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Committee on Health
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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, and I am a Behavioral Health Policy Analyst 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. We are members of the Early Childhood Innovation Network (ECIN)[1] and the co-chair the Strengthening Families Through Behavioral Health Coalition (SFC).[2]

Thank you for the opportunity to testify today about the Department of Behavioral Health's (DBH) FY26 budget. While the District faces a uniquely tight budget season, with decisions around behavioral health funding potentially putting residents at risk of long-term setbacks to their well-being, we must also acknowledge that the District has faced enduring difficulties in ensuring effective and accessible behavioral health services. We see this first-hand when Children's Law Center's clients experience these persistent challenges like having their treatment progress disrupted

due to persistent staffing turnover, experiencing delays in receiving recommended services, or not receiving high-quality appropriate services.[3]

As we testified to at the October 2024 Roundtable on the In-Patient Psychiatric Facilities and the Continuum of Behavioral Health Care in the District of Columbia, the District's continuum of care is inadequate and exacerbates the need for inpatient services.[4] The District has repeatedly deferred maintenance on its behavioral health system, and it is catching up with the city – and while the current budget did not create these problems, we are concerned that the FY26 DBH budget makes proposals that could further harm District children and families and continue the city down a dangerous path.

My testimony will analyze the impact of the proposed budget cuts across the continuum of care in the District. Specifically, my testimony will discuss: (1) the impact of freezing provider payment on the availability of behavioral health services and the behavioral health workforce; (2) the clear need to maintain funding for child-focused crisis response services; (3) a potential revenue-raising tool to support our crisis response system; (4) opportunities to improve SBBH despite proposed cuts; and (5) the need to maintain Healthy Futures funding to ensure services are available for DC's youngest residents and their caregivers.

Families are also facing economic pressures. A looming recession[5] and enduring concentrations of poverty in DC[6] provide the conditions for poor mental health

outcomes. Financial hardship and economic downturns are associated with higher rates of suicide[7] and can affect children's mental health through the stress put on their parents.[8] We can't put families at further risk by decreasing access to behavioral health services in a time of need. Ensuring sufficient investment in the programs discussed in this testimony will put DC on a path forward to strengthening their behavioral health systems continuum of care and ensuring all children and families have access to affordable, high quality, and culturally congruent care.

The District Must Protect The Service Provider Network To Avoid Long-Term Harm To Behavioral Health Infrastructure

Health insurance coverage, provider payment rates, and health care services are major components of health care infrastructure. Children may have avoided getting their Medicaid coverage cut in the FY26 budget, but changes to provider payment rates can cause service-providing organizations to limit services and individual providers to leave the Medicaid network in such a way that children's services effectively do get cut. While provider rates were not reduced in the FY26 budget, inflation-based rate increases were frozen.[9] DHCF asserts this pause for Mental Health Rehabilitative Services (MHRS), Free Standing Mental Health Clinics (FSMHC), and Behavioral Health Waiver Services totals $224,387 in reduced cost.[10] Freezing provider rates can force behavioral health organizations to make finance-based decisions impacting what services are available. Finding qualified behavioral health professionals willing to work in the public system could also become more difficult if payment rates do not grow with

inflation. Payment rates often play a role in determining how many weekly face-to-face clinical hours employees have to perform and may even affect what salaries organizations can afford to pay. We ask the Committee to urge DHCF to support DBH-certified providers by not freezing payment rates and allowing them, at minimum, to adjust with inflation.

When provider rates stay low and strain provider finances, the already struggling provider network can lose further capacity. Although the Evidenced-Based Practices (EBP) services division that oversees and supports Community-Based Intervention (CBI) services is only facing a minor proposed reduction that will not impact programming, CBI services have reached a decreasing number of children year after year since FY20.[11] Since DBH's performance oversight hearing in February, another CBI provider halted its services. DC's only provider of Multisystemic Therapy (MST), often referred to as CBI Level I, stopped providing the service, leaving a distinct void for the youth which the treatment was designed for—those at risk of or currently with juvenile system involvement. This is an example of how without certain types of service providers, other issues, like youth delinquent behavior, may see an increase. A major factor in the deterioration of CBI providers is the requirement for CBI workers to be licensed behavioral health professionals. In FY22, DBH provided up to $35,000 for each CBI provider to use for recruitment and retention efforts.[12] We ask the Committee to ask

the agency to provide data on how effective this funding was in supporting workforce growth to assess if similar funding is necessary going forward.

The District Must Invest In The Behavioral Health Crisis Response System So It Operates According To Best Practices

The Substance Abuse and Mental Health Services Administration's (SAMHSA) framework for crisis response—"someone to contact, someone to respond, and a safe place for help"—provides a guide for the components of a comprehensive crisis response system.[13] DC has the Access HelpLine (AHL) which houses 988 call takers that people can contact in a crisis. We have the Community Response Team (CRT) and the Child and Adolescent Mobile Psychiatric Service (ChAMPS) to respond to crises, but ChAMPS is facing a severe reduction in funding which will diminish capacity to respond to children in crisis. Our crisis response system is still lacking a crisis stabilization unit for children. Long-term growth and development are needed for the call center and crisis team components to operate efficiently and in accordance with best practices, such as having behavioral health professionals be the primary responders to crises.[14]

Significant Proposed Cut to ChAMPS Moves DC Away from Providing Appropriate Responses to Behavioral Health Crises

The proposed FY26 budget cuts children's crisis services, contracted through ChAMPS. DBH stated during the government witness budget hearing that the cut leaves ChAMPS with about $617,000 of funding,[15] but the budget shows a far steeper

reduction from $1,367,000 to $135,000.[16] We ask the Committee to seek clarity from DBH about the actual amount of funding ChAMPS is losing. Unfortunately, either amount significantly limits the operations of the District's only crisis team solely dedicated to children.

DBH justified this cut by claiming it was made in the name of quality and efficiency of services. The main example given focused on crisis response in schools.[17] Schools made 460 calls to ChAMPS in FY24, and DBH seems to be suggesting that many if not most of these could have been handled by people working in the schools.[18] They stated that licensed clinicians in schools are trained to do risk assessments, thus it is inefficient to have ChAMPS respond to crises in schools.[19] This description clashes with the experiences of school-based clinicians, ignores that not all schools have a clinician,[20] and proposes eliminating a specialized service within the continuum of care, unnecessarily creating yet another gap.

Our work through the SFC has shown us that crises can derail school-based clinicians' day and take them away from fulfilling their many other duties. DBH spoke to risk assessment training they have done with educational partners, and while ensuring school staff have skills to assess and de-escalate behaviors is important, they are not a replacement for a mobile crisis team.[21] Even the training licensed clinicians may have in crisis management has limits. DBH did not mention if any school-based clinicians are trained to initiate the FD-12 process, which refers to involuntarily hospitalizing a child.

ChAMPS, however, is able to do this. Although FD-12s should ideally be rare, if ChAMPS can't be called, police are the next option, which goes against national best practice to have behavioral health professionals be the primary responders to crises.[22] The Metropolitan Police Department (MPD) already has troubling involvement in crisis response, as they are required to handcuff children when transporting them to the hospital in MPD vehicles.[23] Increasing police involvement would put responsibility on non-behavioral health professionals to assess need for hospitalization and force children to have these traumatizing experiences more often. We ask the Committee to ask the agency to clarify what plan it has for FD-12 assessment at schools without ChAMPS.

The functionality of ChAMPS going forward remains murky. We need to know from DBH if under their plan schools will not be allowed to call ChAMPS and if ChAMPS will be told they can't respond to calls from schools. This type of directive would create unnecessary confusion and division within the behavioral health system. DBH alluded to ChAMPS' peak hours being 11:00am to 3:00pm, suggesting that they will continue to operate at least during these hours, but new contract terms are being worked on.[24] Any planned coordination with the Community Response Team (CRT) to assist with crisis response outside of schools should be considered in the context that the CRT faces its own staffing issues.[25] There was also a suggestion that billing Medicaid for crisis services would help with ChAMPS funding, but the $20,000-$25,000 that DBH said they currently bill in no way can cover essential functions.[26] The lack of a clear plan

and the lack of notifying ChAMPS about this cut ahead of time raises concerns about DBH's communication and collaboration around children's crisis services. It does not give us confidence that crisis services for children will be efficient or of high quality if this budget is approved. For all the reasons noted, we ask that funding for ChAMPS be restored at the FY25 level to maintain this crucial service. Not only do children need access to reliable crisis services, allowing inadequate provision of crisis services further opens the District up to lawsuits like the one it is currently facing from Bread for the City.[27]

The District Should Explore a 988 Telecommunications Fee to Support the Behavioral Health Crisis Response System

Nationally, crisis response systems are in much earlier stages of development than what exists for physical health emergencies. The first 911 call was made in 1968, but it took nearly twenty years for just half the country to have access to 911.[28] 988 Suicide and Crisis Lifeline call centers already span the country, but according to a 2024 poll by the National Alliance on Mental Illness (NAMI), only 23% of Americans are familiar with the service and half aren't even sure when a situation is serious enough to be considered a crisis.[29] Investment with an eye toward the future is needed to change how our communities respond to crises.

In our testimony at the Sense of the Council on Supporting Humane and Trauma-Informed Responses to Behavioral Health Crises Resolution of 2025 joint roundtable, we emphasized the long-term vision of 988 becoming the front door of the

crisis response system.[30] People in DC are still calling 911 for behavioral health crises, partially due to a lack of awareness around 988, and call diversion procedures for crisis response have not made a significant impact.[31] Developing a trajectory toward better functioning requires sources of sustainable funding.

With continued federal 988 funding uncertain, states need to develop dependable funding streams to support development of the crisis response system. A commonly proposed tool to assist with long-term funding at the state level is the use of a 988 telecommunications fee.[32] So far, 11 states have enacted legislation to collect these fees, with eight more having pending legislation.[33,34] The District can look to its neighbors to see the results of such legislation. Maryland's fee of $0.25 per line per month generates an estimated annual revenue of $27 million, and Virginia's fee of $0.12 per line per month generates an estimated annual revenue of $10 million.[35]

Every state has an existing 911 fee that offers a comparative model for a 988 fee, though there are key distinctions between the two. DC's 911 fee has existed since 2000.[36] At $0.76 per line per month, it generated nearly $13 million in CY23, which covered about 25% of the city's total 911 funding.[37] There is flexibility in how a 988 fee can be structured, so it doesn't have to mirror the format of the 911 fee. For example, Virginia's fee is only $0.08 for prepaid wireless phones, and in California, their fee started at $0.08 and gradually went up to a capped $0.30.[38] As for concerns around cost burdens on residents, the same NAMI poll showed that 71% of Americans are willing to pay a 988

fee, and once learning about existing 911 fees, 54% are willing to pay a 988 fee that is higher than $0.50.[39] So, with more understanding around what current and new fees are used for, it appears people are willing to take on a cost to help our crisis system evolve.

It's also important to note the fee doesn't have to be the sole funding source or cover all costs of the crisis response system; it can be just one facet of braided funding, which DC has already demonstrated using. In FY22, DC's investment into the rollout of 988 included a $383,000 federal grant and $5.1 million in local dollars to add 14 staff to the Access HelpLine and 27 staff to the Community Response Team.[40] This initial investment points to the multiple ways funds collected through a 988 fee can be used.

As part of the oversight of 911 and 988 fees, states set rules on how the fees can be used. The Federal Communications Commission (FCC) provides additional oversight and evaluation, publishing annual reports on the collection and use of these fees.[41,42] While DC's 911 fund is dedicated to the personnel, technology, training, and equipment needs of 911 communications, a 988 fund can have wider uses.[43,44] Oregon structured its 988 Trust Fund in a way that demonstrates how such a resource can help to avert problems caused by budget cuts. The money collected by the 988 fee in Oregon must first be used for call centers, but to the extent call centers are fully funded, the money can then go toward mobile crisis teams. Any other money in the trust fund that does not come from the 988 fee can be used for crisis stabilization services. Using this model and a fee rate the same as our 911 fee, a $13 million 988 fund would easily

prevent the cuts being made to ChAMPS.[45] In fact, ChAMPS services could even return to 24/7 operation, by at least providing FY23 funding levels of $1,867,000.[46] We ask the Committee to explore the utility of a 988 fee as an additional, predictable funding stream and to work with DBH to consider how the funds could be used most effectively across the crisis response system.

The DC Council Should Restore the $3.3 Million Cut to the SBBH Expansion Program and Require a Minimum Grant Amount to Stabilize the Program and Support Continued Implementation and Innovation

During performance oversight, we had the opportunity to extensively share the benefits of the School-Based Behavioral Health (SBBH) Expansion Program.[47] SBBH is a critical investment for the District to address gaps in DC's behavioral health services by meeting youth where they spend most of their time – school. SBBH helps to normalize seeking support, reduces stigma, and addresses access challenges caused by barriers such as a lack of transportation and parents' ability to take time off for medical appointments.[48]

The investments in time, energy, and money across all SBBH programming have been critical and we are starting to see the investments pay off.[49] We want to continue to see these positive trends and to work to ensure every public and public charter students have access to behavioral health services in their schools through a multi-tiered system of supports model (MTSS).[50]

As noted in DBH performance oversight testimony, the funding for DBH SBBH programming encompasses three programs: (1) the SBBH Expansion Program; (2) DBH Clinicians; and (3) DBH Clinical Specialists.[51] The SBBH Expansion Program, funded by DBH grants, partners with CBOs in the District to match them to public and public charter schools. DBH Clinicians and DBH Clinical Specialists are hired directly by DBH.[52]

The Mayor's Proposed FY26 Budget has a $2.3 million cut across the totality of DBH SBBH programming. According to DBH the $2.3 million reduction reflects an ending of funding for additional support services at 25 high need schools and contract savings by bringing mental health training inhouse.[53] DBH goes on to report that this adjustment does not affect any existing school partnerships or impact the funding of any school-based clinicians.

Therefore, it was surprising to learn upon further investigation that DBH had in fact made a significant cut to the SBBH Expansion Program. In FY25 the Expansion Program was funded at $18,854,522.76.[54] The proposed funding for FY26 for the Expansion Program is $15,552.004.00.[55] A proposed cut of $3,302,518.76. It would appear that the $3.3 million from the SBBH Expansion Program was moved internally to DBH SBBH programming. At the DBH government hearing on June 2, 2025, Dr. Bazron spoke of some pilot programs for SBBH including (1) prevention specialists through Hillcrest; (2) telemental health; and (3) hybrid work schedule.[56] We ask the Committee to clarify

with DBH the true impact of this $3.3 million cut to the Expansion Program and how DBH will be using the money to support other SBBH programming.

During difficult and uncertain times, such as these, it is alarming to see the SBBH Expansion Program cut so significantly, when we are hearing directly from DBH there is a growing number of students, parents, and teachers reaching out for support.[57] It is also concerning that every year since FY22 the budget for school-based behavioral health has essentially been cut despite an outcry for adequate, accessible, and high-quality behavioral health services in the District.[58] We know there is more work to be done to improve the implementation of the SBBH Expansion Program but diverting funds is not the answer. Ensuring sufficient investment in the Expansion Program is essential as the District continues to navigate new fiscal and policy realities. We believe that by restoring the SBBH Expansion Program to the full $18.8 million the District will be able to deploy innovative implementation strategies to further the success of SBBH in the District. Therefore, we ask that this Committee to restore the SBBH Expansion Programming funding and ensure no further cuts.

We also ask that this Committee establish a minimum grant amount for the Expansion Program. As we testified to during performance oversight, we believe that establishing a minimum grant amount will help to ensure that the CBOs participating in the SBBH Expansion Program are able to continue providing services to students through this program.[xxi] The current grant amount is $80,819.67. We propose that the Committee

raise the current grant amount to $129,000. Raising the grant amount to a minimum of $129,000 recognizes several key truths about the Expansion Program:

- Billing is cumbersome and inefficient which impedes robust MTSS – many CBOs are only collecting 30% of what they bill due to numerous insurance issues like a CBO not being paneled with a private insurer, low Medicaid reimbursement rates, and private insurance not being required to panel with SBBH providers.
- Federal Medicaid changes make it an unpredictable revenue resource for CBOs. The SBBH Expansion Program relies heavily on Medicaid reimbursement – therefore, as Medicaid remains unpredictable, higher grant amounts will be helpful to subsidize potential Medicaid cuts
- Billing is insufficient to meet the financial realities of the SBBH Expansion program – based on our own internal calculations CBOs need to bill $33,500 and on average are only billing $13,988. CBOs have to place significant pressure on their clinicians to meet high billable hours to even try to break even on the billing requirements.
- CBOs are losing money on the SBBH program every year – with some reporting losing tens of thousands on implementing just this program.

- The current grant funding model is overly restrictive and does not allow CBOs and schools flexibility to meet students' needs. The program places an overemphasis on Tier 3 due to the billing requirements
- The grant amounts have continued to fluctuate year after year which leaves CBOs uncertain about their funding.

Continuing to maintain the grant amount of $80,819.67 means that CBOs will have to make the tough decision to either continue to operate at a loss or leave the program. We, however, can maintain CBOs by increasing the minimum grant amount. The program must stabilize in order to address the deeper systemic issues and dig deep into areas for improvement.

With existing SBBH Expansion dollars the Committee can establish a minimum grant amount for the Expansion Program, which will help to ensure that the CBOs participating in the SBBH Expansion Program are able to continue providing services to students through this program. If the Committee is able to restore funding to $18.8 million, the District can fund all 101 schools that currently have a CBO clinician in place at a grant amount of $129,000 for a total of $13,029,000.[59]

This leaves an additional $5.8 million for the District to use to fund:

- A $1500 stipend per school year for the SBBH coordinator role at all 254 schools for a total of $381,000.[60]

- A new SBBH Coordinator Position at the Office of the State Superintendent of Education (OSSE) to act as coordinator, convener, data collector, data analyst, and overall central point of contact for SBBH coordinators, schools, and clinicians for a total of $128,000.[61]
- B25-0759 – Child Behavioral Health Services Dashboard Act of 2024 which would allow DC Health to hire one additional Data Analyst to maintain and regularly update the required behavioral health directory for a total of $113,000.[62] Adding a directory of SBBH providers will broaden community awareness of services available at DC schools and, in turn, increase utilization of the SBBH program.

Even after raising the minimum grant amount and funding these additional supports, the District will still have funding to grow to include 40 additional schools in the Expansion Program at $129,000 grant amounts.[63] Meaning that the SBBH Expansion Program could be in 141 schools – a number much more reflective of the realities of implementing this program. Over the last four years, the average number of clinicians hired per school year is 116.[xxvii] Therefore, the ability to partner with 141 schools at a higher grant amount is above average for the Expansion Programs' current ability to hire clinicians.

Raising the minimum grant amount does not require DBH to raise the funding level for the SBBH Expansion Program[64] and will stabilize clinicians that are already in place and set the program up for success to grow the number of clinicians in schools in

the future. Setting a higher grant minimum recognizes that there are significant billing issues including cumbersome billing procedures, uncertainty of Medicaid's future, insufficient reimbursement rates, and fluctuating grants. Without setting a higher minimum grant amount, CBOs will have to make the tough decision to either continue to operate at a loss or leave the program. A minimum grant amount allows the Expansion Program to be in a better position to sustain existing partnerships while still aiming to grow. DBH must stabilize the SBBH Expansion Program before doing the tough work of reassessing the funding model to ensure the SBBH Expansion Program is not in jeopardy of losing more clinicians and/or CBO and school partnerships.

Ultimately, we want to make sure that the Expansion Program is adequately funded to support the goal that students at all schools have access to all three tiers of services. To this end, adequate funding should remain a goal for the District and this Committee. We therefore ask this Committee to ensure that the FY2026 budget does not redirect funding from the Expansion Program to other DBH priorities and to establish a minimum grant amount for the Expansion Program.

There is Opportunity for More Consistent Data Collection Across SBBH Programming in the District Through the Healthy Schools Act

As we continue to work towards the goal that students at all schools have access to all three tiers of services, we recognize the need to stabilize to allow for time to address persistent, systemic challenges to implementation of the SBBH in the District. To this end, we have appreciated the opportunity to work with DBH to conduct a landscape analysis

of what SBBH programming -beyond just the Expansion program - across the schools in the District.

We believe the landscape analysis will be a valuable tool in assessing gaps in service delivery and understanding the needs for SBBH in the District. This will, however, only be a snapshot of one school year. Therefore, we believe in general there is room for improved data collection and transparency via the questionnaire used to create the School Health Profiles, as required by the Healthy Schools Act.[65] While we are focused on the behavioral health side of this survey, a more robust survey would be helpful for all areas (for example, better understanding the sexual and reproductive health curriculums within schools).

The Healthy Schools Act questionnaire contains vague language and undefined terms, lacks space for providing details and explanations in some instances, and doesn't always have the correct range of options or doesn't allow for the selection of multiple options. Additionally, not every school is required to fill out the Healthy Schools Act survey.[66] We believe that improving the survey questions to ensure correct selection options and definitions as well as asking more robust and detailed questions about the whole health and wellness program in schools will provide schools, families, government entities, and advocates with more robust information to make informed decisions, whether that is a caregiver selecting a school for a student, an advocate or teacher making

recommended changes to curriculum, or DC Council making budget or legislation changes.

We understand the questionnaire is already rather lengthy and anticipate pushback to any efforts to make it more robust. However, as it stands, since the current survey doesn't appear to always collect accurate information, it makes the data less reliable and valid. We would rather see a more robust questionnaire that may take a little more time but is more user-friendly because it is accurate and clearly defines the terms and asks and also provides a more reliable data set. We, therefore, ask this Committee to work with DBH and OSSE to establish more consistent data collection across all SBBH programming in schools through the Healthy Schools Act.

The DC Council Should Maintain Healthy Futures to Ensure Children and Early Childhood Educators Continue to have Behavioral Health Support in the Classroom

Healthy Futures is a DBH program that provides early childhood mental health consultation (ECMHC) in District's child development centers (CDC) and home providers. 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.[67] The Birth-to-Three for All Amendment Act of 2018 (Birth-to-Three) requires Healthy Futures to be in every eligible CDC and home provider.[68] According to DBH, At the end of FY24, 85 CDCs and home providers with infants and toddlers that accept subsidies were not receiving Healthy Futures services and supports.[69] Of those 85 CDCs and home providers, 44 had been contacted and indicated they were not interested in

services. To provide support for the remaining 41 CDCs and home providers, additional resources are required to maintain the appropriate ratio of staff to CDCs.

We appreciate DBH's continued partnership and their transparency in their ability to grow the program based on existing challenges. The upcoming Healthy Futures evaluation will be very helpful to better assess the current program and future opportunities for growth.[70]

In the meantime, we are glad that the Mayor's proposed budget does not include any further cuts to Healthy Futures.[71] Maintaining funding at the current level will allow Healthy Futures to remain in 101 centers as well as continuing the clinical treatment program in eight child development centers.[72] As the Committee on Health heard during performance oversight heard the CDCs and home providers who have Healthy Futures find this program to be extremely beneficial in supporting positive changes to individual children and classroom dynamics, combating difficult classroom behaviors, and implementing problem solving techniques.[73] We, therefore, ask the DC Council to maintain funding for this critical program so it can continue to have an impact on District children, families, and early childhood educators.

One final note, while analyzing the Healthy Futures budget, we did notice several funding discrepancies across reporting mechanisms including the FY2025 approved budget, the proposed FY2026 budget, and the FY2024 performance oversight responses. For example, in the FY2025 Approved Budget the actual FY24 budget was reported as

$3,897,000, in the FY2026 Proposed Budget the actual FY2024 budget was reported as $2,844,000, and in performance oversight responses DBH reported the sum of total budget for Healthy Futures in FY2024 was $3,087,131.77.[74] We are confused by these three different numbers reported across the same fiscal year. We, therefore, ask this Committee to work with the agency to clarify the true budget of Healthy Futures and understand the cuts to the program over the last four fiscal years. that If we want to engage in future opportunities to expand Healthy Futures there must be a clear understanding of the existing budget as well as the cuts over the last five fiscal years and the justifications for those cuts.

Conclusion

Though the District's budgetary and economic constraints may ultimately be temporary, the children who miss out on needed care won't be able to get this time back. If cuts lead to reductions in options for care, children's behavioral health in DC will get worse. Children with unmet behavioral health needs have been shown to experience issues with lifelong disability, substance use, and suicidality.[75] As time goes on, these children and adolescents will become adults or possibly parents with an extended period when their needs were unmet. Given that parental mental health affects child mental health and development,[76] the diminishing of service provision now can become an intergenerational problem. Thank you for the opportunity to testify and I welcome any questions the Committee may have.

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[9] DHCF FY26 Budget Testimony, *available at*: https://lims.dccouncil.gov/Hearings/hearings/832.
[10] Medical Care Advisory Committee, *available at*: https://dhcf.dc.gov/page/dc-medical-care-advisory-committee
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[23] Chris Gamble, Children's Law Center, Testimony Before the District of Columbia Council Committee on Health, (March 31, 2025), *available at*: https://childrenslawcenter.org/wp-content/uploads/2025/04/C.-Gamble_Childrens-Law-Center_Sense-of-the-Council-on-Supporting-Humane-and-Trauma-Informed-Responses-to-Behavioral-Health-Cris.pdf.
[24] *Budget Oversight of the Department of Behavioral Health (Government Witnesses)*, YouTube, (May 2025), *available at*: https://www.youtube.com/watch?v=UawhlkTTfek
[25]*Performance Oversight of Department of Behavioral Health (Government Witnesses)*, YouTube, (February 2025), *available at*: https://www.youtube.com/watch?v=2k8wdKs4Ba0.
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[27] Bread for the City v. District of Columbia, *available at*: https://www.aclu.org/cases/bread-for-the-city-v-district-of-columbia.
[28] *9-1-1 Origin & History*, *available at*: https://www.nena.org/page/911overviewfacts.
[29] *NAMI/IPSOS 988 Lifeline & Crisis Response Research*, (2024), *available at*: https://www.nami.org/wp-content/uploads/2024/07/NAMI-988-Lifeline-Crisis-Response-Tracker.pdf.
[30] Chris Gamble, Children's Law Center, Testimony Before the District of Columbia Council Committee on Health, (March 31, 2025), *available at*: https://childrenslawcenter.org/wp-content/uploads/2025/04/C.-Gamble_Childrens-Law-Center_Sense-of-the-Council-on-Supporting-Humane-and-Trauma-Informed-Responses-to-Behavioral-Health-Cris.pdf.
[31] *Id*.
[32] Megan Messerly and Sarah Owermohle, *988 set for quiet launch in light of state, federal concerns about crisis call spike*, (July 2022), available at: https://www.politico.com/news/2022/07/12/988-mental-health-line-launch-00045194.
[33] *988 Crisis Response State Legislation Map*, *available at*: https://reimaginecrisis.org/map/.
[34] Alaska, Illinois, New Hampshire, New Jersey, New York, North Dakota, Rhode Island, and Texas all have pending 988 fee legislation.
[35] *States with a 988 Fee*, Reimagine Crisis Response, *available at*: https://reimaginecrisis.org/wp-content/uploads/2025/02/2025-988-Fees.pdf.
[36] D.C. Code § 34-1802, Emergency and Non-Emergency Number Telephone Calling Systems Fund, *available at*: https://code.dccouncil.gov/us/dc/council/code/sections/34-1802.
[37]*Sixteenth Annual Report to Congress On State Collection and Distribution of 911 and Enhanced 911 Fees and Charges*, (December 2024), *available at*: https://www.fcc.gov/sites/default/files/16th-Annual-911FeeReport-2024.pdf.
[38] *988 Crisis Response State Legislation Map*, *available at*: https://reimaginecrisis.org/map/.

[39] *Poll of Public Perspectives on 988 & Crisis Response*, (2024), *available at*: https://www.nami.org/support-education/publications-reports/survey-reports/poll-of-public-perspectives-on-988-crisis-response-2024/#:~:text=Key%20Findings%20on%20Funding%20988%20and%20Crisis%20Services%3A&text=In%20fact%2C%20the%20number%20of,prioritize%20funding%20the%20988%20Lifeline.
[40] *Mayor Bowser Announces Launch of 988 Suicide and Crisis Lifeline*, (July 2022), *available at*: https://mayor.dc.gov/release/mayor-bowser-announces-launch-988-suicide-and-crisis-lifeline#:~:text=In%20Fiscal%20Year%202022%2C%20Mayor,be%20even%20easier%20to%20reach.
[41]*Sixteenth Annual Report to Congress On State Collection and Distribution of 911 and Enhanced 911 Fees and Charges*, (December 2024), *available at*: https://www.fcc.gov/sites/default/files/16th-Annual-911FeeReport-2024.pdf.
[42]*Third Annual 988 Fee Accountability Report - National Suicide Hotline Designation Act of 2020*, (October 2024), *available at*: https://docs.fcc.gov/public/attachments/DOC-406726A1.pdf.
[43] *Sixteenth Annual Report to Congress On State Collection and Distribution of 911 and Enhanced 911 Fees and Charges*, (December 2024), *available at*: https://www.fcc.gov/sites/default/files/16th-Annual-911FeeReport-2024.pdf. DC's 911 fund is also used for the same communications needs related to 311.
[44] For example, Oregon's 988 fee is to first be used for call centers, but to the extent call centers are fully funded, the money can go toward mobile crisis teams and crisis stabilization services. See: https://olis.oregonlegislature.gov/liz/2023R1/Downloads/MeasureDocument/HB2757/Enrolled.
[45] If the $4,483,000 proposed for the Access HelpLine (which houses the 988 Lifeline) is considered full funding.
[46] Amber Rieke, Children's Law Center, Testimony Before the District of Columbia Council Committee on Health, (April 10, 2024), *available at*:
[47] Leah Castelaz, Children's Law Center Testimony for the DC Council, (February 3, 2025), *available* at: https://childrenslawcenter.org/resources/2024-25-oversight-testimony-department-of-behavioral-health/.
[48] Haley McCrary and Caitlin Carney, *Strategies to Expand School-Based Mental Health Services and Support Student Well-being*, Mathematica, (October 31, 2024), *available at*: https://www.mathematica.org/blogs/strategies-to-expand-school-based-mental-health-services-and-support-student-well-being.
[49] Leah Castelaz, Children's Law Center Testimony for the DC Council, (February 3, 2025), *available* at: https://childrenslawcenter.org/resources/2024-25-oversight-testimony-department-of-behavioral-health/.
[50] Multi-Titer System of Supports model (MTSS). 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.
[51] Department of Behavioral Health, School Behavioral Health Program, *available at:* https://dbh.dc.gov/service/school-behavioral-health-program.
[52] Department of Behavioral Health, Guide to Comprehensive School Behavioral Health, (June 2019), *available at*: https://dbh.dc.gov/sites/default/files/dc/sites/dmh/page_content/attachments/PRIMARY%20GUIDE_SCHOOL%20BEHAVIORAL%20HEALTH_JUNE%202019.pdf.
[53] Dr. Barbara Bazron, Department of Behavioral Health Testimony before DC Council, (June 2, 2025), *available at*: https://lims.dccouncil.gov/Hearings/hearings/870.
[54] FY2024 Department of Behavioral Health Performance Oversight Responses, response to Q8, *available at*: https://lims.dccouncil.gov/Hearings/hearings/637.

[55] Agency Financial Officer Department of Behavioral Health Budget Tables, FY2026, on file with Children's Law Center.
[56] Committee on Health, Department of Behavioral Health Budget Oversight Hearing, (June 2, 2025), *available at*: https://www.youtube.com/watch?v=UawhlkTTfek&t=1836s.
[57] Coordinating Council Meeting Discussion on March 17, 2025, "Supporting School Communities during these Difficult Times," on file with Children's Law Center.
[58] Proposed FY 2026 Budget and Financial Plan, Volume 4 Agency Budget Chapters – Part 3, DC Health, p. E-23.
[59] FY2024 Department of Behavioral Health Performance Oversight Responses, response to Q84, *available at*: https://lims.dccouncil.gov/Hearings/hearings/637.
[60] Strengthening Families Coalition Through Behavioral Health Coalition Budget Advocacy, *available at*: https://www.strengtheningfamiliesdc.org/budget-advocacy.
[61] *Id.*
[62] D.C. Law 25-279. Child Behavioral Health Services Dashboard Amendment Act of 2024; Fiscal Impact Statement – Child Behavioral Health Services Dashboard Amendment Act of 2024, (October 21, 2024), *available at*: https://lims.dccouncil.gov/downloads/LIMS/55080/Committee_Report/B25-0759-Committee_Report1.pdf?Id=200066.
[63] Calculations on file with Children's Law Center.
[64] *Id.*
[65] The Healthy Schools Act of 2010, DC Official Code § 38-821.01 et seq.
[66] There are 31 schools who did not fill out the Healthy Schools Act in School Year 2024-2025. *See* Healthy Schools Act reports, 2025, *available at*: https://osse.dc.gov/service/healthy-schools-act-school-health-profiles.
[67] In FY 24 there were two expulsions of the 3,836 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 25 to date. *See* DBH, FY2024 Oversight Responses, response to Q61, *available at*: https://lims.dccouncil.gov/Hearings/hearings/637. 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. Project LAUNCH, Washington D.C. Project LAUNCH -Healthy Futures Program, *available at*: https://healthysafechildren.org/sites/default/files/WDC_Healthy_Futures_Program_Brief.pdf. 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.
[68] D.C. Law 22-179. Birth-to-Three for All DC Amendment Act of 2018.
[69] DBH, FY2024 Oversight Responses, response to Q62, *available at*: https://lims.dccouncil.gov/Hearings/hearings/637.
[70] *Id.*
[71] Proposed FY 2026 Budget and Financial Plan, Volume 4 Agency Budget Chapters – Part 3, DC Health, p. E-23.
[72] DBH, FY2024 Oversight Responses, response to Q61, *available at*: https://lims.dccouncil.gov/Hearings/hearings/637.
[73] Committee on Health, Department of Behavioral Health Performance Oversight Hearing, (February 3, 2025), *available at*: https://www.youtube.com/watch?v=AwR_eEt5WB0&t=16254s.
[74] DBH, FY2024 Oversight Responses, response to Q61, Attachment 1, *available at*: https://lims.dccouncil.gov/Hearings/hearings/637; Proposed FY 2026 Budget and Financial Plan, Volume

4 Agency Budget Chapters – Part 3, DC Health, p. E-23; Proposed FY 2025 Budget and Financial Plan, Volume 4 Agency Budget Chapters – Part 3, DC Health, p. E-23;

[75] Sharon Clark, et al., *Improving Access to Child and Adolescent Mental Health Care: The Choice and Partnership Approach*, Canadian Academy of Child and Adolescent Psychiatry, (2018), *available at*: https://pmc.ncbi.nlm.nih.gov/articles/PMC5777686/pdf/ccap27_p0005.pdf.

[76] *Parenting with a Mental Health Condition*, *available at*: https://mhanational.org/resources/parenting-with-a-mental-health-condition/.