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Committee on Health
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Public Oversight Hearing:
Performance Oversight
Department of Behavioral Health

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Introduction

Good morning, Chairperson Henderson, and members of the Committee on Health. My name is Chris Gamble. I am a Behavioral Health Policy Analyst at Children's Law Center, a Ward 5 resident, and a Licensed Professional Counselor with experience providing behavioral health care to children, teens, and families in the District's public behavioral health system. I am testifying today on behalf of Children's Law Center. Our more than 100 staff work with DC children and families, community partners and pro bono attorneys toward a future where every child can 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.

Thank you for the opportunity today to testify about the performance of the Department of Behavioral Health (DBH) over the past year. 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. Our team of guardians ad litem (GAL) represent over half the kids in DC's foster care system. Over a quarter of the children represented by our GAL team last year were diagnosed with behavioral health conditions.[1] Not only is there a higher incidence of behavioral health needs amongst children in foster care [2], but the specific experiences of foster care require distinct interventions fit for the population.[3] Unfortunately, our clients frequently struggle to have their behavioral needs met in part due to issues of access leading to delays in receiving services, with nearly a third of our GAL clients experiencing such a delay in the last year.[4]

Childhood and adolescence are developmental periods where certain behavioral health conditions may begin to present.[5,6] The diagnosis a child receives does not tell the whole story though. Two children diagnosed with depression may require two different forms of care;

perhaps, one in weekly therapy, and one in an intensive outpatient program. An effective behavioral health system is one that can meet the varying needs of different individuals and populations through the availability of a range of services. The District does not have all the types of behavioral health services that children need, leaving our public system unresponsive to the varying acuity and course progressions of children's behavioral health needs.

We want our clients and all children in DC to receive the services best fit for their needs. In the past year, services overseen by DBH have not expanded in the ways necessary, with some even shrinking in availability. District agencies – especially DBH, the Department of Health Care Finance (DHCF), and the Department of Health (DC Health) – must work together to build our behavioral health system's capacity to meet children's needs. Our 2021 report, *A Path Forward: Transforming the Public Behavioral Health System for Children, Youth, and their Families in the District of Columbia*,[7] lays out 94 recommendations to improve the issues that continue to impact children's ability to access culturally competent, quality services in a timely manner.

For the purposes of today's hearing, my testimony today will focus on the following:

- The lack of acute and intermediate services in the District's continuum of care.
- The impact of reduced access to Community-Based Intervention (CBI) services.
- Concerns related to the District's child crisis services.
- Workforce development actions DBH can take to build toward a sustainably staffed continuum of care.
- The importance of having a vision for DC's continuum of care and transparently communicating it to the public.

The District Over Relies On Existing Acute Services Because The Continuum Of Care Lacks The Full Array Of Intermediate And Acute Levels of Care Our Children Need

In October 2024, Children's Law Center testified at a Council roundtable regarding inpatient psychiatric facilities and the continuum of care in DC. [8] During this roundtable, we and others established that inadequate community level services increase the utilization of acute, inpatient care, and that youth leaving inpatient care do not have access to appropriate step-down or bridge services, ultimately creating a cycle of crisis and hospitalization. [9,10]

Making this cycle more concerning is the fact that we also don't have all the intermediate and acute levels of care available in the District. Intermediate care settings like Intensive Outpatient Programs (IOP) and Partial Hospitalization Programs (PHP), and acute care settings like Psychiatric Residential Treatment Facilities (PRTF) are sometimes the necessary level of care a child needs, but for children in DC, they typically have to be sent away from home in order to access them, since there is no PHP or PRTF and only one IOP for adolescents in DC.[11] This challenge to access can lead to more children utilizing existing acute services as the next best option. In addition to relieving pressure on existing acute services, DBH needs to continue working to establish more intermediate and acute forms of care locally in order to keep children close to their families while receiving needed care.

In 2023, 502 children were involuntarily admitted to Children's National Hospital's (CNH) emergency department for mental health crises, and in 2024, 472 were involuntarily admitted by mid-October. [12] This represents a continuing increase over the past several years that CNH says has led to a shortage of behavioral health beds and increased emergency room boarding of children.[13] The establishment of a Children's Comprehensive Psychiatric Emergency Program (CCPEP) would provide an option for rapid stabilization of immediate crises, helping to avoid hospitalization and the escalation of needs to the point of needing intermediate or acute

levels of care for many children.[14] Reducing the number of admissions would allow CNH's inpatient unit to operate within its longer-term function by not having to take on the crises that only need short-term stabilization. We appreciate being able to meet with Councilmember Henderson and her team to discuss the importance of a CCPEP and encourage DBH to collaborate with CNH, the Psychiatric Institute of Washington (PIW), and other partners to create a plan for establishing this service in the District.

There has been small progress in establishing local intermediate level care with Medstar Georgetown University Hospital opening an adolescent Intensive Outpatient Program (IOP) last year.[15] Now, adolescents ages 13-17 have access to nine hours of group therapy and additional individual and family therapy per week.[16] This provides a middle ground for those clients who need more than once a week individual therapy, but for whom inpatient care is unnecessary. The IOP can also serve as a more appropriate step-down service after inpatient hospitalization, providing a volume and frequency of treatment that can lower chances of readmission to the hospital. We support DBH's plan to explore opportunities for additional IOPs as children under age 13 can also benefit from access to this intermediate level care.

Establishing local options for intermediate and acute care ultimately helps the triaging of services to make sure a child receives the type of care appropriate for their needs. For example, a child from DC successfully placed in a PRTF in Florida could be discharged and recommended a PHP as a step-down service. Their care team may encounter hurdles in finding availability for a PHP in Florida or another state, and the child's family understandably may simply want their child to be home again. Based on the options available, the child could return to DC and start receiving Community-Based Intervention (CBI) services instead of the recommended PHP. A mismatch in services means a child is not receiving the most effective treatment for them. We

ask that the Committee continue checking with DBH for updates on their efforts to expand the local continuum of care so that existing services can focus on fulfilling their intended purposes.

Community-Based Intervention (CBI) – the District's Core Intensive[17] Community-Level Service – Is Reaching Fewer Children

Community-Based Intervention (CBI) is a time-limited, intensive service intended to keep children with significant behavioral health needs from utilizing out-of-home placements for treatment.[18] According to DBH's service utilization dashboard, 198 children received CBI services in FY24, a 19% decrease from the previous fiscal year.[19] The decrease in children receiving CBI has occurred year after year since FY20 when 500 children received the service.[20] Further, the number of organizations providing CBI services has decreased - from seven CBI providers in FY23 to five in FY25.[21] This diminished capacity tracks with experiences of our clients, who in the past two years have waited months to access CBI services or have not received the service once enrolled with a Core Service Agency, despite DBH stating that there are no reports of waitlists or service gaps.[22,23] We ask the Committee to seek clarity from DBH regarding how the agency collects data on CBI availability and whether it is fully capturing the needs of District children.

We also ask the agency and the Committee to continue to assess the impact of the changes to CBI specialist licensure requirements on the CBI workforce.[24] While the change to require CBI specialists to be Master's level licensed behavioral health professionals may have sharpened the clinical aspects of CBI work, we are concerned that it may also have shrunk the available workforce qualified to provide these services—and therefore reduced the availability of this service. We urge DBH and the Committee to consider how non-clinical roles can be integrated with CBI teams for other parts of the work. Comparable models that use a two-person team of a licensed behavioral health professional and a peer support specialist to deliver

intensive home-based treatment to children show that different configurations for CBI teams are valid.[25] There are activities that fall under the umbrella of CBI services like skill building, resource connection, and safety planning that with proper training can be performed by non-clinical staff, leaving the practice of therapy interventions to the licensed professionals.

Non-Behavioral Health Professionals Are Becoming Increasingly Involved In Child Crisis Response, Warranting Considerations About How These Services Are Managed

We are now about two years into the main children's crisis response team, the Child and Adolescent Mobile Psychiatric Service (ChAMPS), having their hours reduced to 8:00am-8:00pm on weekdays, with DBH's Community Response Team (CRT), typically dedicated to adults, receiving the calls outside those hours and on weekends.[26] DBH's pre-hearing responses show that ChAMPS received 1093 calls in FY24, including those re-routed to the CRT during their coverage hours.[27] Of these calls, the CRT was deployed 77 times, resulting in 53 psychiatric hospitalizations of children, 48 of which were done via the FD-12 process, meaning they were transported to the hospital involuntarily.[28] Seeing that 62% of CRT deployments to a child in crisis result in the child being involuntarily hospitalized, questions about their ability to adequately de-escalate children with behavioral health needs are necessary. In the same fiscal year, ChAMPS deployments resulted in 76 involuntary hospitalizations through FD-12, though the data does not tell how many total deployments there were.[29] Still, comparing the available data to last year's pre-hearing responses, there has been a jump in the number of ChAMPS and CRT deployments resulting in involuntary hospitalizations of children from 50 in FY23 to 124 in FY24.[30,31] We ask the Committee to question DBH about this rise and whether the agency's crisis teams, particularly the CRT, are receiving enough training in managing children's crises to avoid involuntary hospitalization.

Increasing involuntary hospitalization of children is also concerning due to the involvement of non-behavioral health professionals in these situations. Drawing from DBH's descriptions of the services, neither ChAMPS nor the CRT transports children to the hospital even when they are on the scene first. Transportation is instead provided by Fire and Emergency Medical Services (FEMS).[32] For CRT deployments, officers from the Metropolitan Police Department (MPD) were also present during all 48 FD-12s in FY24 to assess and maintain safety until FEMS arrived on the scene.[33] Similarly, we learned from last year's pre-hearing responses that "when a child or youth is aggressive, [ChAMPS] will rely on MPD for support and transportation when FD-12 is required".[34] According to the Substance Abuse and Mental Health Services Administration (SAMHSA), the best practice for both adult and children mobile crisis teams is the behavioral health practitioner only model.[35] We urge the Committee to ask the agency to explain the reasons for routinely including non-behavioral health professionals in its child crisis response, and how that aligns with national best practices.

Finally, it is our understanding that in terms of DBH's internal organization, ChAMPS now falls under the purview of DBH's Crisis Services division instead of the Child and Family Services division. If this is so, we ask the Committee to inquire about how this shift will improve the functioning of children's crisis response so that fewer children are involuntarily hospitalized.

To Expand Our Continuum of Care, The District Must Have A Sustainable Behavioral Health Workforce

DC Health's FY23 data shows that there are 10,356 people licensed in DC as what are generally considered core behavioral health professionals (social workers, counselors, marriage and family therapists, psychologists).[36] The data does not allow for enumerating the full behavioral health workforce, including psychiatrists or non-clinical staff who may provide certain types of behavioral health support, like community support workers and peer specialists,

but is enough to demonstrate a needed change in perspective when it comes to workforce development.

In order to know to what extent these 10,000 plus professionals are meeting the behavioral health needs of DC residents, we would have to know where they work and what they do. For example, I am represented in this data set as a Licensed Professional Counselor, but I work as a policy analyst and have not provided therapy since 2020, thus not addressing the demand for services that is typically considered when talking about a workforce shortage. Other licensed behavioral health professionals may be professors, consultants, or run a private practice that doesn't accept any health insurance plans.

There is a DC Health workforce survey completed each renewal cycle for licensed health professionals that has questions about type of practice, job satisfaction, and even considerations of respondents to leave the healthcare profession.[37] Last year, DC Health stated fact sheets based on these survey results would be posted on health professional Board websites, but this does not appear to have been done.[38] It is in DBH's interest to collaborate with DC Health if necessary to get these fact sheets produced because the data collected could help to better understand the current state of our workforce. There is potential that the problem DC's public system faces is not simply an issue with the supply of behavioral health professionals, but also their distribution in the job market. We recommend the Council encourage better data collection practices from the responsible agencies in order to know this definitively.

In last year's pre-hearing responses, DBH stated that "CSAs [Core Service Agencies] have experienced difficulty hiring staff for behavioral health positions due to the national workforce shortage. In addition, when CSAs are able to hire staff, they report having challenges retaining staff. As a result, some CSAs have limited capacity for therapy and other core

services…".[39] In addition to CSAs, Healthy Futures [40] is an effective program that has been hampered by workforce issues.[41]

Where these professionals go after leaving CSAs and other places of work in our public system would tell us more about the potential distribution issue, but what we do know is that their absence impacts children's access to care. Almost a tenth of our GAL clients experienced care access issues due to staff turnover in the last year.[42] Burnout is one factor that has been indicated in research as a relevant factor in staff turnover for mental health service providers.[43] In a meta-analysis and systematic review of burnout among mental health professionals, interventions to prevent and reduce burnout included promoting professional autonomy, having manageable caseloads, developing good team function, and providing quality clinical supervision.[44] Other research has identified organizational climate and culture as having distinct roles in reducing staff turnover and sustaining new mental health service programs.[45] While each DBH service provider has the ultimate influence on its individual organizational functioning, we encourage DBH to explore what actions it can take to support its provider network in improving staff retention.

We recommend the Council and DBH look into methods of addressing behavioral health professionals' financial burdens as a way of making entering and staying in the workforce more manageable. A 2024 workforce survey conducted by the American Counseling Association showed that professional counselors have an average student loan debt of $79,500, which is 113% higher than the national average.[46] While local student debt relief programs like the DC Health Professional Loan Repayment Program are helpful, they only apply to those working in Health Professional Shortage Areas and Medically Underserved Areas.[47] DC has nine Federally Qualified Health Centers (FQHC) and one geographic area (Anacostia) designated as mental

health professional shortage areas by the Health Resources and Services Administration (HRSA).[48] There needs to be local student debt relief programs that are accessible to the behavioral health professionals not working at these facilities or in this one area of the city because student loan debt burdens people no matter where they work.

The Pathways to Behavioral Health Degrees Act, which went into effect last year, is another example of a way to address the economic barriers of entering behavioral health professions by covering graduate school costs while also requiring graduates to work in DC for at least three years.[49] We await future evaluations as to whether the program results in a sustainable pipeline into DC's workforce.

DBH Needs To Be Transparent With Their Process Of Developing A Strategic Plan For Children's Behavioral Health To Build Trust That The System Will Be Improved

DBH says they are on schedule to have a strategic plan with a dedicated section for Child and Youth Services completed by the end of FY25.[50] We support DBH's continued work on this, but there hasn't been clarity on how they're bringing together child-serving agencies, organizations, and advocates, along with children and families to formulate this new plan since last year's performance oversight hearing. Children's Law Center was included in a meeting regarding the strategic plan in September 2024 but has not received any further engagement. Stakeholders deserve clarity on how DBH is gathering information for the strategic plan and receive regular updates to promote accountability.

We hope that the strategic plan contains guidelines for improving the continuum of care and workforce issues outlined in our testimony, along with an emphasis on quality control. The infrastructure of service delivery, process of treatment provision, and outcomes of treatment have been identified by researchers as broad categories for mental health service quality measures that can lead to better care by tracking.[51] There are two quality assurance practices DBH used to

engage in that we think would benefit consumers by giving them voice and choice in utilizing behavioral health services.

Community Service Reviews, while initially conducted under court order, were a way of gathering data through adult and youth consumer and staff interviews along with document reviews to inform how well community-based providers were performing their duties.[52] While DBH still produces utilization and consumer satisfaction reports, they don't contain the same depth of information that can be used to improve service provision.[53,54] Without Community Service Reviews, consumer perspectives on quality are diminished and other stakeholders have lost a valuable source of information that can be used to hold DBH accountable to making improvements.

DBH also used to produce provider scorecards which rated its network of providers on measures of quality and financial performance.[55] With numbered scores and a simplified star system, the scorecards gave the consumers accessible information for making decisions about their behavioral health care and provided stakeholders with a transparent means of seeing which providers needed to make improvements. When our social workers or GALs are looking for behavioral health services for their clients, confidence in the quality of services a child will receive is paramount, diminishing the chances of just choosing a provider with availability. Since these scorecards were last produced in FY16, the public has one less tool to demand internal and external accountability of service providers. Quality services are a central component of any well-functioning health system, and we hope DBH provides opportunities for community stakeholders to advocate for the inclusion of these measures in their strategic plan.

Conclusion

Children and youth in DC deserve access to high quality behavioral health services that meet their various needs. Supporting children in need also requires supporting those providing the services as well as having a clear vision for a functioning system. Thank you for the opportunity to testify today. I welcome any questions the Committee may have.

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[9] *Id.*
[10] Adelaide Robb, MD, Children's National Hospital, Testimony Before the District of Columbia Council Committee on Health, (October 28, 2024), *available at*: https://lims.dccouncil.gov/Hearings/hearings/537.
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[12] Elizabeth Davis, Children's National Hospital, Email Communication to Chris Gamble and Marcia Huff, December 2024.
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[14] *A Path Forward*, at p. 93.
[15] DBH FY2024 Performance Oversight Responses, response to Q67, *available at*: https://lims.dccouncil.gov/Hearings/hearings/637.

[16] Medstar Health, Intensive Outpatient Program for Adolescents, *available at*: https://www.medstarhealth.org/services/intensive-outpatient-program-for-adolescents.
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[19] https://dbh.dc.gov/page/dbh-service-utilization-dashboard-people-served-text.
[20] *Id.*
[21] DBH FY2024 Performance Oversight Responses, response to Q40, *available at*: https://lims.dccouncil.gov/Hearings/hearings/637.
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[23] DBH FY2024 Performance Oversight Responses, response to Q40, *available at*: https://lims.dccouncil.gov/Hearings/hearings/637.
[24] Amber Rieke, Children's Law Center, Testimony Before the District of Columbia Council Committee on Health, (January 29, 2024), *available at*: https://childrenslawcenter.org/wp-content/uploads/2024/01/Amber-Rieke_CLC_Performance-Oversight-Testimony_DBH_Jan-29-2024.pdf.
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[29] *Id*, response to Q55.
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[34] DBH FY2023 Performance Oversight Responses, response to Q44, *available at*: https://dccouncil.gov/wp-content/uploads/2024/08/FY-23-Oversight-Pre-Hearing-Responses.-DBH_UPDATED.pdf.
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[38] DC Health FY23 Performance Oversight Responses, response to Q122, *available at*: https://lims.dccouncil.gov/Hearings/hearings/232.
[39] DBH FY2023 Performance Oversight Responses, response to Q49, *available at*: https://dccouncil.gov/wp-content/uploads/2024/08/FY-23-Oversight-Pre-Hearing-Responses.-DBH_UPDATED.pdf.
[40] Healthy Futures program, which integrates behavioral health services in settings where children are already present at child development centers and home providers and has been a critical investment for the District. Healthy Futures is based largely upon the Early Childhood Mental Health Consultation

(ECMHC) model developed by Georgetown University Center for Child and Human Development (GUCCHD). ECMHC creates a collaborative relationship between a professional consultant with early child mental health expertise and one or more caregivers, typically an early care and education provider and/or family member. The collaborative relationship of consultant and caregiver aims to build the capacity of staff, families, programs, and systems to prevent, identify, treat and reduce the impact of mental health problems among children and their families. See DBH, FY2024 Performance Oversight Responses, response to Q61, *available at*: https://lims.dccouncil.gov/Hearings/hearings/637; Department of Behavioral Health, Healthy Futures Evaluation of Early Childhood Mental Health Consultation, Year 5, September 30, 2015, *available at*: https://www.iecmhc.org/wpcontent/uploads/2020/12/DC-Healthy-Futures-Year-5.pdf; Mary Mackrain, A Day in the Life of an Early Childhood Mental Consultant, Center for Early Childhood Mental Health Consultation, December 2021, *available at*: https://www.iecmhc.org/documents/Day_in_the_Life_MH_Consultant.pdf.

[41] The number of Child Development Centers and Home Providers that have Healthy Futures programing has steadily grown between FY20 and FY23 — FY20 (58 CDCs and home providers); FY22 (87 CDCs and home providers; FY22 (102 CDCs and home providers); and FY23 (111 CDCs and home providers). Unfortunately, in FY24 that number has fallen back to 101 CDCs and home providers offering Healthy Futures. This is primarily due to the challenges in both the behavioral health workforce and childcare sector. Child development centers were particularly hard by the pandemic and are still recovering – many are financially and operationally destabilized, and others have closed permanently. Additionally, there is a workforce shortage of behavioral health professionals including early childhood mental health consultants and supervisors, making it very difficult to expand to more child development centers. Despite these challenges Healthy Futures continues to serve teachers, school staff, administrators, parents, and children with fidelity to the model. In FY 24 there were two expulsions of the 3,836 children served from child development facilities where the Healthy Futures Program was implemented — well below the national average for prekindergarten expulsions. Additionally, FY2024 was the first full year for DBH's expansion of Healthy Futures program to offer on-site treatment at select child development centers and further implementation of successful trauma informed treatment approaches for our youngest children and their families. Helpfully, the evaluation being completed by Georgetown University Thrive Center for Children, Families and Community is near completion, and DBH projects the final report will be released in the Spring of FY 25. This will allow us greater insight to the program and support future implementation efforts. See DBH, FY2020 Performance Oversight Responses, response to Q54, *available at*: https://dccouncil.gov/wp-content/uploads/2021/06/dbh.pdf; DBH, FY2021 Performance Oversight Responses, response to Q45, *available at*: https://dccouncil.gov/wp-content/uploads/2022/01/dbh.pdf; DBH, FY2022 Performance Oversight Responses, response to Q41, available at: https://dccouncil.gov/wp-content/uploads/2023/03/FY-22-DBH-Oversight-Questions-and-Responses_One-Doc.pdf; DBH, FY2023 Performance Oversight Responses, response to Q52, *available at*: https://lims.dccouncil.gov/Hearings/hearings/247; DBH, FY2024 Performance Oversight Responses, response to Q61, *available at*: https://lims.dccouncil.gov/Hearings/hearings/637.

[42] Internal Children's Law Center Data Collection, "GAL Deep Dive," January 2024 through December 2024.

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[49] DC Law 25-104. Pathways to Behavioral Health Degrees Act of 2023. *Available at*: https://code.dccouncil.gov/us/dc/council/laws/25-104

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