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501 3rd Street, NW · 8th Floor
Washington, DC 20001
T 202.467.4900 · F 202.467.4949
www.childrenslawcenter.org

Testimony Before the District of Columbia Council
Committee on Health,
Committee on the Judiciary and Public Safety,
Committee on Recreation, Libraries and Youth Affairs

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Public Roundtable:
Public Safety & Behavioral Health Services and Support for Youth

Amber Rieke
Project Lead
Children's Law Center

Introduction

My name is Amber Rieke, and I am a Project Lead on the policy team at Children's Law Center. Children's Law Center believes every child should grow up with a strong foundation of family, health and education and live in a world free from poverty, trauma, racism and other forms of oppression. Our more than 100 staff – together with DC children and families, community partners and pro bono attorneys – use the law to solve children's urgent problems today and improve the systems that will affect their lives tomorrow. Since our founding in 1996, we have reached more than 50,000 children and families directly and multiplied our impact by advocating for city-wide solutions that benefit hundreds of thousands more.

As part of our advocacy, Children's Law Center chairs the Strengthening Families Through Behavioral Health Coalition, which brings together a diverse group of advocates – spanning education, health and juvenile justice and more – who share a commitment to improving DC's behavioral health care system for children and families.[1] We also partner with the Early Childhood Innovation Network, co-chair Under 3 DC's Family Supports Committee, and are members of the Every Student Every Day coalition and the Ward 8 Health Council.

Thank you for the opportunity to join this Roundtable called to examine the relationship between public safety and youth behavioral health with the objective of assessing the current behavioral health care services system. Our testimony will focus, first, on how exposure to community violence impacts children and deepens an existing mental health crisis for young people, and then describe the gaps in our current behavioral health care system that so many in our client community fall into. Even with recent program investments, there are significant,

identifiable gaps in our broken, overburdened healthcare system – workforce shortages, non-existent services, too little data to inform planning, and lack of coordination at all levels of the system.

In 2021, Children's Law Center co-authored a report with community experts called *A Path Forward – Transforming the Public Behavioral Health System for Children, Youth, and their Families in the District of Columbia* which summarizes the many challenges and recommends 94 remedies.[2] In today's testimony, we will elevate several of those recommendations to address our current crisis. The District must:

1. Implement strategies and incentives to create an adequate labor pool of diverse behavioral health professionals who treat children, especially in the public system.
2. Increase reimbursement rates and grants that attract and sustain providers in the public system.
3. Establish the full continuum of behavioral health care for all children and adolescents in DC, from early intervention programs (such as HealthySteps and the School-Based Behavioral Health program), to acute psychiatric care (including crisis stabilization and intensive outpatient care.)
4. Bring together all of government to create a strategic plan for children's behavioral health.

The challenges before us are profound, complex and, frankly, frightening. Many in Children's Law Center's client community are living in unsafe neighborhoods, attending schools that go

into lockdown, or losing peers to shootings. What is clear: all kids deserve safety and support. We need to both reduce the exposure to violence, *and also* increase services for children who are living with fear, grief and trauma. This two-part approached is described as "reducing the dose of adversity and strengthening the healthy buffer" by pediatrician Dr. Nadine Burke-Harris. We urge the Council to commit to building that buffer.

Community conflict deepens an existing mental health crisis for young people.

Public safety is a "social determinant of health" – an external condition of our environment and daily life that can either support health or inflict harm.[3] Exposure to violence is also considered an Adverse Childhood Experience (ACE).[4] Experts at the U.S. Centers for Disease Control and Prevention call community violence "a critical public health problem":

> Community violence can cause significant physical injuries and mental health conditions such as depression, anxiety, and post-traumatic stress disorder (PTSD). Living in a community experiencing violence is also associated with increased risk of developing chronic diseases. Concerns about violence may prevent some people from engaging in healthy behaviors, such as walking, bicycling, using parks and recreational spaces, and accessing healthy food outlets. Violence scares people out of participating in neighborhood activities, limits business growth and prosperity, strains education, justice, and medical systems; and slows community progress.[5]

Incidents of violence – and more general safety concerns – impact the health of victims, rippling out to families and neighborhoods.[6] Tragically, young people are disproportionately impacted as victims and witnesses; violence is a leading cause of death and injury nationally among adolescents and young adults. More than half of the victims of homicides in the U.S. were 15 to 34 years old in 2020.[7] Since that year, the number of homicides involving juveniles locally

has doubled, with over 100 young people shot and 16 killed.[8] A child is shot in the District two or three times a week, most often Black boys, as young as six years old.[9]

Young people are especially vulnerable amid an ongoing youth mental health crisis. Symptoms of poor mental health, including depression and suicidal ideation, have been steadily increasing among American youth for over a decade.[10] Even before the COVID-19 pandemic, approximately one in five DC children (more than 20,000), were reported to have a mental, emotional, developmental, or behavioral problem.[11] The disruption, isolation, and health impacts of the pandemic only exacerbated these trends.[12] The results of the 2021 Youth Risk Behavioral Survey (YRBS) revealed that a stunning 28% of DC middle school students have seriously thought about killing themselves (18.3% for high schoolers). The survey evidenced a wide range of behavioral health concerns: About 12% of middle and high school students had taken prescription pain medicine without a doctor's prescription. One-fifth (20%) of high school students went without eating for 24 hours or more to lose weight or to keep from gaining weight. Over 19% of middle school students and over 25% of high schoolers reported that their mental health was "not good" most of the time, or always (including stress, anxiety, and depression).[13]

Community violence and crime further contribute to stress, fear, and other negative emotions. Day to day, violence can also interrupt activities of life that are protective of mental health, including sleep, relationships, being outdoors, exercise, and mindfulness. Different studies have shown how exposure to violence leads to "decreased connectedness to school" for adolescents, and overall lower academic achievement, educational attainment and future

earnings.[14] The YRBS survey showed that about one in four middle school students who report missing school due to feeling unsafe also report receiving mostly D's or F's in school.[15]

"Trauma" is a word we may hear a lot in today's hearing. Trauma is not just a psychological effect of an event – it can re-shape a developing body's very biology. When children experience "strong, frequent or prolonged adversity" like abuse, neglect, or exposure to violence without adequate adult support, the physiological stress response can become "toxic."[16] Even when the event ends, the impact of the toxic stress continues to cause upset, wear on the body, disrupt development and functioning, influence behavior, and worsen long-term health outcomes.[17]

A parent in one of our focus groups for the *Path Forward* report put it simply: "a lot of [kids] have been through traumatic situations or hard times, and a lot of times, the mental aspect isn't dealt with." In fact, nearly half (47%) of DC's children have had adverse childhood experiences (ACEs), such as being exposed to violence or abuse.[18] My colleagues at Children's Law Center could also speak to the cascading impacts of unmitigated trauma on a child's behavior, education, family dynamics, housing stability, and child welfare.[19]

A strong continuum of effective behavioral health interventions can improve outcomes across the lifespan - *if* there is a system in place.

To address the distress laid out above, the District must seriously engage with and invest in our broken behavioral health system. This, unfortunately, is a complex task. To borrow a line from Councilmember Janeese Lewis George in a recent newsletter, "because DC's public safety

problems are multifaceted, our solutions must be multifaceted too."[20] We believe the same applies to behavioral health.

Behavioral Health Prevention and Treatment

"Behavioral health" refers to the array of mental health and substance use disorders that can impact individuals. Mental health includes emotional, psychological, and social well-being, which directly relates to how one handles stress and relates to others. Mental illnesses affect a person's thinking, mood, and behavior.[21] (For example, depressive disorders, anxiety disorders, bipolar disorders, Post-Traumatic Stress Disorders, dissociative disorders. There are also other manifestations of emotional and behavior dysregulation, like anger issues, recurring nightmares, substance abuse, grief, and disordered eating.[22]) Our well-being can also be "protected" or shielded by positive factors – even through great stress or trauma – such as secure relationships and a sense of belonging.[23]

An effective and complete behavioral health system should include both prevention[24] and treatment[25] of mental illnesses and substance use disorders, early identification, therapeutic treatment, recovery and rehabilitation services, and long-term supports.

A great example of prevention and early intervention in the District is the HealthySteps program – a national, evidence-based model that provides families with infants and toddlers social-emotional and development support by integrating child development specialists into pediatric primary care, increasing their access to appropriate health screenings, system navigation support, and connection to resources in one central place.[26]

Prevention elements are also embedded in the School-Based Behavioral Health program (SBBH); Tier 1 services include social-emotional lessons for all students, and Tier 2 are more targeted, such as group sessions to build skills and navigate difficult moments. Topics for Tiers 1 and 2 include conflict resolution, emotional intelligence, healthy relationships, bullying, suicide prevention, positive coping strategies, boundaries around social media, self-care, etc. Stress management and self-regulation are foundational for family functioning and attachment, and for a child's resilience and ability to learn.[27] The clinical treatment Tier 3 is a core component of the program.

The behavioral health system should include all needed treatment specializations, accommodating the languages and accessibility needs of patients. Treatment for young people must also be family-centered, meeting needs of a child's caregivers to support family functioning.

Unfortunately, our system is under-equipped and under-staffed at every point on the care continuum – in access to early intervention, therapy, crisis response, hospitalization. Children, teens, and parents wait too long for appointments, or never connect with the kind of therapist they need.[28]

Mitigating Harm and Building Resilience

Certain factors can increase resilience, mitigate harm, and help us manage stress. The greatest influence for children is the presence and support of loving adults.[29] Stability, safe and nurturing environments are paramount. Strong relationships, attachment and affection also have enormous impacts on our nervous system and well-being. Other elements critical for

child (and adult) mental health are sleep, exercise, nutrition, and mindfulness.[30] These pieces all reinforce each other: kids sleep better with enough exercise, and when they sleep better, behavioral issues and grades may improve.[31] Other non-clinical interventions bolster well-being: talking with peers, time outdoors, opportunities for service, movement, participating in team activities or hobbies, reading books, or creating art.[32] Healthy development requires a sense of worth, agency, belonging.[33]

All DC residents of all ages deserve safe places for socialization, self-expression, recreation, and rest – in addition to the multitude of behavioral health interventions that children and families may need to maintain mental well-being and handle trauma. Behavioral health services must not only be available, but also high-quality and appropriate for the age, culture, language, and social environment.

There are significant gaps in DC's overburdened behavioral health system.

DC's behavioral health system has a long way to to go meet the ideals described above. Today, if a child receives services that are timely, high-quality and appropriate for their age, culture, language, and social environment, it is an anomaly. To meet the needs of our youngest DC residents – including those impacted by community violence – we must face the fact that the entire behavioral health system has been broken and overburdened for decades. The major factors include:

1. Workforce shortages among behavioral health professionals and network inadequacy;
2. Insufficient and unsustainable financing support for public behavioral health services;

3. Gaps in the continuum of necessary service and facilities, especially intermediate levels of care;
4. Lack of coordination at all levels of the system – between individual and providers, among providers, and between providers and the government.

1. Workforce Shortages and Network Inadequacy

Families often encounter long waits when attempting to connect with behavioral health services in the District, between a few weeks to a few months, especially when specialty services are required (e.g., medication management, substance use services, etc.). Children's Law Center shared testimony last week about how our clients involved with the child welfare system face hurdles trying to connect with a therapist, even when court ordered.[34] Many factors contribute to extended waitlists, foremost the insufficient network of professionals for children, and low reimbursement rates for behavioral health services. Patients struggle to find a provider with the right fit of languages, specialties, cultural competency, trauma-informed practiced, and accessible hours. We know there is high turnover among behavioral health professionals, but there is insufficient data to track or respond to these trends.

Medicaid Managed Care Organizations (MCOs) should have "adequate" behavioral health provider networks for children per federal requirements, but we do not.[35] It is critical for DHCF to not only routinely monitor but also enforce network adequacy. Meaningful measures of behavioral health network adequacy standards should go beyond travel time and distance standards (the federally mandated standards) to reflect the reality that the functional challenges are often more about length of time until the next available appointment, inability

to meet outside of working hours or in-person, frequent therapist turnover, and lack of available modalities. "Adequacy" is supposed to be a measure of access, and DHCF measures do not currently capture – or enforce – true access to and quality of care.[36]

Despite the persistent workforce shortage, there has been too little investment in the "non-traditional" or informal behavioral health care workforce. We are missing opportunities to leverage the power of families and peers in the behavioral health care of children, such as Community Health Workers or peer specialists on care teams. Studies have repeatedly found peer workers to be effective in assisting people with behavioral health conditions to connect to, engage in, and be active participants in different types of services across the continuum of care.[37] DC should establish the financing for a broader workforce that could be utilized effectively across the care continuum.

Only with adequate provider networks can we meet the current and future behavioral health needs of children in the District in a timely manner.

2. Insufficient and Unsustainable Financing for Public Behavioral Health Services

The best tool the District has to build an adequate provider network is through attractive and appropriate reimbursement rates for participation in public programs. Currently, the rates offered by Department of Behavioral Health contracts and Medicaid are outdated and insufficient, most based on 2016 costs.[38] Reimbursement for behavioral health services nationally has been significantly lower than reimbursement for physical health services; one study found that behavioral health professionals are reimbursed 20 percent below the rate for

primary care physicians, though the time required to evaluate behavioral health is often longer than a primary care visit.[39]

Practitioners delivering behavioral health care and preventive services to children should be compensated at a level that is commensurate with the time and effort expended. We also make recommendations in *A Path Forward* for easing burdens related to the credentialing, billing and reimbursement processes so no willing provider is thwarted by procedures.

The District has also relied heavily on grants to fund programmatic goals, which has limited financial sustainability for many community-based organizations and provider types. For example, the School Based Behavioral Health program still needs a sustainable financing structure. Community Health Work and other prevention activities described in the previous section are not billable to insurance at all. The District was able to use large federal infusions like the American Rescue Plan ACT (ARPA) to supplement program funds, including the CBO grants for SBBH. With ARPA funds expiring this year, the base salary of clinicians must be adjusted to compensate for the loss of these and other one-time funds. Members of DC's behavioral health workforce identified this as a major issue for longevity – people will not stay in a profession with such high emotional burden if they have to take two jobs to make ends meet, or cannot count on the grant that funds them to be renewed year to year.[40]

3. Gaps in the Continuum of Necessary Service and Facilities

In addition to increasing the network of providers, there must be more kinds of services and facilities added to the system. "Intermediate levels of care" refers to intensive services provided in the community or outpatient settings. They provide a safe, secure, and less-

restrictive environment for short-term evaluation and intervention, with the goal of working toward stabilization with both the individual and their family. Examples include Intensive Outpatient Programs (an alternative to or transition from residential or inpatient care), Partial Hospitalization Programs (short term, full-day treatment programs for adolescents experiencing acute psychiatric symptoms but not in need of 24-hour care),[41] as well as Youth Crisis Stabilization Units (often co-located in a hospital emergency department).[42]

The current lack of intermediate levels of care options means that youth may be served at an insufficient level of care for their true needs, which leads to costly, avoidable inpatient psychiatric admissions, excessive numbers of patients boarding in the emergency department, dissatisfaction, and poor patient outcomes.

There are likewise very few venues for the most acute services, such as in-patient services or hospitalization. There are no residential substance use treatment facilities for young people in DC. There are only a few psychiatric beds for children and youth in the District, no therapeutic group homes or community residences, no psychiatric residential treatment facilities (PRTFs), and no "bridge" services for youth who are being discharged from hospitalization to outpatient therapy or medication monitoring. Families (or the child welfare system) must send young people out of state to Maryland, Virginia, or often farther distances for residential services. This separation can cause trauma in and of itself, and caregivers are not functionally incorporated into treatment during or after discharge.

Even where the few crisis services exist, we are seeing decline. One of the few crisis services in DC is the Child and Adolescent Mobile Psychiatric Service (ChAMPS), an on-call

unit that responds to behavioral health crisis calls for young people. It is often dialed by families and schools who need immediate response, de-escalation, or transport to a hospital. ChAMPS, contracted through Catholic Charities, used to be available to callers 24 hours a day, seven days a week. DBH reduced the scope of the contract this year to exclude nights and weekends (out of school time). Instead, the Crisis Response Team – already over stretched in its work to respond to adult crises – has now been tasked to cover nights and weekends for youth. The CRT – already overstretched its work to respond to adult crises – is also dispatched to schools to work with young children and adolescents the day after community tragedies. What is in place for kids after the headlines fade?

In addition to the missing services mentioned above, the District also lacks sufficient behavioral health services on the prevention and promotion side of the continuum, and too few offerings are truly "family-centered." Given that family dynamics significantly impact children's behavioral health, it is essential that behavioral health services for children are family-centered and incorporate the needs of families and caregivers.

4. Lack of coordination at all levels of the system.

Addressing the system improvements described here must involve cross-disciplinary and cross-sectoral collaboration. Governance and leadership of a well-functioning behavioral health system (oversight, policymaking, system design, and accountability) should be shared by both government and nongovernment actors, with transparent communication and engagement from the community. The *Path Forward* report detailed several gaps, including

fragmented leadership and governance, and inadequate institutionalized collaboration with the community.[43]

Coordination and integration are not just good governance, they are also best practices of health care delivery. Care coordination across settings reduces fragmented care, decreases health care costs, and improves the patient experience of care. Integrated care, defined by the World Health Organization, means that "health services organized and managed so that people get the care they need, when they need it, in ways that are user-friendly, achieve the desired results and provide value for money."[44] Unfortunately, our system lacks this kind of coordination on the macro, intragovernmental level, and for individual patient care. The DC Health Matters Collaborative's Community Health Needs Assessments identified care coordination as a priority need across the entire health system in 2016, 2019 and 2022.[45] Existing financing infrastructure does not fully support integrated and coordinated care at provider organizations, which exacerbates fragmented behavioral health service delivery.

There is little publicly available data related to District-wide trends in children's behavioral health outside of self-reported surveys. In the same vein, evaluations and plans for programs are slow to reach the public. Data related to children's behavioral health in DC, including service utilization and outcomes data, while sometimes provided in agencies' annual performance oversight responses to the DC Council, is not reported by agencies in a user-friendly manner on a regular basis. Such lack of data reporting prevents the opportunity for both government and nongovernment organizations to use local evidence to enhance behavioral health decision-making.

DC needs a plan of action that is as broad, deep, and urgent as our mental health crisis.

I have detailed the myriad ways that DC's behavioral health system could – but fails to – meet the needs of youth and families. Trauma experienced by the District's children remains inadequately addressed, with dire consequences.

In order to deliver the effective, comprehensive, and sustainable behavioral health care District children and families deserve, we need major improvements in the areas of workforce, financing, data and coordination necessary outlined above. As detailed in *A Path Forward*, the District must:

1. Invest in workforce development and retention across all position types to improve access to services for youth across the behavioral health care system – substance use treatment, psychotherapy, school-based services, family therapy and more. This work must span agencies, committees, and stakeholder groups, and include workforce pipeline development, and more inclusive and creative staffing models. This calls for Council's increased oversight of and funding to DC health agencies, and continued creativity in development of programs.
2. Increase Medicaid reimbursement rates that support an adequate network of child-serving providers, so that low-income residents impacted by trauma can access therapy. This cannot be done without significant budget allocation to leverage the federal match for Medicaid local dollars.

3. Continue - and increase - investments in early intervention and prevention programs (such as HealthySteps and the SBBH program) to increase and support from skilled, caring adults in convenient locations, and enhance social emotional skills.
4. Invest in creating more kinds of services and facilities specifically for youth, including residential SUD treatment center, partial hospitalization programs, a "bridge clinic" and a psychiatric residential treatment facility. The right service at the right time can change a person's life. This will be a heavy lift for the District, potentially creating capital projects or new partnerships that will need to be championed well into the future. Where can we start today?
5. Coordinate across-government to create a detailed strategic plan for children's behavioral health – a proactive, thoughtful, unified response to youth mental health crisis. DC's former Department of Mental Health created the "Children's Plan," but this was last updated in May 2012.[46] The Council should begin funding, in the next budget, a process that involves the full behavioral health apparatus and relevant stakeholders (government agencies, CBOs, clinicians, community, hospital, primary care and other service providers, public and private insurance, public safety entities, schools and educators, advocates, families, and youth in the District.) Our report, for example, brought in stakeholders and carefully crafted recommendations, but without government co-signing goals, we cannot achieve our goals: to deliver high-quality mental health and substance use services along the full continuum of care that meets the evolving needs of children.

Conclusion

The current behavioral health care services system is woefully inadequate to serve the escalating mental health crisis. We need to ensure the gaps are filled for our community's health and well-being. Further, improved access to treatment for substance use and mental health is significantly associated with reductions in violent crime, property crime and recidivism.[47] We urge the Council to make transformational investments because behavioral health is a critical, but under-resourced, part of our community safety infrastructure. Supporting children and families should be the focus of the City's response.

Thank you for the opportunity to testify on these important issues. I am happy to answer any questions you may have.

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[1] The Strengthening Families Through Behavioral Health Coalition's mission is to ensure DC has a fully integrated behavioral health care system in which all DC students, children, youth, and families have timely access to high-quality, consistent, affordable, and culturally responsive care that meets their needs and enables them to thrive. https://www.strengtheningfamiliesdc.org/.

[2] *A Path Forward – Transforming the Public Behavioral Health System for Children and their Families in the District* (December 2021), *available at*: https://childrenslawcenter.org/wp-content/uploads/2021/12/BHSystemTransformation_Final_121321.pdf. This report is released by Children's Law Center, Children's National Hospital, the District of Columbia Behavioral Health Association, Health Alliance Network, Early Childhood Innovation Network, MedStar Georgetown University Hospital Division of Child and Adolescent Psychiatry, Parent Watch, and Total Family Care Coalition.

[3] World Health Organization, *Social Determinants of Health, available at:* https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1.

[4] National Center for Injury Prevention and Control, Division of Violence Prevention, *Adverse Childhood Experiences*, U.S. Centers for Disease Control and Prevention, (June 29, 2023), *available at:* https://www.cdc.gov/violenceprevention/aces/index.html.

[5] National Center for Injury Prevention and Control Division of Violence Prevention, *Violence Prevention*, U.S. Centers for Disease Control and Prevention, (June 8, 2022), *available at:* https://www.cdc.gov/violenceprevention/communityviolence/index.html.

[6] *Id.*

[7] *Id.*

[8] FOX 5, *DC Juvenile Homicides Continue to Rise as Gun Violence Sweeps Across City* (November 20, 2023), *available at*: https://www.fox5dc.com/news/dc-juvenile-homicides-continue-to-rise-as-gun-violence-sweeps-across-city.
[9] NBC Washington, *New Data on Young People Shot in DC in 2023*, (May 24, 2023), *available at:* https://www.nbcwashington.com/news/local/new-data-on-young-people-shot-in-dc-in-2023/3354799/.
[10] U.S. Office of the Surgeon General (OSG), *U.S. Surgeon General Advisory: Protecting Youth Mental Health,* p. 8 (December 7, 2021), *available at:* https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf.
[11] *A Path Forward*, at p. 10.
[12] In addition to increased suicidality, the 2021 DC Youth Risk Behavior Survey (YRBS) revealed that about 12% of middle and high school students had taken prescription pain medicine without a prescription. Over 19% of middle school students and over 25% of high schoolers reported that their mental health was not good most of the time, or always (including stress, anxiety, and depression). One-fifth (20%) of high school students went without eating for 24 hours or more to lose weight or to keep from gaining weight. In the general population, only 20% of children with a behavioral health disorder will ever receive care from a specialized provider. The unmet need is worse for children of color. *See* OSSE, 2021 DC YRBS Middle School Trend Analysis Report, QN29, p. 8, QN62, p. 17, *available at*: https://osse.dc.gov/sites/default/files/dc/sites/osse/page_content/attachments/2021DCBM%20Trend%20Report.pdf; OSSE, 2021 DC YRBS High School Trend Analysis Report, QN49, p. 14, QN106, p. 32, *available at*: https://osse.dc.gov/sites/default/files/dc/sites/osse/page_content/attachments/2021DCBH%20Trend%20Report.pdf; 2021 American Academy of Child and Adolescent Psychiatry, Best Principles for Integration of Child Psychiatry into the Pediatric Health Home (June 2012), *available at*: https://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/systems_of_care/best_principles_for_integration_of_child_psychiatry_into_the_pediatric_health_home_2012.pdf; Vikki Wachino, et al., *The Kids Are Not All Right: The Urgent Need to Expand Effective Behavioral Health Services for Children and Youth*, USC-Brookins Schaeffer on Health Policy (December 22, 2021), *available at*: https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2021/12/22/the-kids-are-not-all-right-the-urgent-need-to-expand-effective-behavioral-health-services-for-children-and-youth/.
[13] OSSE, *2021 DC Youth Risk Behavior Survey (YRBS) Data Files* (2021), *available at*: https://osse.dc.gov/node/1635216.
[14] Borofsky, L. A., Kellerman, I., Baucom, B., Oliver, P. H., & Margolin, G. (2013). Community violence exposure and adolescents' school engagement and academic achievement over time. Psychology of Violence, 3(4), 381–395. https://doi.org/10.1037/a0034121;
Jackson, J, Tiry, E, Thompson, PS, Jannetta, J, *Educational Costs of Gun Violence: Implications for Washington DC,* Urban Institute (July 2022), *available at:* https://www.urban.org/sites/default/files/2022-07/Educational%20Costs%20of%20Gun%20Violence.pdf.
[15] YRBS
[16] Dr. Nadine Burke-Harris, *The Deepest Well: Healing the Long-Term Effects of Childhood Trauma and Adversity*, (2021).
[17] *Id*.
[18] *A Path Forward*, at p. 10.
[19] Public safety issues can impact school attendance and performance absenteeism due to anxiety, avoidance, depression, fear, etc. Families utilizing public housing may stay in asthma-triggering conditions because of fear about the violence in other locations. The general foster care placement crisis is made worse with foster parent perceptions that bringing teens into homes would be dangerous, so our kids in care are especially vulnerable without safe places to be. Further, increased police presence is not without risks. People with mental illness and disabilities at increased risk of harm – this is well documented. And altercations with police become a risk factor for continued involvement with criminal legal system.

[20] Community newsletter, Nov 3, 2023
[21] *What is Mental Health?*, SAMHSA, (April 2023), available at: https://www.samhsa.gov/mental-health.
[22] *Id.*
[23] Behavioral health is dynamic, can vary throughout our lives, and is influenced by biology, life experiences and environments.
[24] Prevention is an essential response to any health challenge. Prevention interventions keep a threat at bay, as well as prevent relapse, disability, and the consequences of severe mental illness or substance abuse. Interventions for children should focus on identifying and addressing risk factors while building on protective factors in the child's environment to promote resiliency during childhood and adolescence. Screening and testing identify a need to intervene with appropriate treatments as early as possible.
[25] Behavioral health treatments are diverse; some are responsive to an episode or event, others may involve medication, ongoing counseling, support groups, or more expressive methods like art therapy (especially useful with children). Psychotherapy is one of the most well-supported interventions. Over one's life, they may also move further along a continuum as needs are more acute, such as intensive outpatient or residential treatment.
[26] HealthySteps DC ensures access to behavioral health services in a setting child frequent, their pediatric primary care practice. Children are more likely to go to their primary care provider due to scheduled well-child visits, thus a primary care provider is well positioned to detect the early onset of behavioral problems. However, a primary care provider may not have the knowledge or skill set to address developmental, behavioral, social, and emotional needs of a child. *See* HealthySteps, *Our Model*, available at: https://www.healthysteps.org/what-we-do/our-model/.
HealthySteps in the District embeds Family Services Coordinators (FSCs) and HealthySteps Specialists (HSSs) within the primary care setting to engage with families at each routine pediatric visit from birth to three years of age. Family Service Coordinators provide dedicated case management and care coordination for families through the support of DC residents with lived experience navigating systems. Early Childhood Innovation Network, *Innovation Spotlight: HealthySteps DC*, May 2019, ECIN Newsletter, available at: https://www.ecin.org/newsletter-may-2019.
HealthySteps Specialists can deliver clinic-based mental health visits with families to address critical needs in areas such as maternal depression, grief and loss, and child behavior management. Specialists can also answer questions about behavioral health as well as facilitate the development of attachment, self-regulation skills, and family resiliency.
[27] Burke-Harris, *The Deepest Well*.
[28] Tami Weerasingha-Cote and Amber Rieke, Children's Law Center, *Testimony before the District of Columbia Council Committees on Facilities and Family Services and Health*, (December 6, 2023), *available at:* https://childrenslawcenter.org/wp-content/uploads/2023/12/Childrens-Law-Center-Testimony-for-Dec-6-2023-Hearing-on-B25-0500-and-Foster-Youth-Behavioral-Health_FINAL.pdf;
[29] Burke-Harris, *The Deepest Well*.
[30] *Id.*
[31] *Id.*
[32] *Dr Rangan Chatterjee Interviews Dr Gabor Maté on Trauma, Illness and Healing in a Toxic Culture*, Feel Better Live More podcast, (September 14, 2022), *available at*: https://drchatterjee.com/dr-gabor-mate-on-trauma-illness-and-healing-in-a-toxic-culture/.
[33] Burke-Harris, *The Deepest Well*.
[34] Megan Conway, *Testimony before the District of Columbia Council Committees on Facilities and Family Services and Health*, (December 6, 2023), *available at:* https://childrenslawcenter.org/wp-content/uploads/2023/12/Megan-Conway-Testimony-for-Dec-6-2023-Hearing-on-Bill-B25-0500-and-Foster-Youth-Bheavioral-Health_FINAL.pdf; William Cox, Children's Law Center, *Testimony before the District of Columbia Council Committees on Facilities and Family Services and Health*, (December 6, 2023), *available at:* https://childrenslawcenter.org/wp-

content/uploads/2023/12/Wil-Cox-Testimony-for-Dec-6-2023-Hearing-on-Bill-B25-0500-and-Foster-Youth-Bheavioral-Health_FINAL.pdf;
Rachel Ungar, Children's Law Center, *Testimony before the District of Columbia Council Committees on Facilities and Family Services and Health*, (December 6, 2023), *available at:* https://childrenslawcenter.org/wp-content/uploads/2023/12/RU-Draft-Testimony-EM-updated_-narrative_final.pdf.

[35] MCOs are subject to ensuring access to behavioral health services in accordance with the 42 CFR § 438.68 (network adequacy standards) and § 438.206 (availability of services), as well as the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 (ensures that behavioral health coverage is on equal footing with medical and surgical coverage) and the District of Columbia Behavioral Health Parity Act of 2018.

[36] *A Path Forward*, at p. 56.

[37] Robertson, H. A., Biel, M. G., Hayes, et al. *Leveraging the Expertise of the Community: A Case for Expansion of a Peer Workforce in Child, Adolescent, and Family Mental Health*. International Journal of Environmental Research and Public Health, (2023), *available at:* https://doi.org/10.3390/ijerph20115921.

[38] Amber Rieke, Children's Law Center, *Testimony before the District of Columbia Council Committee on Health*, (March 30, 2023), *available at*: https://childrenslawcenter.org/wp-content/uploads/2023/03/Amber-Rieke_CLC_DBH-FY24-Budget-Testimony_3.30.23.pdf;
Leah Castelaz, Children's Law Center, *Testimony before the District of Columbia Council Committee on Health*, (April 3, 2023), *available at:* https://childrenslawcenter.org/wp-content/uploads/2023/04/L-Castelaz_Testimony-before-DC-Council-Committee-on-Health_DHCF_4.5.23_FINAL.pdf

[39] *A Path Forward*, at p. 56.

[40] *Improvements to Behavioral Health Integration and Service Provision in D.C.: Listening to our Behavioral Health Workforce and Youth*, DC Health Matters Collaborative, (October 2021), *available at*: https://www.dchealthmatters.org/content/sites/washingtondc/DCHMC_Behavioral_Health_Integration_and_Workforce_Listening_Sessions_White_Paper_with_Appendix_Oct_2021.pdf.

[41] Partial Hospital Programs may offer group therapy, family therapy, individual counseling, and/or psychoeducational sessions. Research on PHPs has shown they have been proven to prevent future hospitalizations and decrease the length of stay in the hospital. A 2014 study with 35 adolescents demonstrated that the PHP was effective in improving psychological symptoms and resulted in positive self-perceptions of getting better. *See A Path Forward* at p. 76.

[42] In Youth Crisis Stabilization Units, children and youth who are experiencing acute concerns but do not rise to the level of needing residential treatment are admitted on average for three to five days and receive brief intensive mental health therapy (e.g., one-on-one therapy, family therapy, crisis intervention, psychiatric evaluation, and, if necessary, medication management). *See A Path Forward* at p. 77.

[43] Path Forward

[44] World Health Organization, *Integrated Health Services-What and Why?* (2008), *available at:* https://www.who.int/healthsystems/service_delivery_techbrief1.pdf.

[45] District of Columbia 2016 Community Health Needs Assessment, DC Health Matters Collaborative, *available at*: https://www.dchealthmatters.org/content/sites/washingtondc/2016_DC_CHNA_062416_FINAL.pdf;
District of Columbia 2019 Community Health Needs Assessment, DC Health Matters Collaborative, *available at*: https://www.dchealthmatters.org/content/sites/washingtondc/2019_DC_CHNA_FINAL.pdf;
District of Columbia 2022 Community Health Needs Assessment, DC Health Matters Collaborative, *available at*: https://www.dchealthmatters.org/content/sites/washingtondc/2022_CHNA/2022_CHNA_DC_Health_Matters_Collab.pdf.

[46] DC Department of Mental Health, *The Children's Plan*, (Updated 2012), *available at:* https://dbh.dc.gov/page/childrens-plan.

[47] Sebastian, T, Love, H, Washington, S, et al, *A New Community Safety Blueprint: How the Federal Government can Address Violence cnd Harm Through a Public Health Approach*, The Brookings Institution (SEPTEMBER 21, 2022), *available at*: https://www.brookings.edu/articles/a-new-community-safety-blueprint-how-the-federal-government-can-address-violence-and-harm-through-a-public-health-approach/.