2023, to date. Please provide breakdowns by consumer age, consumer home ward, ward where services took place, format (in-person/virtual/hybrid), and the types of services provided;*

Please see Attachment 1. SUD Services Provided.

b. *Total number of agencies or organizations that provide substance abuse services to adults. Please provide (via spreadsheet) a list of all agencies and organizations that provide substance abuse services to children and youth. Include their location, Ward, how many children and youth they served in FY 2022 in FY 2023, to date, the format of their services (virtual/in-person/hybrid), what services they provided, and contact information (staff contact, email address, phone number, and website);*

There are 27 SUD adult DBH certified providers and three providers who serve children/youth. Please see Attachment 2. SUD Services Provided and SUD Providers and Youth Data.

c. *Plans in FY 2023 to expand the types of substance abuse services offered to adults;*

In FY 23, DBH plans to expand the types of SUD services and supports offered to adults in a number of areas: assessment and referral, early intervention services, residential treatment, recovery housing, and the expansion of medication for opioid use disorder programs.

In the spring of this year, DBH plans to open the District's first Stabilization and Sobering Center (Sobering Center). The Sobering Center will provide individuals under the influence of alcohol or drugs with person-centered care and a recovery-oriented alternative to law enforcement response or transfer to an emergency department. The DCSSC will include onsite services to screen and assess medical and behavioral health status and address immediate personal needs (i.e., food, bathrooms, shower, and laundry), transportation services, communication support, and other immediate supports. The DCSSC will also provide consumers with referrals to the appropriate ASAM level of care either on-site or in the community and offer care management and coordination directly or through community partners. DCSSC staff will assist with navigation, linkages and referrals to housing, transportation, social services, and other supports to address unmet social needs. The Sobering Center will be open 24/7 and serve individuals 18 years or older.

During the coming year, DBH plans to fund the establishment of a community-based level 3.5 SUD treatment facility for youth, which would include transitional age youth, in a clinically managed, medium intensive residential program using Federal Substance Use Prevention, Treatment, and Recovery Services (SUPTRS) Block Grant funds. In addition, proposals were submitted to the Substance Abuse and Mental Health Services Administration (SAMHSA) to use SUPTRS funds to support expanded services at the Comprehensive Psychiatric Emergency Program (CPEP) and skilled/long-term care facilities. CPEP provides emergency psychiatric treatment services for individuals experiencing a mental health crisis, however at least 70% have a co-occurring SUD. The funding would support nurses and social workers to provide HIV Early Intervention services to individuals with SUD that are being treated in the CPEP Extended Observation Beds where withdrawal management and buprenorphine induction will be offered.

The majority of individuals experiencing fatal overdoses are older, African American males. To better target this population, DBH proposed to SAMHSA to use SUPTRS funds to create a pilot

SUD unit at long-term care/skilled nursing facility to allow for treatment of individuals traditionally unable to receive SUD treatment in this setting. In addition, SOR funding will support a consultant to conduct SUD training and technical assistance in at least 19 skilled nursing/long-term care facilities with the goal to encourage them to provide medication for opioid use disorder (MOUD) and other treatment in their facilities.

DBH also plans to award SOR grants in the near future to community providers to establish new recovery residences for individuals with stimulant use disorder/opioid use disorder (STUD/OUD). Through this grant, individuals with OUD/STUD will receive intensive care management while living in a safe and monitored recovery residence. Intensive care management includes an assessment of an individual's functional life skills (e.g., personal living skills, social skills, vocational skills and service procurement skills) in order to establish a long-term plan for ongoing recovery. Individuals will not be immediately asked to leave if they return to using; the staff will work with the resident to get back on their recovery path.

Through six new SOR Expanding Access and Retention in Care for Opioid and/or Stimulant Use Disorder Treatment grantees, DBH will implement strategies that reduce barriers to accessing treatment for prospective patients with STUD/OUD, re-engage clients who have unexpectedly or prematurely discontinued their treatment, support current patients to promote retention, and provide whole-person care. By addressing clients' connection to care, this grant initiative will seek to further reduce behavioral health disparities within underserved communities and improve access to behavioral health care services.

The SOR grant has also recently funded three syringe services programs. Two of these programs will be expanding their mobile MOUD programs. The Department of Corrections has requested additional SOR funding to expand their MOUD program by conducting a pilot using Sublocade, which is injectable long-acting buprenorphine. Lastly, the DBH SOR grant is funding four Fire and Emergency Medical Services (FEMS) outreach teams to connect in real-time to overdose survivors to refer them to MOUD and other services and supports and follow up with them as needed.

53. Please describe what substance abuse services are offered to adults and the process for obtaining these services. Please include:
    a. The total number (via spreadsheet) of adults who received substance abuse services in FY 2022 and FY 2023, to date. Please provide breakdowns by consumer age, consumer home ward, ward where services took place, format (in-person/virtual/hybrid), and the types of services provided;
    b. Total number of agencies or organizations that provide substance abuse services to adults. Please provide (via spreadsheet) a list of all agencies and organizations that provide substance abuse services to children and youth. Include their location, Ward, how many children and youth they served in FY 2022 in FY 2023, to date, the format of their services (virtual/in-person/hybrid), what services

they provided, and contact information (staff contact, email address, phone number, and website);

c. Plans in FY 2023 to expand the types of substance abuse services offered to adults;

d. Types of services and interventions offered;

DBH Response: Saint Elizabeths Hospital provides recovery-based and trauma-informed mental health treatment to District residents with severe mental illnesses. The following services are offered at Saint Elizabeths Hospital: Psychiatric Services, Psychology Services, Nursing Services, Social Work Services, Rehabilitation Services, Physical Therapy, Dental Services, Respiratory Therapy, General Medical Services, Laboratory Services, Pharmacy Services, Barber and Beautician Services, Chaplain Services, Volunteer Services, Consumer Advocacy, Positive Behavioral Support Services, Neurology and Neuropsychology Assessment and Treatment, Infection Control Services, Nutrition Services , Forensic Services, Facilities and Engineering Services, Housekeeping Services, Safety (Security) Services, Materials Management, Transportation Services, and Administrative Services.

e. The types of mental health professionals providing services at the facility;

DBH Response: Each treatment team includes a psychiatrist, psychologist, general medical officer, psychiatric nurse, social worker, clinical administrator, and behavioral health technicians who along with the individual in care are responsible for identifying treatment goals, objectives and interventions. Mental health services are also provided by rehabilitation therapists, creative arts therapists, chaplains, mental health counselors, licensed practical nurses, certified addictions counselors, positive behavioral support clinicians, and recovery advocates.

f. Number of adult admissions;

DBH Response:

Fiscal Year (FY)	Admissions
2021	180
2022	189
2023 (to date 1/18/23)	78

g. Number of adult walk-ins;

DBH Response: Saint Elizabeths Hospital does not admit adult-walk-ins. The pathways to admissions at Saint Elizabeths Hospital are through transfer from a community hospital (after up to 14 days stay), or through court order for psychiatric evaluation and/or treatment. The Hospital is a tertiary care (long-stay) facility.

h. Number of children admissions;

DBH Response: Saint Elizabeths is an adults only psychiatric hospital.

i. Number of children walk-ins;

DBH Response: Saint Elizabeths is an adults only psychiatric hospital.

j. *Number of FTEs (broken down by type);*

DBH Response: Saint Elizabeth Hospital FTEs by type as of January 18, 2023:

FTEs By Type	Number	Percentage
Clinical	560.95	76%
Non-Clinical	173.00	24%
TOTAL	733.95	100%

k. *Number of open work orders; and*

DBH Response: Saint Elizabeths Hospital utilizes its own work order management system. In June 2022, the Hospital transitioned from its old work order system (SiteFM) to Total Maintenance System (TMS). There are 22 work orders open from FY 2022 due to supply chain delays for parts or awaiting preventative maintenance. Since the start of FY 2023, there are 300 open work orders to date (1/18/2023).

l. Major facility upgrades and renovations (including plans for FY 2023).

DBH Response: In FY 2021 – FY 2022, the Hospital completed the renovation and transformation of Therapeutic Learning Centers to livable spaces to provide additional COVID-19 quarantine/cohorting areas. Security upgrades included the installation of card readers on back doors (Hallways A, B, & C), and the installation of sounders and electronic sensors by every exit door. Campus lighting was also upgraded. In FY 2023, the following projects are planned:

- Emergency Power Electrical Upgrade (DGS)
- HVAC Modernization at SEH, Phase I & II (DGS)
- Flooring Upgrade (DGS)
- Thermal Docking Stations/Dinex System (DGS)
- Upgrade Security Surveillance System (DGS)
- Upgrade PA and Lighting Systems – included in Security System Upgrade (DGS)
- Nursing Station Enclosure 2TR (DGS)
- Automated Electronic Key Management System
- Installed Acoustical Ceiling Panels in Rooms
- Repair and Upgrade roadways, pathways, and courtyards
- Replace Doors on units 1C & 1D

In-Patient Care

54. Please provide an update on Saint Elizabeths Hospital operations including the following for FY 2021, FY 2022, and FY 2023, to date:
    a. Types of services and interventions offered;
    b. The types of mental health professionals providing services at the facility;
    c. Number of adult admissions;
    d. Number of adult walk-ins;
    e. Number of children admissions;
    f. Number of children walk-ins;
    g. Number of FTEs (broken down by type);
    h. Number of open work orders; and
    i. Major facility upgrades and renovations (including plans for FY 2023).

DBH Response

Immediately following this tragic incident, Saint Elizabeths Hospital strengthened its safety protocols including

- doubling the number of nursing staff who conduct evening and night safety checks at 30-minute intervals
- random searches and unannounced visits on the units by the nurse supervisors
- accounting for all utensils after meals and snacks to reduce the risk of their use for harm, and
- routine review of videotapes to make sure safety protocols are being followed

All staff have been retrained on the safety protocols. The Department of Behavioral Health is committed to providing a safe, healing environment at Saint Elizabeths and took appropriate personnel actions including terminations for staff who failed to follow safety protocols in place at the time of the tragic incident.

55. Please share any changes to hospital policies resulting from the tragic incident in March 2022 where a patient was murdered.

DBH Response

DBH has contractual agreements with United Medical Center (UMC), Psychiatric Institute of Washington (PIW) and Washington Hospital Center (WHC) to admit and treat patients admitted on an involuntary legal status. These hospitals are required to notify DBH of all adult admissions and discharges. Admission and discharge notifications to DBH are made through the Chesapeake Regional Information System of Patients (CRISP). All three hospitals are required to participate in CRISP, the District's designated Health Information Exchange (HIE). In addition, DBH receives notification of admissions and discharges for any adult enrolled in a facility participating in CRISP.

DBH does not currently receive live notifications of children admissions and discharges from Psychiatric Institute of Washington or Children's National Hospital. DBH does receive non-live, aggregated data from both hospitals, however, which includes a monthly and weekly count of admissions and discharges after both hospitals have billed DHCF for services. DBH is actively working currently with Qualifacts, owner of the Credible system, to correct this situation in the future so we can have live notifications of hospital admissions and discharges of children concurrent with treatment.

56. Does DBH receive notification of all admissions and discharges for District residents (including children and youth) who receive inpatient behavioral health treatment at either the Psychiatric Institute of Washington (PIW) or Children's National Hospital? If not, what steps are being taken to receive these notifications?

DBH Response

DBH has an established discharge policy which provides the required procedures for providers for effective and safe discharges for children and youth. The child/youth's Core Service Agency or (CSA) and/or Community-Based Intervention (CBI) provider is required to participate in the development of an appropriate discharge plan with the individual's family and the hospital staff. Discharge planning must be documented to include the following:

- A face-to-face appointment between the CSA and/or CBI provider and the consumer within seven days of the child/youth's discharge from the facility to the community.
- A scheduled medication somatic appointment for each child/youth prescribed psychotropic medications with the CSA within 10 days of discharge.
- A Child Adolescent Functional Assessment Scale (CAFAS) should be administered to indicate level of acuity and appropriate service needs.
- Plans to have CBI authorized and in place within two days of discharge, if appropriate.

As a part of the discharge planning process, the CSA and/or the CBI Provider coordinates transportation services through the youth's managed care organization. Managed care organizations are required to provide transportation services to their enrollees.

DBH also has Continuity of Care Guidelines which specifically outline the roles and responsibilities of DBH certified providers to ensure engagement with an adult who has been admitted to an inpatient unit and begin discharge planning upon admission. Providers are expected to engage within 48 hours of admission and within seven days thereafter while hospitalized, and within 30 days post-discharge. DBH monitors timeliness of services post-discharge from a psychiatric hospital for adults as a Key Performance Indicator (KPI). In FY 22, the performance target was 60% and the actual performance was 54%. The actual performance is consistent with HEDIS reported performance for Medicaid/Medicare plans which ranges from 50.1% to 58.9%.

The, DBH's Integrated Care Division (ICD) within Adult Services administratively authorizes hospitalization for a person admitted in an involuntary legal status. ICD care managers work with the contracted community hospitals and the community provider to ensure discharge planning begins upon admission, that discharge plans are safe and appropriate, and that individuals have adequate transportation home.

57. What specific steps is DBH taking to ensure an effective and safe discharge for District residents (including children and youth)? Please include what type of transportation assistance is provided to discharged residents.

DBH Response

DBH conducts oversight of PIW both because of our role as the state authority for behavioral health and because of our contract with PIW to provide acute care services to adults who are admitted in an involuntary legal status for treatment. We recognize, however, that DC Health is the licensing authority for hospitals responsible for ensuring compliance with the law and health and safety standards and we work closely to coordinate our oversight and focus our monitoring activities as appropriate. In addition, our contract for involuntary acute care services requires that a hospital remain in good standing with its regulatory agencies.

During FY 22, when quality of care issues came to our attention, the DBH Accountability Administration conducted an unannounced site visit to review select clinical records, policies and operational practices to determine whether the hospital was complying with DBH's contractual requirements and DC Health policies. Based on various issues brought to their attention around the same time, a separate site visit was conducted by DC Health to address their concerns regarding PIW's compliance with requirements pertaining to the patient health and safety requirements.

During its review, DBH focused on the care received by patients admitted under the contract for involuntary treatment and whether clinical and quality standards were being met during these admissions. The DC Health audit focused on whether their licensing requirements were being

followed. After the site visits, DC Health and DBH shared information/data regarding their findings. DBH met with PIW's clinical leadership and requested an corrective action plan to address the identified concerns regarding continuity of care, discharge planning, and record keeping errors. DC Health also required a separate corrective action plan from the hospital to address their concerns.

DBH met with PIW monthly to review their progress until satisfied that appropriate corrective actions had been taken. DBH then informed DC Health that the requirements of the DBH corrective action plan had been met and that PIW was adhering to the requirements of their contract.

58. How does DBH coordinate with DC Health to ensure that the Psychiatric Institute of Washington (PIW) is adhering to the protections provided in the Mental Health Consumers' Rights Protection Act, including incident reports, investigation, and other risk management requirements?

DBH Response

DBH continues to lead monthly meetings of the PRTF Interagency Collaboration Committee which is working to resolve concerns about payments. This Committee is comprised of DBH and all referring government agencies (CFSA, DYRS, CSS, DCPS, and OSSE), the Managed Care Organizations, DC Department of Disability Services, and the Department of Health Care Finance.

OSSE currently has MOUs with CFSA and DYRS to pay for the educational component of "committed" youth enrolled with their agencies who require placement in a PRTF and are reviewed and approved for placement by the PRTF Review Committee. However, there is no policy in effect that governs whether or how payment for educational services will be paid for "non-committed" youth or youth in general education without an IEP who have no other agency involvement other than needing mental health services. DBH, DHCF, and OSSE continue to explore viable processes and procedures through the PRTF Interagency Collaboration Committee to develop a standardized process regarding the referral process for these youth and how the educational component of these placements will be financially supported.

59. Please provide an update on the work of DBH, OSSE, and the Psychiatric Residential Facility (PRTF) Interagency Collaboration Committee regarding youth placed in PRTFs, with and without Individualized Education Plans (IEPs). How is the educational component of these placements financially supported? Please provide relevant documents (MOAs or MOUs) related to this subject.

DBH Response

In FY22, 449 (this does not reflect unique individuals) youth were discharged from a community hospital inpatient psychiatric hospitalization. Of the youth discharged, 35 youth received CBI with 30 days, seven youth received CBI within 60 days, one received CBI within 61 days and eight were engaged in CBI within 90 days or more. In addition to CBI, additional Mental Health Rehabilitative Services (MHRS) are available to youth based on recommendations of the discharge plan from hospital. Additional services include medicine management, therapy, community support, substance use services and/or group. Data show of the 449 youth discharged from inpatient treatment, 328 were involved in additional services 30 days upon discharge, 46 were involved 30 days or more, 20 were involved 60 days and more and 24 were in services 90 days or more.

In Quarter 1 of FY23, 102 (this does not reflect unique individuals) youth were discharged from a community hospital inpatient psychiatric hospitalization. Of the youth discharged, 10 youth received CBI within 30 days, 2 youth received CBI within 60 days and zero beyond 61 days or more. In addition to CBI, additional MHRS services are available to youth based on recommendations on discharge plan from hospital. Data reflect, of the 102 youth, 65 youth received additional MHRS 30 days or more and 2 youth 60 days or more.

In FY22, 31 youth were discharged from a Psychiatric Residential Treatment Facility (PRTF). Out of the 31youth discharged, 17 youth received CBI with 30 days and 2 youth were seen within 60 days. There were no youth who received CBI after 60 days. The other 12 youth discharged from a PRTF received community support, therapy, medication management, High Fidelity Wraparound and Assertive Community Treatment (ACT). Once youth are discharged, DBH continues to monitor the youth's transition and assess the need for additional behavioral health services. One youth has been discharged from a PRTF in Quarter 1 of FY23. Upon discharge, he was enrolled with a CSA and engaged in CBI within 60 days of discharge.

60. In FY 2022 and FY 2023, to date, how many children were discharged from inpatient psychiatric hospitalization or psychiatric residential treatment facilities and received in-home and community-based mental health services? Please include CBI, intensive care coordination, and intensive case management services—within 30 days, 60 days, or 90 or more days of their discharge.

DBH Response

DBH conducts a variety of individual and community-focused activities to address the prevention, early intervention and treatment of trauma related to gun violence using a public health approach and its impact on children, adults, and families. Broadly, much of the work DBH does directly and through certified partners serves to prevent and reduce violence including

anger management and anti-bullying for children and youth, treatment for substance use disorders and mood disorders, and evidence-based trauma treatment modalities.

This work crosses multiple administrations within DBH and Dr. Richard Bebout, Chief of Crisis Services, serves as the lead in our violence prevention and response efforts. The Community Response Team (CRT)) is central to many of the activities in which DBH engages. CRT sometimes collaborates with violence interrupters to assist an individual at risk of perpetrating or becoming a victim of gun violence to access needed behavioral health care, especially treatment for substance use disorders. CRT also frequently is asked by faith leaders, stakeholders and community leaders to intervene and provide support to communities dealing with loss and trauma, in addition to crisis responses and ongoing outreach in communities at high risk of experiencing violence. CRT team members provide immediate support to individuals at memorial events in the community and disseminate printed information about behavioral health resources available through DBH and its provider network in every ward in the District.

Agency and Community Partnerships. DBH's partnership with DMPSJ and public safety agencies including OUC, MPD, and FEMS are spotlighted at length in our response to Q64 which discusses enhanced crisis services and alternative 911 responses. In addition, DBH has partnered with many other District agencies to support the Building Blocks DC Initiative under the direction of Linda Harllee Harper and has a number of individuals and families assigned to it within the People of Promise initiative. These cross-agency initiatives adopt a public health approach to gun violence prevention and target the individuals and neighborhoods at highest risk of being adversely affected by gun violence.

DBH frequently collaborates with MOCRS and ONSE offices with a primary focus of providing detailed information about how to individuals they encounter can access the city's robust array of behavioral health services. DBH is also targeting and working with key community providers and leaders in the target neighborhoods to conduct ongoing outreach and engagement activities in non-clinical settings to address stigma and to promote basic behavioral health literacy and coping. An example of this is the CRT's weekly participation in outreach to the Minnesota Avenue/Good Hope Road community. This takes place Wednesdays from 1-5 pm and is spearheaded by DMPSJ in partnership with the MPD and FEMS.

Prevention. Clinicians in public schools provide prevention, early intervention, and treatment services related to violence prevention. Specifically, the clinicians implement classroom-based violence prevention activities through programs such as anti-bullying Too Good For Violence (TGFV) and Kimochis. TGFV is a school-based violence prevention and character education program designed to improve student behavior and minimize aggression. TGFV is designed to help students learn the skills they need to resolve conflict peacefully. Kimochis is a social-emotional curriculum that uses characters to teach young children about emotions and how to communicate their feelings with others.

DBH also works through the four ward-based DC Substance Use Prevention Centers (DCPC) to conduct outreach and engagement in communities throughout the District that are experiencing gun violence. With community partners, the prevention centers distribute information on

marijuana, underage drinking, opioid misuse, and synthetics. In the last two years, the DCPCs have greatly increased their social media presence through virtual platforms including Twitter, Instagram, and Facebook. Social media messaging for targeted populations includes information on the legal and health risks associated with drug use and promotes positive alternatives to substance use and other destructive behaviors such as exercising and finding creative outlets for expression.

Services to youth and adult crime victims. DBH collaborates with the Office of Crime Victims to provide direct support and services to youth crime victims and their families. Clinicians in the School Based Behavioral Health Program (SBBHP) support the victims and help to connect both youth and adults to services. In addition, school-based behavioral health clinicians include information regarding gun and community violence in trauma-focused presentations and often provide trauma-informed clinical services to students exposed to gun violence in a variety of ways. Some clinicians are trained in trauma-specific modalities, including TF-CBT and can implement this intervention to address traumatic symptoms due to exposure to violent crimes including gun violence.

DBH also makes available several evidence-based treatment approaches through certified providers to address the impact of traumatic events such as gun violence. These services include Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Trauma Systems Therapy (TST), and Child-Parent Psychotherapy (CPP). These therapy models have been proven to reduce symptoms and behavioral disturbances for children who are victims of trauma. TF-CBT is a psychotherapy model for youth ages 3-18 years old designed to help children, youth, and their parents overcome the negative effects of traumatic life events and address feelings. TST is a psychotherapy model for youth ages 6-18 years old which aims to stabilize the child's environment while simultaneously enhancing their ability to regulate emotions and behaviors. CPP is a psychotherapy model for children ages 0-6 years old and their parents that helps restore normal developmental functioning in the wake of violence and trauma by focusing on safety, affect regulation, improving the child-caregiver relationship, normalization of trauma related response, and joint construction of a trauma narrative.

In the past year, DBH has responded to many requests for support from the community as well as sister District agencies impacted traumatic events. For example, in June 2022, DBH provided a support to staff at a DC Health operated COVID Center who witnessed the shooting death of an individual in front of their door. In July, CRT and ChAMPS responded jointly to children and families who witnessed a fatal officer-involved shooting in Slocum Park.

DBH supports to school communities. Sometimes after a violent incident (e.g., death of a student or a teacher, drive by shooting) occurs additional supports and services are needed to support school communities. For over 20 years, DBH has provided crisis response services to the District of Columbia Public Schools (DCPS) and District of Columbia Public Charter Schools (DCPCS). DBH school-based behavioral health clinicians and supervisors are trained in a psycho-educational crisis model developed by William Steele. This model explains the grief/trauma process and promotes healthy coping strategies in an attempt to prevent prolonged

grief disorder and Post Traumatic Stress Disorder (PTSD). When requested to respond to a crisis, clinicians and supervisors use the model to help support students and staff.
All requests that come to DBH for school crisis are triaged through the Branch Chief or designee of the DBH SBBHP. School leaders, members from other government agencies (e.g., Deputy Mayor's' Office, the Charter Board, OSSE Health and Wellness), and behavioral health clinicians at schools can reach out to the Branch Chief directly or her designee, and request support and a formal response. The DBH crisis team responds mostly to crises at public charters schools, because DCPS has their own crisis teams and responds to crises in their buildings. If needed, DCPS will reach out to DBH directly for additional support or when there are multiple crises.

Once a principal has invited DBH to provide a crisis response at their school, an assessment of need is provided by the Branch Chief or a Crisis Lead. Based on the information gathered a plan is put in place and the number of clinicians needed is determined. The crisis team can be deployed immediately or the next school day, whatever is most appropriate. A typical crisis will start with classroom presentations being implemented in identified classrooms. During the presentations, two clinicians provide accurate information, dispel rumors, identify common grief/trauma reactions, identify positive coping strategies, help each student identify coping strategies that have worked in the past, have each student identify an adult they can talk to, make sure the students are aware of the supports in the building and how they can be reach out to that person, provide additional resources and identify students that may need extra support. Additional supports offered during a crisis response are individual staff and student sessions, group sessions with students or staff, morning meetings for staff to help with messaging, parent meetings, and connection with on-going resources. Often schools identify special groups of individuals who may be impacted at a higher level. The crisis team may target or provide extra support to these individuals. These groups may include: family members, members of a specific club/sport that the child participated in, or a group of teachers who taught the youth. Those groups often have their own support group to address their unique needs.
On average, the crisis team spends two days onsite with the time spent responding to each crisis dependent on the type of crisis, the school, the number of previous crises the school has suffered, and the overall impact on the staff and students. The DBH crisis response team supports the school until the mental health team at the school indicates they are prepared to manage the on-going needs of the school.

Budget and spending. DBH's work on gun violence prevention and response is integrated in multiple administrations and is not tracked and reported as a discrete budget activity.

Violence Prevention and Response, Department of Corrections & Behavioral Court Diversion

61. Please provide a detailed narrative of DBH's role in the District's city-wide violence prevention and response strategy. In the narrative, please include the following:
    a. The name(s) of DBH staff who lead DBH's violence prevention and response work within the agency;
    b. How DBH partners with the other agencies, such as the Office of the Deputy Mayor for Public Safety and Justice, the Office of Neighborhood Safety and Engagement, the Office of Gun Violence Prevention, the Office of the Attorney General for the District of Columbia, the Department of Parks and Recreation, the Office of the City Administration (Building Blocks), and other relevant agencies;
    c. How DBH works with community-based organizations;
    d. What services DBH provides to child and adult crime victims and how DBH communicates the availability of these services to the community;
    e. How DBH supports school communities after violent incidents. Please include the process (contact initiation, duration, types of support) DBH takes after a school community experiences violence; and
    f. DBH's budget and spending (in Microsoft Excel) in FY 2021, FY 2022, and FY 2023, to date, on violence prevention and response programming and resources.

DBH Response

The Juvenile Behavioral Diversion Program (JBDP) is a voluntary, mental health solution-based specialty court that provides intensive case management and mental health services to youth in the juvenile justice system with significant mental health concerns. The JBDP has operated within the DC Superior Court Juvenile Division since January 2011. This program connects and engages juveniles and their caregivers/families in appropriate community-based mental health services and supports and provides for a period of engagement during which time the court monitors both the implementation of mental health services and the youth and families' participation in those services. Court-involved juvenile status offenders are given the option of voluntarily participating in mental health services rather than being prosecuted. If successful, participants can have their cases dismissed or shortened lengths of probation sentences.

The goals of the program are to: (1) increase the number of youth able to remain in the community with improved functioning in the home, school and community with appropriate mental health services and supports, (2) reduce the likelihood of the youth's further contact with the criminal justice system as a youth and later as an adult, and (3) to reduce crime in the community and protect public safety. 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 required to attend regular court status hearings to monitor progress and to participate in mental health services and other specified court conditions. Youth generally participate in the program from three months to one

year, depending on the pace of their overall progress towards individualized goals, as determined by the "team," i.e., all individuals assisting in the youth's service plan (e.g., the youth/family/service providers/probation officer/defense counsel/Education Attorney/AAG and JBDP Judge).
a. The Juvenile Behavioral Diversion Program (JBDP) serves juvenile offenders who are 18 years of age or younger at the time of the instant offense. All court-involved youth receive mental health screening at the time of initial intake, following arrest. Youth are administered the Connor's Comprehensive Behavior Rating Scale (CBRS) which measures social, emotional, behavioral, and academic problems in children and adolescents ages 8 to 18 years. Additionally, youth are administered the Sex Trafficking Assessment Review (STAR) to determine a child or adolescent's risk of sexual exploitation in the community. These screenings are used to initially identify youth who may be appropriate for either the JBDP or Here Opportunities Prepare You for Excellence (HOPE) Court for youth at-risk or involved in the commercial and sexual exploitation of children (CSEC).

Determining eligibility for the JBDP is a two-step process. The Office of the Attorney General (OAG) reserves the right to permit or deny a youth to participate in the program on a case-by-case basis as an initial step in determining a youth's overall eligibility for the program. The OAG makes its determination of "legal eligibility" based on a variety of factors including prior and current contacts with the court, nature and circumstances surrounding the offense, mental health needs, and other relevant social factors. The second step in determining eligibility is a referral to the "Suitability Committee" of the JBDP. There, the Committee determines if the youth meet basic, clinical criteria, i.e. (1) the presence of a primary mental health diagnosis and (2) that the youth can participate in community-based services at the time of entry into the program. The Committee then takes into consideration multiple, additional factors that may impact a youth's ability to fully participate in the program, utilizing a biopsychosocial model of assessment, to determine final, clinical "suitability."

b. A juvenile offender can be referred by the initial hearing judge, the juvenile calendar judge, the Assistant Attorney General (AAG), the youth's defense attorney or a Court Social Services Probation Officer. Once a juvenile is deemed legally eligible, a referral is made to the Suitability Committee whereupon clinical eligibility is determined. The Suitability Committee, co- chaired by a DBH and a Court Social Services Division (CSSD) representative, is otherwise comprised of members from CSSD, the Child Guidance Clinic (CGC), and the DBH "preferred providers," i.e., those Community Services Agencies (CSAs) that are affiliated with the JBDP. These CSAs provide services to the majority of the youth in the program and collectively offer the range of services most highly utilized by program participants, including trauma-focused services. Following the clinical review, the Committee establishes recommendations for individualized services for each youth that are both comprehensive and holistic. These recommendations are forwarded to all court officials involved in the youth's case, regardless of their outcome of eligibility for the program. The Committee's recommendations can be implemented outside of the JBDP, should a youth decline to enter the program or voluntarily op-out later. All youth enrolled in JBDP receive mental health services through the DBH provider network (or outside DBH's network, as needed) and are supervised by specialized probation officers (trained in the DC mental health System of Care) of Court Social Services Division (CSSD).

c. Court Social Services gathers data on a calendar basis. The number of youth who participated in the JBDP program in CY22 is 53. The number of youth participating in JBDP thus far in CY23 is 54. Though referrals can be prompted by multiple court or community sources, i.e., judges, probation officers, defense attorneys, etc., it is the OAG that ultimately becomes the main referral source, as all referrals must first be found legally eligible by the OAG. Once legal eligibility is established, a referral is sent by OAG to the Child Guidance Clinic of CSSD, where the clinical referral packet is compiled for review for the Suitability Committee.
The chart below details the types of offenses committed by youth in CY22. Data for CY23 will not be captured until the end of year.

Type of Offenses	**Number of Offenses Of all youth enrolled in CY 22**
Unlawful Entry and Assault (Threats, Simple Assault, Assault on Police, Disorderly Conduct)	32
Theft (Shoplifting, Theft I & II)	11
Robbery – UUV-Unlawful Entry Motor Vehicle, Burglary-No Permit	29
Destruction of Property/Fare Evasion	7
Runaway	1
Truancy	0
Sex Abuse	0
Possession of Weapon/Ammunition	27
Robbery while armed/Assault with Weapon/Carjacking	16
Possession of Controlled Substance	0
Credit Card Fraud	1
Total Offenses	**124***

+*Youth are often charged with multiple offenses. This list includes pre- and post-adjudicated charges

d. Of the 53 youth that were involved in JBDP in CY22, 26 youth are receiving or have received Community-Based Intervention (CBI) services, i.e., CBI I (Multisystemic Therapy (MST), CBI II and III, and CBI IV (Functional Family Therapy (FFT)) for a total percentage of 49.05%. This data point indicates that a very high percentage of youth participants of the JBDP meet criteria for the most intensive, community-based services that DBH offers, further indicating that JBDP youth participants are among the highest at-risk youth (and families) served by DBH through this one program. Although CBI was not provided to all youth involved in JBDP, participants received an array of services that are offered through the Mental Health and Rehabilitation System (MHRS) through DBH, e.g., community support, individual and family-based therapies, evidence-based practices (Trauma-Focused CBT, Trauma Systems Therapy, High Fidelity Wraparound, Transition to Independence Process (TIP) and Transition Age Youth (TAY) services), and substance use services. Each youth enters the program with a preliminary, individualized plan for services and treatment created by the Suitability Committee following a comprehensive review of the case. The plan is then implemented once the youth begin the program and is adjusted per the needs of the youth and family as they progress through the

program. Recommendations for services while in JBDP are based on clinical determinants, services already in place, willingness to engage in intensive services and service criteria.

e. DBH does not have access to the universe of youth involved with Family Court Social Services Division. Therefore, we are unable to provide the number of youth receiving CBI services through Court Social Services Division.

f. The average and median wait time for a first appointment with a psychiatrist is within a two-week period from the time of referral for medication management, per the protocols established with preferred providers of the program. However, advocacy is made on a case-by-case basis by the DBH Program Coordinator to assist program participants in securing earlier appointments with the youth's Core Service Agency (CSA) or through DBH's Urgent Care Clinic at 821 Howard Road SE, in the event of an urgent need.

g. Court Social Services' Child Guidance Clinic (CGC) is responsible for collecting and analyzing the majority of the JBDP data. Recidivism is defined as "a plea or found involved" in a crime up to one year after completion of the program. The data collected to date for the CY2021 cohort indicates a recidivism rate of 12%, far below the national average of 43% to 50%. Recidivism rates are calculated one-year post-graduation. Since youth enter and exit the JBDP on a rolling basis, data cannot be analyzed until the entire cohort for the year has reached one-year post-graduation. Therefore, the rate of recidivism for the CY2022 cohort is not yet available as not all participants have reached the one-year post-graduation mark.
Below is the recidivism data for the JBDP since the program's inception in calendar year 2011.

Calendar Year	Total Number of Youth Enrolled	Total Youth w/ Reconvictions within 12 months of exiting JBDP	Recidivism Rates
2021	33	4	12%
2020	25	7	28%
2019	47	10	21%
2018	56	17	30%
2017	95	19	20%
2016	61	9	14.5%
2015	33	6	18%
2014	54	12	22%
2013	42	6	14%
2012	62	19	30%

h. The direct cost for DBH is the salary and fringe for one FTE Social Worker. The salary for the Social Worker FTE is currently $126,444.00.

i. The program capacity is 100 youth per year however the number of youths served in JBDP has decreased from previous years due to the pandemic and the existence of HOPE Court which is another specialty court for juveniles at-risk-of or engaged in commercial, sexual exploitation requiring behavioral health services. Currently, there is no plan for expansion as the current program has sufficient capacity.

62. Please provide a description and an update on the Behavioral Court Diversion program including:
    a. A description of which youth are eligible to participate in the program;
    b. The process or protocol of selecting or referring youth to the program;
    c. The number of youth who participated in FY 2022 and FY 2023, to date, 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 number of youth currently receiving CBI services through the Juvenile Behavioral Diversion Program;
    e. The number of youth currently receiving CBI services through the Family Court Social Services Division;
    f. The average and median wait time for a first appointment with a psychiatrist after referral from the Juvenile Behavioral Diversion Program and the Family Court Social Services Division;
    g. The recidivism rate of the youth participants and an explanation of how recidivism rates are measured;
    h. Any costs associated with the program; and
    i. The program's capacity and any expansion plan or barriers to expansion.

DBH Response

Though the READY Center was closed from early March 2020 to late June 2022 due to the public health emergency, DBH has sustained its work supporting individuals with behavioral health needs in the custody of the Department of Corrections (DOC). The Forensic Services Division continues to link individuals to behavioral health services, track the contact of returning citizens with DBH community-based providers on a monthly basis, and report ongoing performance data to relevant partners including DOC.

To further assist consumers in custody, Forensic Services staff provide DOC and Unity, its contracted healthcare provider in the DC Jail, with pertinent mental health information on individuals while they remain in custody. Forensic Services staff cross-reference electronic medical records to identify whether new admittees have received mental health services locally

and, if so, their diagnosis, treatment provider, and when last seen. These efforts expedite the identification of individuals that need help and promote the continuity of care and delivery of mental health services while incarcerated.

While full in-person READY Center operations in the DC Jail were suspended, DBH worked with Unity Health Care's discharge planning team at DOC to maximize follow-up in the community after individuals with known behavioral health challenges were released. Additionally, a DBH liaison at DC Superior Court works with DOC representatives daily to link incarcerated residents who are suddenly released from the courthouse to the community.

Until the DBH team is able to resume in-reach to all individuals temporarily housed at DOC, DBH and Unity are prioritizing three distinct groups: (1) individuals who are linked to a DBH certified Core Service Agency (CSA) upon admission; (2) individuals not previously connected to a CSA but whose psychiatric symptoms are sufficiently acute that they are admitted to one of the acute behavioral health units during their time at the DC Jail, and (3) those who are participating in Medication Assisted Treatment (MAT) while at the jail. Unity is consistently proactive about arranging immediate community follow-up for MAT participants, has expanded its distribution of naloxone upon release, and now has the ability to provide greater prescription coverage for MAT upon release so individuals have up to a week to be connected or re-connected to a provider in the community. To promote continuity of care, funding was identified through the federal State Opioid Response grant and a technology transfer grant from the National Association of State Mental Health Program Directors to incentivize individuals to keep mental health appointments upon release from DOC custody.

Collectively, these efforts have allowed DBH's Forensic Services Division to sustain most of its READY Center functions despite the COVID-related closure. Prior to the public health emergency, the READY Center was operating and performing functions as designed. The Center was fully staffed, programmatic objectives were codified in the form of standard operating procedures (SOPs), which included regular communication to strengthen partnerships with relevant agencies including the Department of Human Services, Department of Employment Services, and the Department of Motor Vehicles.

In mid-November 2022, DBH and DOC executed a MOA to reestablish full in-person operations within the DC Jail.

63. Please provide an update on the DBH services to consumers under the custody of the Department of Corrections, including services provided in the READY Center.

DBH Response

Inception. The Community Response Team (CRT) launched in June 2019, bringing together three existing services within DBH—homeless outreach, mobile crisis, and the pre-arrest diversion program—into a newly restructured, 24-hour crisis response program. In her FY 20 budget, Mayor Bowser invested an additional $1.1 million to support the new CRT and expand it to a 24-hour program. In testimony on the proposed FY 20 budget, Interim DBH Director, Dr. LaQuandra Nesbitt articulated a vision for the new Community Response Team that would allow the District to better respond to individual and community crises including public health emergencies and tragic events that traumatize entire communities. DBH was charged with creating an integrated, place-based approach to outreach and crisis response to residents who may be experiencing psychiatric emergencies, trauma, substance use disorders, or co-occurring mental health and substance use disorders. The vision called for teams of peers, behavioral health specialists, and licensed clinicians to have a regular and ongoing presence in communities to:

- Conduct low or no barrier assessment and referral to behavioral health care
- Engage individuals who are connected to care but are not actually in treatment due to barriers
- Provide short-term support in solving crisis issues to reduce barriers and increase access to available care, and
- Promote harm reduction options for individuals living with unmet needs who are unwilling to engage in behavioral health treatment.

Communities had been calling for such an approach to crisis response to include sustained engagement with community leaders and community members to assess needs and report back to DBH executive leadership on emerging and unmet issues and to propose new solutions.

The CRT continues the close collaboration between DBH and MPD to support individuals in psychiatric crisis or whose behavior suggested mental or substance use disorders. It is appropriate and necessary for law enforcement to respond to some mental health crisis calls. In these cases, we want the encounter to end with everyone safe and the people in crisis getting the help they need. DBH and MPD have jointly held Crisis Intervention Officer (CIO) training since 2009 to teach patrol officers the most effective de-escalation techniques when they encounter people who may be in a psychiatric crisis. During the training, the officers meet with consumers to better understand mental illness and to hear their perspectives and past experiences with police officers. In FY 22, the Mayor mandated that all officers receive Mental Health First Aid training.

The CRT and CIO officers often respond to the same crisis situations. In addition, DBH relies on MPD to transport consumers who the CRT clinicians have determined need emergency treatment against their will.

Expansion. In October 2019, just four months after its official launch, CRT expanded and began operating out of two locations—the DBH Comprehensive Psychiatric Emergency Program facility (CPEP) on the Hill East Campus in Southeast, and 35 K Street NE, the DBH's adult urgent care clinic. A substantial portion of the funding for the expansion came from the

District's federal State Opioid Response grant to increase CRT's role in Naloxone education and distribution, outreach to "hotspots" where individuals congregate and use substances in public spaces, and to support individuals experiencing homelessness including those living in encampments.

In her FY 22 budget, the Mayor added $5 million to fund 36 new CRT positions and five AHL clinicians to expand crisis services and support the new 911 diversion program. CRT is now fully supported with local funds.

Alternative 911 Responses. Phase one of the Behavioral Health Call Diversion Initiative launched on June 1, 2021, with DBH and OUC serving as lead partners supported by MPD and FEMS. The pilot phase was 12 hours per day (6 a.m. to 6 p.m.). As the OUC and DBH teams gained experience and added staff, operations expanded to 24/7 beginning in the second quarter of FY22. Throughout FY 22, DBH, OUC, MPD, FEMS and the Lab @ DC met at least bi-weekly as a group with smaller working groups meeting regularly in between. MPD hired a behavioral health initiatives coordinator early in 2022, further strengthening the cross-agency team.

In July 2022, DBH along with MPD and FEMS participated in a 3-day joint site visit with law enforcement in Houston and the surrounding county and the local behavioral health authority. The delegation received extensive training on their 911 diversion program and co-responder program and observed a new initiative designed to link officers in the field with clinicians for real-time video-consults when co-responder teams were not available. MPD and DBH are currently planning for the soft-launch of a co-response model with five CIO-trained officers paired with five crisis specialists from CRT.

In July 2022, the District's 911 Behavioral Health Diversion program was selected to participate in a year-long technical assistance program and learning collaborative provided by the Harvard Kennedy School of Government's Government Performance Lab (GPL). The District of Columbia is one of just four jurisdictions in the country selected for the second cohort of the GPL's 911 Alternative Response program.

The GPL team is currently assisting OUC in developing its methodology for selecting calls that are eligible for transfer. OUC has procured a new platform known as PowerPhone that will both standardize the screening questions for call-takers and generate a recommended action (e.g., dispatch MPD or divert call to DBH). This new platform will strengthen consistency in decision making and is expected to significantly increase the number of calls being transferred. To date, a fraction of the projected number of eligible calls are being diverted to DBH instead of referral to MPD or FEMS. In FY 22, a total of 327 calls were diverted to DBH, of which 90 (28%) resulted in a referral to CRT. Thus, more than 70% of calls are resolved through telephone-only support. Phase 2 of the Harvard GPL technical assistance will focus on training and preparation for Access Helpline and CRT team members to manage the higher volume of calls we anticipate will be diverted.

DBH has procured and is working with its vendor to customize and implement a "Customer Relationship Manager" platform or CRM that will have the capability of interfacing with OUC's and MPD's call tracking systems. The CRM will strengthen the clinical response by giving DBH

clinicians access to information directly from OUC's system with much greater efficiency as they work to address the needs of callers in real-time. It also will increase the comfort and confidence of the caller by reducing redundant questioning. The CRM will enhance our ability to track calls across all three agencies and to report out on key data elements, like follow-up services and the frequency with which calls diverted to DBH subsequently require MPD support, that will support system analysis and improvements.

DBH Crisis Calls

64. Please provide a narrative on the Community Response Team, established in 2019, as a partnership between DBH, the Office of the Deputy Mayor for Public Safety and Justice, Office of the Deputy Mayor for Health and Human Services, Office of the City Administrator, and the Office of Unified Communications. Please provide details on Community Response Team operations including how they partner with Metropolitan Police Department, how call center representatives determine which calls from 911 are diverted to DBH, whether services are billed to insurance or Medicaid, and call follow-up protocol.

DBH Response

Inception. The Community Response Team (CRT) launched in June 2019, bringing together three existing services within DBH—homeless outreach, mobile crisis, and the pre-arrest diversion program—into a newly restructured, 24-hour crisis response program. In her FY 20 budget, Mayor Bowser invested an additional $1.1 million to support the new CRT and expand it to a 24-hour program. In testimony on the proposed FY 20 budget, Interim DBH Director, Dr. LaQuandra Nesbitt articulated a vision for the new Community Response Team that would allow the District to better respond to individual and community crises including public health emergencies and tragic events that traumatize entire communities. DBH was charged with creating an integrated, place-based approach to outreach and crisis response to residents who may be experiencing psychiatric emergencies, trauma, substance use disorders, or co-occurring mental health and substance use disorders. The vision called for teams of peers, behavioral health specialists, and licensed clinicians to have a regular and ongoing presence in communities to:

- Conduct low or no barrier assessment and referral to behavioral health care
- Engage individuals who are connected to care but are not actually in treatment due to barriers
- Provide short-term support in solving crisis issues to reduce barriers and increase access to available care, and
- Promote harm reduction options for individuals living with unmet needs who are unwilling to engage in behavioral health treatment.

Communities had been calling for such an approach to crisis response to include sustained engagement with community leaders and community members to assess needs and report back to DBH executive leadership on emerging and unmet issues and to propose new solutions.

The CRT continues the close collaboration between DBH and MPD to support individuals in psychiatric crisis or whose behavior suggested mental or substance use disorders. It is appropriate and necessary for law enforcement to respond to some mental health crisis calls. In these cases, we want the encounter to end with everyone safe and the people in crisis getting the help they need. DBH and MPD have jointly held Crisis Intervention Officer (CIO) training since 2009 to teach patrol officers the most effective de-escalation techniques when they encounter people who may be in a psychiatric crisis. During the training, the officers meet with consumers to better understand mental illness and to hear their perspectives and past experiences with police officers. In FY 22, the Mayor mandated that all officers receive Mental Health First Aid training.

The CRT and CIO officers often respond to the same crisis situations. In addition, DBH relies on MPD to transport consumers who the CRT clinicians have determined need emergency treatment against their will.

Expansion. In October 2019, just four months after its official launch, CRT expanded and began operating out of two locations—the DBH Comprehensive Psychiatric Emergency Program facility (CPEP) on the Hill East Campus in Southeast, and 35 K Street NE, the DBH's adult urgent care clinic. A substantial portion of the funding for the expansion came from the District's federal State Opioid Response grant to increase CRT's role in Naloxone education and distribution, outreach to "hotspots" where individuals congregate and use substances in public spaces, and to support individuals experiencing homelessness including those living in encampments.

In her FY 22 budget, the Mayor added $5 million to fund 36 new CRT positions and five AHL clinicians to expand crisis services and support the new 911 diversion program. CRT is now fully supported with local funds.

Alternative 911 Responses. Phase one of the Behavioral Health Call Diversion Initiative launched on June 1, 2021, with DBH and OUC serving as lead partners supported by MPD and FEMS. The pilot phase was 12 hours per day (6 a.m. to 6 p.m.). As the OUC and DBH teams gained experience and added staff, operations expanded to 24/7 beginning in the second quarter of FY22. Throughout FY 22, DBH, OUC, MPD, FEMS and the Lab @ DC met at least bi-weekly as a group with smaller working groups meeting regularly in between. MPD hired a behavioral health initiatives coordinator early in 2022, further strengthening the cross-agency team.

In July 2022, DBH along with MPD and FEMS participated in a 3-day joint site visit with law enforcement in Houston and the surrounding county and the local behavioral health authority. The delegation received extensive training on their 911 diversion program and co-responder program and observed a new initiative designed to link officers in the field with clinicians for real-time video-consults when co-responder teams were not available. MPD and DBH are

currently planning for the soft-launch of a co-response model with five CIO-trained officers paired with five crisis specialists from CRT.

In July 2022, the District's 911 Behavioral Health Diversion program was selected to participate in a year-long technical assistance program and learning collaborative provided by the Harvard Kennedy School of Government's Government Performance Lab (GPL). The District of Columbia is one of just four jurisdictions in the country selected for the second cohort of the GPL's 911 Alternative Response program.

The GPL team is currently assisting OUC in developing its methodology for selecting calls that are eligible for transfer. OUC has procured a new platform known as PowerPhone that will both standardize the screening questions for call-takers and generate a recommended action (e.g., dispatch MPD or divert call to DBH). This new platform will strengthen consistency in decision making and is expected to significantly increase the number of calls being transferred. To date, a fraction of the projected number of eligible calls are being diverted to DBH instead of referral to MPD or FEMS. In FY 22, a total of 327 calls were diverted to DBH, of which 90 (28%) resulted in a referral to CRT. Thus, more than 70% of calls are resolved through telephone-only support. Phase 2 of the Harvard GPL technical assistance will focus on training and preparation for Access Helpline and CRT team members to manage the higher volume of calls we anticipate will be diverted.

DBH has procured and is working with its vendor to customize and implement a "Customer Relationship Manager" platform or CRM that will have the capability of interfacing with OUC's and MPD's call tracking systems. The CRM will strengthen the clinical response by giving DBH clinicians access to information directly from OUC's system with much greater efficiency as they work to address the needs of callers in real-time. It also will increase the comfort and confidence of the caller by reducing redundant questioning. The CRM will enhance our ability to track calls across all three agencies and to report out on key data elements, like follow-up services and the frequency with which calls diverted to DBH subsequently require MPD support, that will support system analysis and improvements.

65. Please provide (via spreadsheet) the following information on the Community Response Team for FY 2021, FY 2022, and FY 2023, to date:
    a. Number of Helpline/Mental Health Hotline FTEs;
    b. Number of Community Response Team FTEs;

c. Helpline/Mental Health Hotline budget and spending;
d. Community Response Team Budget and spending;
e. Number of calls received and responded to;
f. The locations where the team was dispatched including the ward;
g. Breakdown of how many calls related to children and youth or adults; and
h. Types of crisis.

DBH Response:

DBH's crisis services division works to improve clinical outcomes for individuals experiencing behavioral health crises—to provide the right response at the right by the right responder—and to move away from an automatic law enforcement response. The Mayor has invested additional resources to expand both Access Helpline (AHL), the DBH operated call center, and the Community Response Team (CRT). Specifically, AHL is expanding from 16 to 31 staff and CRT is expanding from 38 to 65 team members. DBH is recruiting for the new positions and have added two new crisis counselors to the AHL and five to the CRT. AHL has 14 staff onboard and 17 vacancies for which 2 candidates have been selected and are in the pre-employment process. CRT currently has 43 team members and 22 vacancies with five candidates in the pre-employment process.

It is important to note, however, behavioral health staff shortages are severe and projected to worsen nationwide. DBH is working with SAMHSA to develop alternative recruitment and retention strategies with other states in the region in the short-term while pursuing longer term strategies for growing the pipeline for the behavioral health workforce.

The CRT data shows referrals for children and youth under the age of 18 more than doubled from nine in FY21 to 21 in FY22 though most requests for mobile crisis for youth are directed to ChAMPS, the District's youth mobile crisis service. We believe the CRT has begun to receive more youth referrals because of its high visibility in the community and because crises often involve multiple individuals experiencing a shared crisis within their family or community. This has prompted a reexamination of the organization of crisis services including further alignment and cross-training of the adult and youth mobile teams. Joint responses have begun to happen more often. To support this integration, the CRT will assume overnight and weekend responsibility for youth referrals. Beginning in January 2023, referrals from 8 pm to 8 am Monday through Friday and weekends are routed to CRT.

Reporting on crisis type is continuing to evolve as we implement the 911 Behavioral Health Call Diversion project, the nationwide 988 rollout, the newly configured youth mobile crisis program, and DBH and MPD explore a possible co-responder approach. The data collection is being reshaped in consultation with a team from The Lab@DC who the City Administrator enlisted to support design and evaluation of the 911 diversion project as well. In addition, the District was one of four jurisdictions to receive a year-long intensive technical assistance award from the Harvard Kennedy School's Government Performance Lab (HKS-GPL). As a result, DBH and

OUC are plugged into emerging best practices and benefitting in real-time from other governments' experience implementing alternative 911 responses.

Extensive work is being done to establish data definitions and to achieve consistency in the way calls are coded across the DBH crisis continuum and assure good alignment with key partners like OUC, MPD, and FEMS. The DBH electronic health record known as iCAMS also is undergoing a reconfiguration in association with the Medicaid Managed Care Carve-In/System Redesign with the goal of improving data capture and reporting. Improved data quality in crisis services is a major objective which will also be supported by the addition of a supervisory level quality coordinator who will focus on training and documentation.

In response to the question for the location of dispatch, the CRT responds to thousands of calls for assistance and is dispatched in all eight wards. DBH can provide the addresses of individuals who receive services or interventions, but this frequently is different from the CRT dispatched location. There are several scenarios when using the address of the individuals as the location of the dispatch is misleading. For example, many of the calls are from residents for unhoused individuals who are transient and we may engage the same person in different locations but do not have an address. The CRT also responses to "hotspots" with spikes in opioid overdoses and to locations where a large number of people congregate, but again are not able to provide addresses for individuals in those cases as they refused services. Another example is an initial call to the CRT may be from a family member's home, but the individual has a home address different from the dispatch location. DBH can provide the addresses of only individuals who received services from our claims data by zip code which we can match to wards as much as possible. But, this is not the same as the CRT dispatch locations.

Number of FTEs Assigned to Crisis Services (a. and b.)			
	FY21	FY22	FY23 YTD
Access Helpline (AHL)	17	31	31
Community Response Team (CRT)	38	65	65
Budget and Spending by Service (c. and d.)			
AHL Budget	$1.8M	$2.3M	$2.4M YTD

Spending	$2.1M	$1.9M	$ .3M YTD
CRT			
Budget	$8.6M	$7.8M	$12.3M
Spending	$7.5M	$5.9M	$ 1.8M

AHL and CRT Referrals by Service

e.	# Referrals to CRT	5,645	5,828	1,586
	# Services/Interventions	3,229	3,145	803
g.	# Referrals for Youth	9	21	7
	# Referrals for Adults	5636	5807	1579
h.	Types of Crisis (CRT)			
	Crisis Assessment –		2399	0
	Mental Health –		802	431
	Non-Crisis Engagement –		331	0
	MH and Substance Use –		89	50
	Other (specify) –		51	0
	Substance Use Outreach –	*Unavailable	26	0
	Substance Use –	Due to Change	8	4
	Co-Response –	In Coding	5	0
	DBH Internal –		4	0
	Traveler's Aid –		3	0

	Missing – Total		2110 5828	1101 1586

66. Please provide an update on DBH's implementation of the National Suicide Hotline Designation Act of 2020, which created a new 9-8-8 universal telephone number for the purpose of suicide prevention and mental health crisis response. Please include:
    a. The FY 2022 and FY 2023, to date, DBH cost for 9-8-8 implementation;
    b. How many calls were received through 9-8-8 in FY 2022 and FY 2023, to date; and
    c. Please share any updates to how DBH collaborates with the Office of Unified Communications or other public safety cluster agencies to implement this program.

DBH Response:

a. Mayor Bowser announced the new 988 telephone number with a press release and social media on July 15, 2022, the day before the official launch. The DBH Access HelpLine (AHL), has been the District's sole National Suicide Prevention Lifeline affiliate for years and maintains its accreditation through the American Association of Suicidology. Therefore, the cost to launch the new 988 was absorbed by existing staff. However, the activation of the 988 three-digit call code and rebranding of the 988 Suicide & Crisis Lifeline are expected to increase call volume in the coming years. DBH was awarded $840,000 in federal funding that will be used to hire new AHL staff to support the anticipated increase and implement the chat and text functions required of all Lifeline affiliates in the next year.

b. DBH received 7709 incoming Lifeline calls in FY22 and 2564 through the first quarter of FY23. To assess the impact of the 988 implementation and to adjust for possible seasonal variation, we compared the number of calls in Q1 FY22 (1674) with Q1 FY23 (2564) and found an increase of more than 53% year-over-year for the same period. We attribute that increase directly to the introduction of the easy to remember 988 dialing code. However, we do not assume this reflects to a 50% increase in actual suicide related crises as we have observed that many callers are testing the line after learning of the change. This is generally consistent with what has been reported nationally.

DBH has maintained a local answer rate at or above 90%, the standard SAMHSA established for July 2023. SAMHSA and its vendor, Vibrant, track this metric because local call-takers are best positioned to assist callers in accessing local mental health resources if desired. The Lifeline comprises more than 200 calls centers that are networked. Calls that are not answered within a specified time are automatically rerouted to another call center in the network, thus callers can always reach a live, trained specialist for telephone support.

c. 988 Lifeline updates regularly are provided in the 911 cross-agency meetings so that OUC, MPD, and FEMS are aware of the work happening in parallel and jointly working to assure coordination and promote the new number. Information about 988 is included in the joint DBH/MPD Mental Health First Aid and Crisis Intervention Officer training classes. FEMS released a blast text message promoting the 988 Lifeline to its list of tens of thousands of residents during the week of Thanksgiving 2022.