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Introduction

Good afternoon, Chairperson Henderson and members of the Committee on Health. My name is Amber Rieke. I am the *Path Forward* Project Lead 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.

Children's Law Center chairs the Strengthening Families Through Behavioral Health Coalition which brings together a diverse group of advocates 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 Ward 8 Health Council and Fair Budget Coalition.

The Department of Behavioral Health (DBH) is central to addressing the profound and complex youth mental health crisis we see through our work. Children's Law Center's clients include children who are in foster care, students with special education needs or health conditions, and caregivers who need legal support. Across our client communities, our attorneys and social workers spend a significant number of hours trying to coordinate much-

needed behavioral health services through the public system.[2]

Locally and nationally, symptoms of poor mental health like depression and suicidal ideation have been steadily increasing among youth for over a decade.[3] Even before the COVID-19 pandemic, an estimated one in five DC children had a mental, emotional, developmental, or behavioral problem.[4] Nearly half (47%) of DC's children have had adverse childhood experiences (ACEs), such as being exposed to abuse or not having basic needs met.[5] The 2021 Youth Risk Behavioral Survey (YRBS) revealed that a stunning 28% of DC middle school students and 18.3% of high schoolers said they have seriously thought about killing themselves.[6] As we testified at last month's hearing on youth, public safety and behavioral health, community violence contributes further to stress, fear, and trauma in families and neighborhoods.[7] Yet our clients and their caregivers still struggle to access behavioral health services, which ultimately impacts the well-being and stability of the entire family. Despite our diligence, our clients are frequently unable to find providers offering the services they need – or if they manage to find a provider, the waitlist for an appointment is prohibitively long. Even when our clients successfully connect with a provider, they encounter issues of quality and cultural competence, and frequent turnover. [8]

We want our clients – and every child in the District – to be able to access the appropriate services, treatments, and programs to meet their behavioral health needs.[9] For this to happen we must have a functioning public behavioral health system with a full continuum of services and adequate capacity to meet the needs of the District's children. To this end, we co-authored

a 2021 report called *A Path Forward – Transforming the Public Behavioral Health System for Children, Youth, and their Families in the District of Columbia*.[10] Through extensive collaboration, research and stakeholder input, the report details 94 concrete recommendations to better meet the needs of DC children and families with services that are timely, high quality, culturally appropriate, equitable, and sustainable.

We appreciate the opportunity to testify today about DBH's important role in system transformation, made even more urgent during the youth mental health crisis. Our testimony will review the performance of several impactful DBH programs that have made progress, as well as identify where services are not meeting expectations – or missing entirely. With the ongoing Medicaid transformation with the Department of Health Care Finance (DHCF), the District's behavioral health system will look entirely different this time next year, for better or worse. In this pivotal time for our system, we want to elevate specific challenges that must be addressed this year:

- Reimbursement rates for providers are still woefully inadequate.
- The transition of behavioral health services from DBH into Medicaid Managed Care Organization (MCO) contracts (also referred to as the "transformation" or "carve-in") has been delayed and protracted, hampering providers and potentially impeding access for beneficiaries.
- The behavioral health workforce shortage continues to limit access to and capacity of providers.

- Critical services are missing entirely from DC's continuum of care, especially those that expand access to intermediate and acute care interventions.
- The public data infrastructure is outdated, public reporting is inconsistent, and evaluations have been delayed.

Given these substantial challenges, it is imperative that the public and the Council understand how DBH will carry out its mission to "develop, manage, and oversee" the public behavioral health system in the future we are approaching, how the agency will continue to support its workforce, and how it will ensure all DC families can access quality behavioral health services in a timely manner.

The Public Behavioral Health System Will Look Entirely Different This Time Next Year – While Transformations Should Ultimately be Positive, They Will Also be Disruptive

After expansions through the Affordable Care Act, DHCF started moving most Medicaid beneficiaries from a fee-for-service model to a managed care model through MCOs in 2019.[11] With built-in care coordination[12] and value-based purchasing requirements,[13] managed care rewards good patient outcomes instead of high volume,[14] helping the District move toward the "triple aim" of better care, better health outcomes and reduced costs.[15] At the same time, upon approval of the District's Section 1115 Medicaid Behavioral Health Transformation Demonstration waiver in 2020, DHCF has also been preparing to "carve-in" a "broader continuum of behavioral health treatment" into its managed care contracts and "support the District Medicaid program's movement toward a more integrated healthcare experience that facilitates coordinated treatment of behavioral and physical health needs."[16]

Taken together, DC Medicaid is implementing new regimes for care delivery and payment while also assuming responsibility for more behavioral health services. Theoretically, "integrating services into the managed care plans allows the plans to see the complete picture of the beneficiary/consumer needs, allowing them to better coordinate care."[17] This also allows the District to pull in federal matching dollars for the carved-in services.[18]

While these transformations should be ultimately positive, they will also be disruptive. Community-based organizations and Core Service Agencies (CSAs) that are currently paid through contracts with DBH must make significant administrative changes to participate in the Medicaid infrastructure, certify and contract with the new insurance companies, and adjust to new billing procedures, timelines, and methodologies.[19] Even providers who have previously participated in Medicaid must adjust to new requirements.[20]

Due in part to the COVID-19 Public Health Emergency, the "carve-in" was delayed from 2022 to October 2023, and again to April 2024 because the mechanics were not ready, nor were the rate decisions.[21] Even now, with two months to go, providers are still not informed what reimbursement to expect for all anticipated services, with some changes already delayed to July 2024.[22] If providers are not able to transition seamlessly on Day One, they may lose revenue and potentially displace their patients. Any loss of capacity in the provider network will hurt patients. To prevent this, DBH must continue to actively support providers in the transition. DBH should also continue to use the ACCESS HelpLine to support callers with care navigation, even if the services they navigate callers to are now paid for by another agency.

We need attentive Council oversight in the coming months, especially attuned to the provider and beneficiary experience of the Medicaid transformation, while also monitoring the performance of ongoing DBH programming.

Healthy Futures Provides Critical Support to Early Childhood Educators

Healthy Futures is a DBH program that provides early childhood mental health consultation (ECMHC) in District's child development centers and home providers. ECMHC use early childhood clinical specialists (referred to as consultants) to provide in-classroom support to teachers to identify when their students might be at risk of or is displaying signs and symptoms of social, emotional, or other mental health problems.[23] The consultants work with teachers to help understand students who are exhibiting difficult behaviors and provide tools that allow students to thrive in the classroom. The goal of ECMHC programs is to minimize the use of exclusionary discipline in childcare centers and preschools by providing resources and supports to teachers.[24]

Since the passage of Birth-to-Three for All Amendment Act of 2018 (Birth-to-Three), Healthy Futures, on average, has grown by 18 sites per year, for a total of 111 sites across the District as of Fiscal Year (FY) 2023.[25] In addition, over the past two years, Healthy Futures has piloted the use of early childhood clinicians to provide evidence-based treatments and programs directly to children and families at eight existing Healthy Future sites.[26] Given ongoing behavioral health workforce challenges and budgeting errors, the ability for Healthy Futures to continue to hire individual clinicians to expand the program to more sites is

impressive.[27] While DBH has reported some turnover in Fiscal Year (FY) 2023, the DBH team has worked diligently to backfill those positions and is working closely with local partners in the hiring process.[28] While we will continue to work to get Healthy Futures in every eligible CDC and home provider, per Birth-to-Three,[29] we are happy with the growth and understand that DBH is working hard to implement it to the fullest of its current funding level.

Finally, DBH is moving forward with an evaluation of Healthy Futures. In Fall 2022, DBH awarded the evaluation contract to Georgetown University Center for Child and Human Development (GUCCHD) to conduct the evaluation for a period of two years. GUCCHD evaluated Health Futures between 2011 and 2015.[30] Over the last year GUCCHD has diligently moved the evaluation forward, including interviews with the consultants, educators, and parents. Given how much has changed since the last evaluation in 2015, we believe this will be an invaluable tool to understand the challenges the program faces and what it needs to move forward and be successful.

The School-Based Behavioral Health Program Removes Barriers to Behavioral Health Services and Facilitates Social-Emotional Skill-Building in DC Schools

The goal of the School-Based Behavioral Health program (SBBH) is to ensure students in every DC public school have access to the full range of behavioral health services. The Multi-Tier System of Supports model (MTSS) is administered by a licensed clinical social worker or therapist through a community-based organization (CBO). The MTSS ranges from foundational social-emotional lessons for all students (Tier 1 and 2) to one-on-one therapy for those with the most acute needs (Tier 3). Tier 1 and Tier 2 programming looks like school-wide

skill-building or group sessions on special topics like conflict resolution, emotional intelligence, bullying, suicide prevention, coping mechanisms, and self-care.[31]

The delivery of services is the visible work, but it is supported by layers of bedrock under the surface – interagency coordination, complex funding systems, school activities, and staffing. First, SBBH relies on two primary sources of funding: (1) a direct DBH grant to the CBOs who hire and supervise the clinician, and (2) insurance claims (mostly Medicaid) for the billable services (only Tier 3 activities). Second, each clinician is part of an individual school community. To effectively navigate their unique ecosystems, clinicians rely on other staff in the school building for referrals, coordination, and communication. The SBBH Coordinator is tasked with taking the lead on coordinating the work of the clinician and other members of the school's behavioral health team, which includes overseeing the School Strengthening Tool (SST) and Work Plan to identify each school's unique needs and guide its behavioral health services, resources, and programs. Each clinician is also supervised; in fact, the supervisor may serve in the clinician role during vacancies. Among these layers, there should also be outreach with and coordination between students and their families, with the potential to bring in other support from the clinician's CBO if the case requires. We believe these pieces each require investment and intentionality – and, in some cases, retooling – to support the program's success.

After rolling out the program in cohorts, every school has access to SBBH – in theory. However, the latest numbers show that only 172 of 254 schools (68%) are staffed with a

clinician.[32] According to an analysis by DC Action for Children this summer, coverage was better for high schools than elementary and middle schools. Schools in Wards 7 and 8 seem equally likely to have a clinician as other wards, which is worth celebrating when the distribution of resources often disadvantages these wards. DC Action observed that DC Public Schools (DCPS) were more staffed than charter schools – 62% versus 41%.[33]

Where staff are in place, and referrals are made, recent surveys of students, caregivers, school staff and Coordinators show high satisfaction with services:

- Most students and families reported comfort seeking help from a therapist or counselor at school.
- School staff reported feeling knowledgeable about warning signs of behavioral health challenges and familiarity with the referral process.
- Many school staff who reported referring students for behavioral health services believed the students benefited from treatment services in several ways such as decreased behavior incidents and improved symptoms.[34]

One student's feedback epitomizes the core purpose of the program: "I like how [provider name] listens to me. I don't talk to any other adult about my feelings."[35]

These surveys also showed where continued attention is needed. Highlighting a need for more information sharing, one parent reported, "I've never seen a principal's email or any school announcement saying 'we have counselors you can talk to if you or your child need [them].'"[36] Other challenges were identified:

- About half of students are not confident that they know where to go for help and more than one third would not want to see a therapist or counselor at school.
- Twice as many LGBQ students reported unmet need compared to their heterosexual peers; they also perceived lower levels of support from teachers and principals.
- Though staff report feeling relatively hopeful and engaged, many staff report high levels of stress and exhaustion.
- SBBH Coordinators report limited or no involvement of students and families in the development and monitoring of school behavioral health plans.[37]

Students would also like better support for well-being after negative events. As one said in 2022, "one time we were promised a schoolwide session where we can express our mental grief with a school lockdown, and we never got it."[38]

We know the SBBH team at DBH is attentively working to staff up and address barriers, including piloting the ability for charters to hire clinicians directly when they have been unable to do so through the CBO model.[39] We also appreciate the strategic thinking DBH has committed to addressing other issues revealed during implementation, especially related to the other professionals who can contribute to SBBH's efficacy. As noted above, SBBH coordinators play a critical role in ensuring students, families and/or teachers navigate to the correct behavioral health resource in a school building. Currently, however, this is an unpaid position; duties are layered on top of the designated staff person's primary job. At a recent Coordinating Council meeting, DBH invited DCPS to present findings about whether

Coordinators have the resources, bandwidth, or training needed to do their job properly. It concluded that the position should be compensated, either through a stipend or by hiring a part- or full-time staff person for the role, depending on the school.[40] We believe that coordination is essential to the expansion and efficacy of SBBH, and agree that Coordinators should receive compensation, adequate guidance and other needed supports. This ultimately means students, families and teachers can better access the services the District is funding.

DBH is also considering non-clinical positions to provide Tier 1 services in partnership with CBO clinicians. These services on topics like conflict resolution, suicide prevention, coping mechanisms, and self-care, may be effectively and safely delivered by an individual with a different background than a licensed independent clinical social worker (LICSW). DBH has discussed creative staffing approaches with stakeholders, which we support. Such an action could have the dual impact of increasing access to much-needed Tier 1 and 2 services while creating bandwidth for clinicians to focus on crucial Tier 3 therapeutic services.

In all cases, sufficient funding for each of these professionals is crucial to fill positions, provide services, and ensure the longevity and success of SBBH. DC must fund competitive salaries with increases for inflation to attract and retain a robust, consistent workforce. The CBO grant amount continues to be our greatest concern about SBBH. In past fiscal years, CBOs received a patchwork of vacancy savings, American Rescue Plan ACT (ARPA) funds, and a persistently low base salary for clinicians. 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.

Rebasing the clinician salary will allow both clinicians and CBOs more financial stability, which promotes retention and recruitment.

Lastly, as we call for DBH to continue improving implementation of SBBH, we are still waiting for essential information; the SBBH cost study and programmatic evaluations are many months overdue.[41] For oversight, service delivery, and the creation of meaningful access to care, stakeholders need this data as soon as possible.

Healthy Futures and SBBH are immensely valuable programs and need continued, smart investment as they continue to expand. We ask the Council to continue to uplift, support, and oversee these programs to ensure they can effectively serve children, educators, and families.

DC MAP Consultation Service Needs Increased Transparency about Reach and Quality

While we celebrate the success and promise of several DBH programs, we also want to share concerns about programs that are either declining in quality or capacity. In a time of so many concurrent challenges, we cannot afford to lose any ground. The DC Mental Health Access in Pediatrics (DC MAP) integrates mental health consultation within pediatric primary care to improve service delivery and patient health outcomes, while also reducing care costs.[42] CLC advocated for the program's creation in 2015, so that pediatricians with mental health-related inquiries have real-time phone access to psychiatrists, psychologists, social workers, and care coordinators.[43] The program was also meant to provide technical assistance to pediatricians, and facilitate referrals for patients needing community-based specialty services.

This kind of coordination is sadly uncommon in the healthcare system.

We have previously testified to the cost-effectiveness and innovation of the DC MAP's population-based, prevention framework.[44] We also have testified about our concern that the number of consultation requests from primary care settings – which had consistently increased in previous years – has been declining in the last two years. Since the contract transitioned from Children's National Hospital to Paving the Way,[45] the reported number of consultations decreased by about 40%, from 1,480 in FY 2021 to 881 reported in FY 2023.[46] Anecdotally, we have heard physicians were unsatisfied with their recent interactions. We hope to see DC MAP continue to serve as a valuable resource to pediatricians to identify and treat the behavioral health needs of District children and families. To support this goal, we ask the Committee and DBH for renewed oversight of the program, and improved reporting on impact and outcomes from the provider to inform any needed improvements.

DBH Must Clarify the Role of the Expanded Access HelpLine Post-MCO Integration

Another critical call-based service is DBH's Access HelpLine. In recent years, the role of the HelpLine has expanded to be more central in both crisis response and navigation to care. According to a 2023 DC Auditor's report, "there was more than a 200% increase in crisis/suicide calls to the [DBH] Access Helpline in the first year of the pandemic compared to the year prior."[47] It has also been central to the introduction of the national 988 mental health emergency hotline, and changes in the OUC workflow for mental health-related calls. This kind of 24/7, on-demand support separate from law enforcement is an essential feature of

effective crisis response systems, according to the National Alliance on Mental Illness (NAMI), SAMHSA and the Justice Collaborative Institute.[48] We have been hopeful that quality and functionality would improve as the role expanded.

Along with the general public, Children's Law Center's clients are often routed from court or Child and Family Services to a Core Service Agency provider via the Access HelpLine. This navigation support is one of the HelpLine's most widely-promoted purposes. Our primary concerns are: (1) whether the Access HelpLine will continue to help callers navigate to a service provider, and (2) whether adequate resources will be applied to ensure quality and maintain functionality. Among the many changes with the MCO transformation, we were surprised to learn that the HelpLine will instead direct Medicaid enrollees to contact their MCO for any assistance navigating to care. In fact, we have heard from other stakeholders that as early as last year, DBH was already directing people to contact their MCO. It is unclear how it is operating now and will going forward, but we believe it is important and valuable for the District to offer on-call support and navigation help for residents. If the duties and offerings of HelpLine are changing, it is important to clearly delineate – especially while emergency response services are under scrutiny, while opioid overdoses and fentanyl poisoning increase, and as there will inevitably be growing pains in the service landscape post-transformation – where callers can go for the support Access HelpLine has been known to provide.

As the Only Crisis Response Service for Young People, ChAMPS Should Continue to Respond to Calls 24/7

Along with 911 or ACCESS HelpLine, the Child and Adolescent Mobile Psychiatric

Service (ChAMPS) is one of the few crisis response options in DC specifically for youth. This on-call unit is uniquely equipped to respond 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. It is a national best practice for a child and adolescent crisis system to be available 24 hours a day, regardless of payer.[49]

DBH reduced the scope of the contract this year to exclude nights and weekends. Instead, the Crisis Response Team (CRT) has been tasked to cover nights and weekends for youth.[50] This is a problem, firstly, because youth in crisis need specialized and dedicated response. Further, CRT is overstretched in its work to respond to adult crises; the agency's oversight responses showed that call volume for CRT has increased 37% from last year, with only 60% of CRT positions staffed.[51] Disturbingly, the average time from 911 call to CRT arrival is 91 minutes versus the average ChAMPS response time of 38 minutes.[52] This data show that CRT is not a reasonable substitute for ChAMPS. We are seeing real impacts from the reduction in ChAMPS; one of our social workers recently had a client attempt to call ChAMPS, but the police came instead, which escalated the conflict the caregiver was attempting to mitigate in the first place. We ask the Committee to probe whether this change to operations is permanent and whether it is prudent.

Licensing Changes Diminished the Capacity and Potential Positive Impact of Community-Based Intervention Services

Community-Based Intervention (CBI) services, similarly, have been integral to clients'

treatment in the past, but have recently declined in impact. CBI includes intensive home- and community-based therapies and support delivered by CSAs to children and their families.[53] We testified last year about how DBH increased the license requirement for CBI professionals in 2019 to require a master-level license (LGSW, LICSW, LGPC, or LPC). This change immediately shrunk the provider pool and made it almost impossible to get CBI services.[54] CBI was often indicated in our foster care cases, however, few of our clients could get CBI after the change, or their CBI workers were forced to change jobs or retire. According to one former provider, there are not "any workers with a degree who will work those kinds of hours."[55] We reiterated these concerns at the December 6, 2023 hearing with DBH and CFSA, and were surprised to hear the agencies state that there are no capacity concerns or wait times for CBI.[56] As recently as this month, we have experienced clients struggling to access CBI without success. It is a shame to see a once-well-utilized service atrophy and become inaccessible, especially one so uniquely family-centered and home-based. Therefore, we ask the Committee to ask the agency for: (1) more specifics regarding the availability and utilization of CBI services since the change, and (2) to provide publicly accessible and clear guidance on how to access CBI services.

The School-Based Behavioral Health Student Peer Educator Pilot Will Miss the Deadline to Impact this School Year

The services noted above – DC MAP, Access HelpLine, ChAMPS and CBI – are long-standing, but another notable program is still waiting to launch. This committee created the School-Based Behavioral Health Student Peer Educator Pilot in the FY 2024 Budget Support

Act.[57] The subtitle specified that DBH should make awards by December 31, 2023 to "recruit, train, and supervise at least 50 high schoolers to work as peer educators during the 2023-2024 school year."[58] However, according to DBH, the Request for Applications (RFA) is not expected to post until February, giving interested groups like Young Women's Project very little room to provide services this school year.[59] We are disappointed about the missed opportunity to empower students to better support one another and connect their peers to much-needed services this school year. We hope the Committee will investigate the reasons for the delay and what can be done to maximize the benefit from this investment in the limited time left in the year.

Provider Payment Rates Continue to be Woefully Inadequate Because They Are Based on 2016 Costs

The financing in the public behavioral health system continues to be outdated and inadequate, which hurts the provider network and constrains service availability. While providers look forward to the anticipated DBH/DHCF rate study to plan for future business with MCOs, they were forced to shuffle through another year on old rates. The District's current reimbursement schedule was calculated based on 2016 costs and has only been adjusted by 6.2%, despite over 23% inflation since 2016 (based on the specialized Medicare Economic Index used by DHCF for Medicaid rate setting).[60] As noted above, the rate study has been years in development, with updates shared very piecemeal, which raises concern about whether the results will actually support today's true cost of service delivery.

If we expect to attract and retain providers in the public network, rates must be

competitive with private markets and adjusted annually for inflation. A report from the National Bureau of Economic Research demonstrates that more competitive Medicaid reimbursement rates are tied to better access to care and outcomes for children.[61] To this end, *A Path Forward* also recommends easing burdens related to the credentialing, billing and reimbursement processes so no willing provider is thwarted by administrative procedures.[62]

The District has relied heavily on grants to fund programmatic goals, which has limited financial sustainability for many organizations and providers. For example, Community Health Work and prevention activities are not billable to insurance and only funded through grants.[63] The District was able to use large federal infusions like ARPA to supplement program funds in the last two fiscal years, including the CBO grants for SBBH.[64] With ARPA funds expiring this year, appropriations must be adjusted to compensate for the loss of one-time funds.[65] Members of DC's behavioral health workforce have long identified financing deficiencies 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 a grant to be renewed year to year.[66]

In summary, DBH and other public players must improve payment for providers – in dollars and in structure – so that children and families can access timely services, and the provider network is supported through adequate and reliable financing.

DBH Must Fulfill its Important Role in Addressing the Persistent Workforce Shortage,

The ongoing shortage of behavioral health professionals inhibits service quality and

timeliness; DBH has a central role in remedying the ongoing workforce shortages. Chronic understaffing in public programs cause patients to struggle to find a provider with the right fit of languages, specialties, cultural competency, trauma-informed practiced, and accessible hours. Workforce shortages are why our clients wait months to connect to a CSA provider, and why a third of schools have not been able to hire a SBBH clinician, despite having the position funded. Many factors contribute to these vacancies, but the fundamental reasons are: (1) insufficient numbers of active professionals, and (2) low reimbursement or compensation for behavioral health services in public programs.

There is work to do regarding recruitment, as well as retention. We know there is high turnover among behavioral health professionals, but there is insufficient data to track or respond to these trends. OSSE surveyed school mental health professionals to understand their challenges, finding that the main complaints were burnout, workload, lack of support from leadership, and pay.[67] It is important to act on these results, especially noting that over half of respondents had been in the job for eight or more years – programs cannot afford to lose this expertise.

Fortunately, we do have a roadmap. The Mayor Bowser's Healthcare Workforce Task Force issued their recommendations in 2023 to "rebuild, strengthen, and expand the District's healthcare workforce" and to "address current supply and demand challenges in the healthcare workforce."[68] Membership included all agencies at work in the behavioral health workforce, as well as leaders in the education, employment, and healthcare sectors. It deserves

the government's attention and follow-up. Many recommendations were tasked to DBH as a leader or partner, such as:

- Set a payment floor for District healthcare workforce wages at 120% of the District's Living Wage or minimum wage, whichever is greater, to ensure competitive wages and access to apprenticeship training funding.
- Enhance healthcare workforce worksite wellness and safety to support workers.
- Increase the ease of entrance into the healthcare field for returning citizens, and address age limitations and citizen status barriers that prohibit/restricts individuals' ability to gain employment in the health care sector.
- Build cross-agency partnerships and clarify roles to ensure alignment of programs, strategies, policies, and funding allocations contribute to a strong and sustainable health care workforce in the District of Columbia.
- Create partnerships with local universities that enroll high numbers of DC-based students to provide training in career ladder jobs, i.e., entry level to licensed clinical level positions.
- Create retention incentives for current health care workers.

DBH, along with other health agencies, should commit to implementing these recommendations from local experts.

Lastly, 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 healthcare provision, such as Community Health Workers or peer specialists on care teams.[69] 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.[70] DC should establish the financing for a broader workforce that could be utilized effectively across the care continuum. For example, a critical component of the Attachment and Behavioral Catch-up (ABC) evidence-based intervention,[71] piloted by DBH and included Medicaid rate study, does not require a clinician. With training, non-licensed individuals can deliver ABC. The ability to have a diverse group of professionals deliver the intervention is crucial given the severe current and forecasted shortage of licensed psychologists and social workers. This is a critical feature of the recent inclusion of ABC in the Medicaid fee schedule, which allows those who deliver the model (clinicians and non-clinicians) to be reimbursed.

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

DC Must Fill the Gaps in the Continuum of Care with New Therapy Models and Services for Intermediate and Acute Care Needs

The public behavioral health system should include all needed treatment specializations, accommodating the languages and accessibility needs of patients. For children, who have limited control over their environment, successful therapy should also support the young person's caregivers and family functioning. Services are not one-size-fits-all.[72] The majority of our clients involved with foster care need behavioral health supports to address

the pain and stress they have experienced, in addition to any other disorders or relationship challenges.[73] After reviewing several hundred of our most recent cases, we found that more than a third of our clients had at least one diagnosed mental health condition, including ADHD, depressive disorders, anxiety disorders, bipolar disorders, trauma and stressor related disorders (like PTSD), dissociative disorders, and/or disruptive, impulse-control, and conduct disorders. Of these clients, many presented with ongoing emotional and behavior dysregulation and some with suicidal thoughts, problem sexual behaviors, and histories of sexual abuse.[74] An additional quarter of our clients had suspected mental health conditions but were not formally diagnosed.[75] Nearly all of these individuals could benefit from therapy or other support. Some needs are quite urgent. Unfortunately, our system is under-equipped and under-staffed at every point on the care continuum, especially in intermediate or acute levels of care. We believe DBH should act to remedy these deficiencies in the year ahead.

To expand access to therapy, other states are seeing success with new service delivery models like Certified Community Behavioral Health Clinics (CCBHCs), but the District has not capitalized on opportunities to pilot this in DC. As an integrated and sustainably-financed model for care delivery, CCBHCs ensure access to integrated, evidence-based substance use disorder and mental health services, and receive flexible funding to support the real costs of expanding services to fully meet the need for care in communities. According to the National Council, CCBHCs have dramatically increased access to mental health and substance use disorder treatment, expanded states' capacity to address the overdose crisis and established

innovative partnerships with law enforcement, schools and hospitals to improve care, reduce recidivism and prevent hospital readmissions.[76] This model aligns well with ongoing work between DHCF and DBH on the 1115 waiver, and our clients would benefit from broader access more therapies, especially family therapy. We do not know of active efforts by DBH to pursue or explore it here in the District.

"Intermediate levels of care" refers to intensive services provided in the community or outpatient settings. They provide a less-restrictive environment for short-term evaluation and intervention. 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),[77] as well as Youth Crisis Stabilization Units (often co-located in a hospital emergency department).[78]

There are many kinds of services that could provide crisis stabilization for youth, but all we have now is the emergency room and (reduced) ChAMPS coverage. There are currently no "bridge" services for youth who are being discharged from hospitalization to outpatient therapy or medication monitoring. A Children's Comprehensive Psychiatric Emergency Program (CCPEP) model could address two key needs: crisis stabilization unit with extended observation, and "step down" services for youth who are being discharged from emergency rooms or inpatient psychiatric units. Intakes and evaluations are done by youth-focused multidisciplinary teams, with ability to see patients for needed services on-site, in-patient or

outpatient, or at home.[79] There are other compelling models at Erie County Medical Center in Buffalo,[80] Children's Hospital of the King's Daughters in Southeast Virginia,[81] University of California-San Francisco's Langley Porter Psychiatric Hospital,[82] and Massachusetts General Hospital in Boston.[83]

There are likewise very few venues for the most acute services, in-patient services or hospitalization. There only a few psychiatric beds for children and youth in DC, no therapeutic group homes, and no psychiatric residential treatment facilities (PRTFs). District youth do need these acute placements, as evidenced by the number who travel across state lines to get services, and many more who could benefit from such treatment but never get it.[84]

We have heard that DBH plans to create a SUD residential treatment facility for youth. We were glad to see that DBH stated in oversight responses that it is "currently seeking a youth SUD residential treatment facility provider to support youth 21 years old and younger who have been diagnosed with a substance use disorder and need inpatient treatment services" with applications due in February of 2024.[85] This is urgent, as opioid overdose becomes more common.[86] We agree with Councilmember Henderson statement at a hearing in December, "The fact that we don't have any residential treatment beds for young people struggling with substance abuse disorder… and given what the opioid situation looks like in the District, this is one of those things we have got to figure out – and quickly."[87]

Looking at where capacity increased in 2023, we celebrate the opening of a new Stabilization Center facility, which will take the pressure off emergency rooms and offer

appropriate support to adults who need that setting. The quick work transforming spaces for this important kind of care was commendable, and we hope to see similar efforts to better serve young people and their families in the very near future.

DBH Must Upgrade Data Collection and Reporting to Improve Performance, Planning and Transparency

There is little publicly available data related to children's behavioral health outside of self-reported surveys. This makes it difficult to discern trends, trajectories, disparities, or outcomes, District-wide or by population. Data related to children's behavioral health in DC, including service utilization and outcomes, 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 both government and stakeholders from using local evidence to understand needs, correct inequities, discern return-on-investment, or otherwise enhance behavioral health decision-making. It prevents us from truly understanding the scope and nuances of DC's youth mental health crisis, or the degree of imbalance in supply versus demand for services. Further, DBH's evaluator Child Trends recommended the agency add positions related to SBBH data collection to inform program implementation, quality improvement efforts, and training and technical assistance to school teams.[88] This should be a priority for DBH in the year ahead.

In the same vein, evaluations and plans for programs are frustratingly slow to reach the public. We are over a year late receiving the SBBH Cost Study and have not seen Child Trends evaluation for the most recent school year, as noted above, as well as the rate study for the

carve-in. The Healthy Futures evaluation is expected soon. The Committee and the public deserve to receive data about publicly funded programs when it is promised, and we should understand how the delays will be prevented in the future.

In general, DBH – and other health agencies – are behind the curve on data collection and reporting. The DC Auditor published a report in 2023 with a team from Georgetown University called "COVID-19 & Behavioral Health in the District of Columbia" which highlighted the need for major upgrades to data collection and infrastructure, which DBH should attend to this year.[89] The report recommended:

- The DC government should continue publishing Medicaid trends, and make the existing DBH dashboards into publicly available and long-term platforms.
- DBH should build on existing public-private working groups to identify and generate shared metrics for behavioral health needs across the District.
- DBH should coordinate with care providers across the District to define data sources and metrics to track needs for behavioral health services, especially among youth.
- The DC government should develop reporting with specific data requirements for those providing behavioral health services in the District for both public and private systems, including:
    - Counts of individuals served, grouped by age and type of service.
    - Capacity of each service provider across each domain.
    - Length of wait time to receive care/services (beyond DBH and Medicaid).
    - Attrition from waiting lists (e.g., enrolled but never seen).

The District's public behavioral health data infrastructure is already so delayed and underbuilt

that it will take dedicated attention, enhanced expertise, and strategic investments to get to where we need to be. Data-driven decision-making is an important part of the health system reform the District has been pursuing over the last decade.

We hope that in the year ahead, once the seismic shifts settle, DBH will turn its attention to the challenges we have outlined today – creating the financing, workforce, facilities, and data infrastructure to truly move the public behavioral health system ahead.

Post-Carve-In and Post-ARPA, DBH Should Reappraise Its Mission and Structures for the New Era

This testimony detailed the many areas for improvement in the behavioral health system. In addition to stabilizing and sustaining the programs that are working, we should understand DBH's next steps to improve services, support providers, and develop the workforce. We need plans and measures of success for the new future that is quickly approaching.

Currently, the mission of DBH is to "develop, manage, and oversee the District of Columbia's behavioral health system for adults, children, and youth and their families using a population health approach that advances health equity." Will this explicitly remain the mission going forward? There is plenty of work needed to develop new services and data infrastructure. DBH will continue to need to manage programming and ensure it is fully staffed, accessible, and well-compensated. Post-Carve-In, DBH will no longer assume sole agency responsibility to oversee the whole behavioral health system. Arguably, the system has always had many administrators and inputs. DBH has the opportunity this year to determine

its vision for itself once DHCF becomes the main payor for BH services.

DBH will also need to reappraise financing structure so that ARPA's expiration is not an existential threat to program survival. We hope the agency protects the progress it has made in the upcoming FY 2025 budget by replacing one-time dollars with local dollars. We have also outlined several needed improvements: regularly increased reimbursement, more reliable forms of payment than grants, more creative approaches to staffing, and better data reporting.

We should also understand how DBH is meaningfully involved in other administration initiatives, such as Healthy People 2030 and Maternal Mental Health Task Force in DC Health, the new 211 Warmline, and the Mayor's Work Force Task Force. Since the 1115 waiver project aims for "integration" of the health system, we should expect more integration across the *whole* system and across government projects.

DBH Must Lead the Development of a District-Wide Strategic Plan for Children's Behavioral Health

Our public investments to date have not overcome workforce shortages, financing deficiencies, licensing challenges, quality issues, cultural incongruities, historical harms that cause distrust, and more. In order to deliver the effective, comprehensive, and sustainable behavioral health care District children and families deserve, we call on the District to create a strategic plan that encompasses the full behavioral health apparatus and relevant stakeholders, including government agencies, CBOs, clinicians, community, hospital, primary care and other service providers, public and private insurance, schools and educators, advocates, families, and youth in the District. Child Trends has also recommended that DBH create a formal cross-

sector plan to establish priorities and a citywide vision of behavioral health, "aligning policies and resources across sectors to achieve that vision, and ensuring staff training and development are integrated and complementary across sectors."[90] DC's former Department of Mental Health created the District's first-ever comprehensive "Children's Plan," which was last updated in May 2012.[91]

We were very glad to read in DBH's pre-hearing responses this month that it plans to undertake an update to the Children's Plan:

> "The Department of Behavioral Health will begin working with team members from other child-serving government agencies, community behavioral health providers, private and non-profit child-serving organizations, child advocates, and youth and families to update a strategic plan for children's behavioral health services in the District of Columbia in the spring. We anticipate this will be a year-long process and a revised plan will be published by the end of FY 2025.[92]

This is something we recommended in *A Path Forward* and called for in hearings last year.[93] We hope that Children's Law Center will be included in the agency's process.

Instead of focusing only on programs, we believe the strategic plan should consider how to build a professional pipeline, create needed facilities, and modernize the internal and public-facing data infrastructure. We look to the Interagency Council on Homelessness' (ICH) Homeward DC plans as an example of a robust and oft-referenced government strategic plan.[94] We hope the necessary funding for the expeditious production of a coordinated plan will be

allocated in FY 2025. We also encourage the Committee to keep abreast of the status of the plan, to ensure the process is inclusive, the strategies are appropriately ambitious, and the plan is delivered on time.

Conclusion

Access to behavioral health services is essential to our children's well-being and future success. The District has been on a path of systemic transformation, which presents many opportunities to build a more comprehensive, responsive, and equitable behavioral healthcare system and a stronger network of providers to serve DC's children and families. Across the areas detailed in our testimony, DBH must articulate the future vision and how the agency will achieve the goal we share – that all youth receive timely, impactful, appropriate care, across the full spectrum of services, for the diverse and pressing issues they face. Thank you for the opportunity to testify today. I welcome any questions the Committee may have.

[1] The Strengthening Families Through Behavioral Health Coalition's vision is to ensure DC has a fully integrated behavioral health care system in which all 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. Our coalition is composed of advocates, parents, educators, community-based organizations, and behavioral health providers. Learn more at: https://www.strengtheningfamiliesdc.org/.

[2] According to the American Academy of Pediatrics, behavioral health is the largest unmet health need for children and youth in foster care nationally. *See* American Academy of Pediatrics, *Mental and Behavioral Health Needs of Children in Foster Care,* (2021), *available at*: https://www.aap.org/en/patient-care/foster-care/mental-and-behavioral-health-needs-of-children-in-foster-care/; *see also* Children's Law Center, Testimony before DC Council Committee on Health and Committee on Facilities and Family Services, (December 6, 2023), *available at*: https://childrenslawcenter.org/resources/testimony-behavioral-health-for-children-and-youth-in-foster-care/.

[3] 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.

[4] *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.

[5] *A Path Forward*, at p. 10.

[6] 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/.

[7] Amber Rieke, *Testimony before the District of Columbia Council Committees on Health, Judiciary and Public Safety, and Recreation, Libraries and Youth Affairs*, (December 13, 2023), *available at:* https://childrenslawcenter.org/wp-content/uploads/2023/12/Amber-Rieke-CLC_Public-Safety-BH-Roundtable-Testimony_Dec-13-2023.pdf.

[8] 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.

[9] Reports, news and policy testimonies by Children's Law Center staff dating back to 2013 are available at: https://childrenslawcenter.org/search/behavioral+health/.

[10] *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.

[11] Most states have moved to a managed care model to provide comprehensive care and services. Rather than Fee-for-Service, which will reimburse every separate service, prescription, test, etc., MCOs are paid a set per member per month payment. This capitation provides upfront fixed payments to plans for expected utilization of covered services, administrative costs, and profit. The benefits of managed care models for the state are that they increase budget predictability and constrain Medicaid spending. Insurers and providers are therefore incentivized to use their constrained resources to achieve better health outcomes for each patient, rather than longer bills for high volumes of services and diagnostics. This also incentivizes good prevention care versus "sick care," reducing redundant or excessive testing, good communication between providers about a patient's care, attentive medication monitoring, expansion of navigation and one-on-one supports for patients, and more import on the social and environmental conditions contributing to a patient's health. For the beneficiary, managed care is meant to result in improve access to care and value of received care. States may also require MCOs to participate in Performance Improvement Projects (PIPs) focused on reducing health disparities. *See:* Elizabeth Hinton, Jada Raphael, *10 Things to Know About Medicaid Managed Care*, KFF (March 1, 2023), *available at:* https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/;
See also: DHCF, *DHCF Announce Medicaid Program Reforms and Intent to Re-Procure Managed Care Contracts*, (September 11, 2019), available at: https://dhcf.dc.gov/release/dhcf-announces-medicaid-program-reforms-and-intent-re-procure-managed-care-contracts.

[12] Care coordination refers to the organization of a patient's care across multiple health care providers and settings, requiring increased communication and information sharing on behalf of the patient, to improve care and reduce redundancies in treatment, testing, etc. *See: Key Concepts: Care Coordination*, U.S. Centers for Medicare and Medicaid Services, (accessed January 25, 2024), *available at:* https://www.cms.gov/priorities/innovation/key-concepts/care-coordination.

[13] Value-based care is a financing concept, meant to put greater emphasis on integrated care and quality of care received by a patient. Financial models or incentives are designed to help a patient's providers work together to address the "whole person" – or all of the physical, mental, behavioral and social needs – rather than focusing on a specific health issue or disease. The patient may experience more support than traditional care delivery models paid for, such as navigation support, options in how they receive care, better communication with/between their providers, and opportunities to participate in disease prevention programs or health education. *See: Key Concepts: Value-Based Care*, U.S. Centers for Medicare and Medicaid Services, (accessed January 25, 2024), *available at:* https://www.cms.gov/priorities/innovation/key-concepts/value-based-care.

[14] *Id.*

[15] Donald Berwick, *The Triple Aim: Why We Still Have a Long Way to Go*, Institute for Healthcare Improvement (February 14, 2019), *available at:* https://www.ihi.org/insights/triple-aim-why-we-still-have-long-way-go.

[16] District of Columbia Section 1115 Medicaid Behavioral Health Transformation Demonstration, Department of Health Care Finance, (accessed January 25, 2024), *available at*: https://dhcf.dc.gov/1115-waiver-initiative.

[17] Behavioral Health Integration, Department of Health Care Finance, (accessed January 25, 2024), *available at*: https://dhcf.dc.gov/page/behavioral-health-integration

[18] *Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier, Fiscal Year 2025*, KFF, (accessed January 25, 2024), *available at:* https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[19] *Medicaid Business Transformation DC: Recommendations for Technical Assistance*, Health Management Associates, (September 2023), *available at*: https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/TA%20Recommendations%20Report_DC%20BTTA_Final.pdf;
See also: Integrated Care DC Managed Care Readiness Workshop, Department of Health Care Finance, DBH Training Institute, and Integrated Care DC, (May 9, 2023), *available at*: https://www.integratedcaredc.com/resource/integrated-care-dc-managed-care-readiness-workshop/.

[20] *Id.*

[21] *Id.*

[22] Public Forum on Integrated Care meeting, December 6, 2023, https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/Public%20Forum%20on%20Integrated%20Care%2C%20December%206%2C%202023%20-%20Presentation.pdf

[23] Project LAUNCH, Washington D.C. Project LAUNCH -Healthy Futures Program, *available at*: https://healthysafechildren.org/sites/default/files/WDC_Healthy_Futures_Program_Brief.pdf.

[24] In FY 2023 there were three expulsions of the 3,025 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 2024 to date. *See* DBH, FY2023 Oversight Responses, response to Q52, *available at*: https://lims.dccouncil.gov/Hearings/hearings/247.

[25] During FY 2020, Healthy Futures was in 40 Child Development Centers and 18 Home Providers for a total of 58 Healthy Future sites. DBH, FY 2020 Performance Oversight Responses, responses to Q54, available at: https://dccouncil.gov/wp-content/uploads/2021/06/dbh.pdf. In FY 2021, Healthy Futures was in 69 child development centers and 18 home providers for a total of 87 facilities. DBH, FY 2021

Performance Oversight Responses, responses to Q45, available at: https://dccouncil.gov/wp-content/uploads/2022/01/dbh.pdf. During FY 2022 the Healthy Futures program provided services in 85 child development centers and 17 home providers for a total of 102 locations. DBH FY 2022 Performance Oversight Responses, response to Q41, *available at*: https://www.dropbox.com/sh/z6g48dc4tq8528u/AAA0mmhCy-4vOYWjouWtnc2Da/COH%20Performance%20Oversight/DBH/Agency%20Responses%20and%20Testimony?dl=0&preview=FY+22+DBH+Oversight+Questions+and+Responses_One+Doc.pdf&subfolder_nav_tracking=1. During FY 2023 the Healthy Futures program provided services in 95 child development centers and 16 home providers for a total of 111 locations. DBH, FY2023 Performance Oversight Responses, response to Q52, *available at*: https://lims.dccouncil.gov/Hearings/hearings/247. FY 2021 (87 cites) - FY 2020 (58 cites) = increase of 29 sites between 1 year. FY 2022 (102 cites) – FY 2021 (87 cites) = increase of 15 cites between 1 year. FY 2023 (111 sites) – FY 2022 (102 sites) = increase of 9 sites. Average = 29+15+9 divided by 3 = 17.6 (rounds to 18) sites increase on average over three years.

[26] DBH, FY 2023 Performance Oversight Responses, response to Q52, *available at*: https://lims.dccouncil.gov/Hearings/hearings/247.

[27] Some hiring has been slowed due to incorrect budget programming. It is critical that in the budget, the funds for Healthy Futures are correctly programmed. For the FY 2024 budget, the funds were programmed as "non-personnel" when the funds should have been programmed as "personnel" as they are used to hire consultants directly to DBH's staff under the Healthy Futures program. DBH is working alongside the CFO's office to remedy this error. However, this incorrect programming delayed DBH's ability to use the funds. We want to call the Council's attention to this error to ensure first it does not happen again and two to ensure that there are no cuts to DBH's Healthy Futures funding even if they are not able to utilize all the funds this year to make the necessary hires due to these delays.

[28] Georgetown University School of Continuing Studies, *Online Certificate in Infant & Early Childhood Mental Consultation, available at*: https://scs.georgetown.edu/programs/518/certificate-in-infant-early-childhood-mental-health-consultation/; DBH, FY2023 Performance Oversight Responses, response to Q52, *available at*: https://lims.dccouncil.gov/Hearings/hearings/247.

[29] D.C. Law 22-179. Birth-to-Three for All DC Amendment Act of 2018.

[30] Department of Behavioral Health (formerly "Department of Mental Health"), Healthy Futures Year One Evaluation of Early Childhood Mental Health Consultation, September 30, 2011, *available at*: https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/Children%20Youth%20and%20Family%20Services%20Healthy%20Futures%20Year%20One%20Report.pdf; Department of Behavioral Health, Healthy Futures Year Two Evaluation of Early Childhood Mental Health Consultation, September 30, 2012, *available at*: https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/Children%20Youth%20and%20Family%20Services%20Healthy%20Futures%20Year%20two%20report.pdf; Department of Behavioral Health, Healthy Futures Year Three Evaluation of Early Childhood Mental Health Consultation, September 30, 2013, *available at*: https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/HealthyFuturesThreeYearEvaluationReport.pdf; Department of Behavioral Health, Healthy Futures Year Four Evaluation of Early Childhood Mental Health Consultation, September 30, 2014, *available at*: https://www.iecmhc.org/wp-content/uploads/2020/12/DC-Healthy-Futures_Year4Report-executive-summary.pdf; and Department of Behavioral Health, Healthy Futures Year Five Evaluation of Early Childhood Mental Health

Consultation, September 30, 2015, *available at*: https://www.iecmhc.org/wp-content/uploads/2020/12/DC-Healthy-Futures-Year-5.pdf.

[31] *How Does School-Based Behavioral Health Work?* Strengthening Families through Behavioral Health Coalition, https://www.strengtheningfamiliesdc.org/how-does-sbbh-work.

[32] DBH Coordinating Council on School Behavioral Health slides, presented January 16, 2024

[33] Rachel Metz, *DC Must Continue Tackling the Youth Mental Health Crisis*, DC Action for Children Blog (August 21, 2023), *available at:* https://www.wearedcaction.org/blog/dc-must-continue-tackling-youth-mental-health-crisis.

[34] DBH Coordinating Council on School Behavioral Health slides, presented May 15, 2023, on file with the Children's Law Center.

[35] *Id.*

[36] School Behavioral Health Expansion Evaluation, *Summary of Findings from SY 2021-2022: Providing Multi-tiered Support for Behavioral Health*, Child Trends and DC Department of Behavioral Health, 2023, obtained via the Freedom of Information Act.

[37] *Id.*

[38] *Id.*

[39] DBH Coordinating Council on School Behavioral Health slides, presented October 16, 2023, on file with the Children's Law Center.

[40] DBH Coordinating Council on School Behavioral Health slides, presented November 20, 2023, on file with the Children's Law Center.

[41] D.C. Law 24-167. Fiscal Year 2023 Budget Support Act of 2022. Title V, Subtitle M: School Behavioral Health Program Implementation and Funding Analysis.

[42] Leandra Godoy, et al., *Behavioral Health Integration in Health Care Settings: Lessons Learned from a Pediatric Hospital Primary Care System*, Journal of Clinical Psychology in Medical Settings 24, no. 3, 245–58, September 19, 2017, retrieved from: https://doi.org/10.1007/s10880-017-9509-8.

[43] DBH, FY 2020 Performance Oversight Responses, responses to Q54, *available at:* https://dccouncil.gov/wp-content/uploads/2021/06/dbh.pdf.

[44] "Over the past six years, DC MAP has received over 4,250 consultation requests regarding 3,745 unique patients… Programs like DC MAP…target children in their natural context support early identification (and thereby, treatment) of behavioral health issues, potentially circumventing escalation to severe behavioral health problems over the lifetime of beneficiaries. In the long-term, effective implementation of [DC MAP] can result in decreases in behavioral health service utilization and related costs." Sharra Greer, Children's Law Center, Testimony Before the District of Columbia Council Committee on Health, (February 12, 2021), *available at*: https://childrenslawcenter.org/wp-content/uploads/2022/06/SGreer_CLCTestimony_DBHOversightHearing_Updated-5.24.22.pdf.

[45] DC MAP: Mental Health Access in Pediatrics Homepage, *available at*: https://dcmap.org/. *See* also Paving the Way, DC Map, *available at*: https://www.pavingthewaymsi.org/dc-map.

[46] DBH, FY 2023 Performance Oversight Responses, responses to Q54, *available at*: https://lims.dccouncil.gov/Hearings/hearings/247.

[47] Georgetown University Center for Global Health Science and Security for the Office of the D.C. Auditor, *COVID-19 & Behavioral Health in the District of Columbia*, (April 20, 2023), *available at:* https://dcauditor.org/report/covid-19-behavioral-health-in-the-district-of-columbia/.

[48] *Getting Treatment During a Crisis,* National Alliance on Mental Illness (NAMI), (accessed January 19, 2024), *available at:* https://www.nami.org/Learn-More/Treatment/Getting-Treatment-During-a-Crisis;

Patrisse Cullors, Tim Black, *Community-Based Emergency First Responders: Explained*, The Appeal, June 25, 2020, *available at:* https://theappeal.org/community-based-emergency-first-responders-explained/; *Assessment #9: Improving the Child and Adolescent Crisis System: Shifting from a 9-1-1 to a 9-8-8 Paradigm*, National Association of State Mental Health Program Directors, August 2020, *available at:* https://www.nasmhpd.org/sites/default/files/2020paper9.pdf.

[49] *Id.*

[50] DBH, FY 2023 Performance Oversight Responses, responses to Q44, *available at*: https://lims.dccouncil.gov/Hearings/hearings/247.

[51] *Id.*

[52] *Id.*

[53] Family Preservation Services of Washington D.C., *Our Services*, *available at*: https://www.familypreservationdc.com/our-services/.

[54] Sharra Greer, Children's Law Center, *Testimony before the District of Columbia Council Committee on Health*, (February 1, 2023), *available at*: https://childrenslawcenter.org/wp-content/uploads/2023/02/Sharra-Greer_CLC_Performance-Oversight_DBH_General_February-1-2023_final-1.pdf.

[55] *Id.*

[56] 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.

[57]D.C. Act 25-172. Fiscal Year 2024 Budget Support Emergency Act of 2023. Title V, Subtitle F: School-Based Behavioral Health Student Peer Educator Pilot.

[58] *Id.*

[59] DBH Coordinating Council on School Behavioral Health slides, presented January 17, 2024.

[60] 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

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[62] *A Path Forward*, at p. 64, p. 118, p. 119, p. 148.

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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.

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