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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 citywide solutions that benefit hundreds of thousands more.

Thank you for the opportunity to testify today about the Department of Behavioral Health's (DBH) performance 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. In FY25, over 40% of our clients in the care of CFSA had either a diagnosed behavioral health condition or suspected behavioral health needs.[1] Children's Law Center has been an engaged and present partner with DBH both through our client-facing work as well as being the co-chairs of the Strengthening Families Coalition and as a seated member of the

Coordinating Council. We believe in the goal of the agency – to ensure children, youth, and families have timely access to behavioral health services.[2] However, our clients remain without viable options for necessary care—we see firsthand that gaps persist in the continuum of care, and vital services have had funding cuts impacting access to timely, appropriate behavioral health services.

The District is currently embroiled in ongoing litigation regarding the state of the District public behavioral health system. In *M.J. v. D.C.*, plaintiffs allege that the District is not providing federally required intensive community-based services, thus unnecessarily institutionalizing children.[3] At a pre-trial hearing last October, both sides presented data and scientific research that frames their respective stances on what DC is doing to provide children with appropriate community-based services. During the settlement discussions that followed, the District's attorney stated, "If somebody could say do this thing and kids will get better, I feel confident the District officials would want to do the thing."[4] This is an admirable position to take – but unfortunately, DBH's actions in recent years stand in stark contradiction to this sentiment. Time and time again, DBH has turned away from taking concrete steps to improve access to and quality of services – avoiding transparency, disregarding public input, and refusing to partner with community providers.

Children's Law Center's advocacy has consistently offered specific recommendations that District officials could and should take to improve the

behavioral health system. Our 2021 report, *A Path Forward: Transforming the Public Behavioral Health System for Children, Youth, and their Families in the District of Columbia*,[6] lays out 94 recommendations to address the issues that undermine children's ability to access culturally competent, quality services in a timely manner. The recommendations apply across several domains, including leadership and governance, financing, service delivery, workforce, information and communication, and technology. Almost five years after *A Path Forward's* release, DC still has a long way to go to meet children's behavioral health needs.

Despite so many needed improvements in DC's behavioral health system and clearly identified opportunities on how to move those forward, DBH has instead kept the system stagnant and even moved it backward in several ways. DBH must recognize the urgency of a deteriorating system that denies kids the services they need.

Therefore, my testimony today will identify four areas in which DBH should focus their efforts to make true sustained change. First, DBH should be more transparent regarding both funding and the availability of services to ensure a clear understanding of the gaps in the continuum of care. Second, DBH should better integrate the perspectives of youth, parents, and service providers when engaging in planning to ensure equitable decision making. Third, DBH should stop prioritizing control of service provision by moving programs in-house and instead focus on acting

as a regulator in partnership with community-based organizations. Finally, DBH must prioritize long-term strategic decision-making rather than short-term, reactive choices.

DBH Lacks Transparency Which Hinders the District's Behavioral Health Continuum

In our experience, DBH, lacks the transparency needed to make true progress towards improvement of service access and delivery. This lack of transparency undermines community trust and masks the true needs of the agency to build the behavioral health continuum in the District. We, therefore, ask this Committee to ask DBH to be more transparent in their needs, their budget, and their progress on implementation of programs and projects.

Over the past year, Children's Law discovered that DBH has pulled significant funding from Healthy Futures funding.[7] Healthy Futures provides early childhood mental health consultation (ECMHC) in District's child development centers (CDC) and home providers. ECMHC programs seek to minimize the use of exclusionary discipline in childcare centers and preschools by providing resources and supports to teachers.[8] The Birth-to-Three for All Amendment Act of 2018 (Birth-to-Three) requires Healthy Futures in every eligible CDC and home provider.[9] However, according to DBH's FY24 oversight responses, 85 eligible CDCs and home providers were not receiving Healthy Futures services and supports.[10] Of those, 44 had been contacted but indicated they were not interested in services.[11] To provide ECMHC for the remaining 41 CDCs and home providers, additional resources will be needed.

Despite this shortfall in connecting Healthy Futures to CDCs and home providers, the budget for Healthy Futures has been reduced year after year. In FY22, DBH planned to expand to additional 17 centers and was hiring to be staffed up to serve 138 centers.[12] The following year building on DBH's momentum, the DC Council made significant investments in Healthy Futures by providing in the FY23 budget an additional $700,000 to expand Healthy Futures to an additional 25-35 sites.[13] Now DBH is reporting that it only has funding available for 101 sites.[14] DBH has provided no information on how money that was once available for Healthy Futures expansion has been redirected or used. Last year, we asked this Committee to clarify the Healthy Futures budget and raise this issue again with the Committee – hoping to get clarity.[15]

We understand that during times of budget strain, difficult choices must be made. However, Healthy Futures is a proven resource with demand in a sector – early childhood education – that could use all the support it can get as highlighted by public witnesses during performance oversight, performance oversight responses, and inclusion of Healthy Futures in Birth-to-Three. We ask this Committee, in its oversight capacity, to closely monitor investments in DBH programs like Health Futures and follow the money to ensure that the agency is fulfilling District priorities. Better budget transparency will allow the Council and DC residents to see the fruits of our investments and understand where money is – or perhaps is not – being spent.

Further, we have testified several times regarding the much-anticipated release of the Healthy Futures evaluation done by Georgetown University to better understand the true successes and continued gaps in the implementation of ECMHC in the District.[16] However, this report – funded with public dollars – has not yet been released. In FY 23 Georgetown University was selected to evaluate the Healthy Futures Program and was supposed to be completed in FY24.[17] It is our understanding that the evaluation is complete, but that DBH does not want to release it. We ask this Committee to demand that the agency release this evaluation both to provide public transparency but also to inform the tough decisions this Committee will have to make during the upcoming budget season.

DBH Planning Processes Lack Necessary District Youth, Parents, and Service Provider Perspectives

In Fiscal Year 2025, DBH undertook the development of both the SBBH Comprehensive Plan and the Children's Plan. With both of these efforts, DBH purportedly sought to incorporate community perspectives to support equitable decision-making. However, in our experience, this was not the case. As we testified during this Committee's November 5th hearing on the SBBH Comprehensive Plan, the lack of stakeholder engagement is a fundamental flaw in the Comprehensive Plan.[18] We have identified several ways in which DBH failed to account for stakeholder engagement including termination of the Community of Practice (CoP) for SBBH, the

ineffectiveness of the Coordinating Council on SBBH, and poor coordination for stakeholder engagement ahead of the Comprehensive Plan release.[19]

In response to this feedback, DBH announced at the last minute that it would host three feedback sessions in November ahead of the release of the implementation plan on November 30, 2025 – a plan that as of January 2026 has still not been released. DBH hosted one in-person session and two virtual sessions. Children's Law Center attended all three. It is our view that DBH tried to control the narrative, relying heavily on a presentation that repeated but did not expand upon the Comprehensive Plan. Stakeholders repeatedly shared the need for greater transparency of materials like the Child Trends Evaluations and the Environmental Scan before being able to give meaningful feedback on the Comprehensive Plan. While DBH did not require participants to stay on mute, like in the August sessions, the virtual sessions felt significantly less engaged then the in-person session. Ultimately, it was difficult to give feedback on the Comprehensive Plan when no new information was being presented, and many of the stakeholders had just presented testimony with feedback that had yet to be interpreted or incorporated.[20] This opaque process has created apprehension which will hinder how this plan moves forward. DBH must work to regain trust through transparency and meaningful engagement with the school leaders, students, teachers, parents and those who work closely with them.

Since the November feedback sessions, DBH has primarily relied on the Coordinating Council to provide updates on the Comprehensive Plan. DBH has incorporated some the feedback – such as the suggestion to join existing community meetings of parents/caregivers and youth to present the Comprehensive Plan and obtain feedback. They also noted a plan to reach out to the leaders of schools that do not currently have a DBH-funded resource to affirm that these schools have not been forgotten. Lastly, links to the Child Trends Evaluation reports and Continuous Quality Improvement reports have been posted on the Coordinating Council on School Behavioral Health page of DBH website.[21] We appreciate these responsive efforts from DBH. But, DBH has much more to do to repair and regain community trust. This opaque process has created apprehension which will hinder how this plan moves forward. DBH must work to regain trust through transparency and meaningful engagement with the school leaders, students, teachers, parents and those who work closely with them.

The Comprehensive Plan is not the only example of a disorganized process that left out community perspectives. The original Children's Plan, a strategic plan outlining principles and actions toward developing a coordinated System of Care, was published in 2009 with an implementation update published in 2012.[22] After over a decade of requesting an updated plan, DBH finally started the process in May 2025 with a goal to have the plan finished by October 1, 2025. The plan is still not done. Children's Law

Center joined advocacy and provider organizations to work alongside DBH in updating the Children's Plan. From the start, the need for parent and youth participation was raised to DBH. Especially with such a long time between plans, it was imperative to understand what service users and other community members needed from the public behavioral health system. No forum or other means to facilitate community input was created.

The process DBH led for developing the plan was disorganized to the point of sowing doubt in the final product. When groups were formed to develop goals and objectives based on consumer age group, poor guidance was given as to the format, creating the likely result of disjointed goals that would have to be heavily revised to create some sort of unity in the final plan. Unfortunately, we never found out what that process would look like because no further meetings took place. Only recently was another meeting set for February 2026, after today's performance oversight hearing. We ask the Committee to press DBH for updates on the development of the Children's Plan.

DBH Prioritizes Controlling Service Provision by Moving Programs In-House Rather Than Operating As a Regulator in Partnership with Community-Based Organizations

DBH's lack of transparency and community stakeholder engagement is particularly alarming in light of their recent definitive decisions to move SBBH in-house to DBH and the consideration to do the same with Youth Mobile Crisis services.[23] While we recognize that something must be done to improve student access to behavioral

health in school, Children's Law Center does not support bringing these services in-house to DBH.

By moving these programs in-house, DBH further isolates them from those who are both calling for and utilizing the services. And in fact, this decision is in tension with a public health approach – providing wrap around services from the community. Community-based organizations are better positioned to ensure that all the child's needs are being met – clinicians often provide behavioral health services while also connecting families to other resources that alleviate mental health concerns.[24]

Additionally, we encourage the agency to not think of crisis response as duplicative of SBBH but instead as a continuum. At a time when DBH and DC Health are reporting a significant increase in suicide attempts amongst children and youth, this is not the time to reduce service availability. [25] This is not the time to cause further disruption by shifting everything in-house. Instead, this is the time to analyze the current landscape, assess resources, and ensure adequate investments. We encourage this Committee to continue to work with DBH as well as community stakeholders to build a truly comprehensive behavioral health system that provides the full continuum of services. Specifically, we urge the Committee to explore alternatives to DBH's in-house proposals for SBBH and Youth Mobile Crisis.

DBH's SBBH Comprehensive Plan Halts Forward Momentum of SBBH, Therefore the Agency Should Slow Down, Stabilize, and Mitigate Disruption

As this Committee is well aware, achieving the goal of getting one clinician into all 253 DC Public Schools (DCPS) and DC Public Charter Schools (DCPCS) has been difficult.[26] Last year, thanks to this Committee, steps were taken to move the District forward after years of stagnation. Specifically, the FY2026 Budget Support Act of 2025 required: 1) that DBH write a comprehensive plan on improving SBBH, 2) that SBBH grant amounts be increased to $120,000, and 3) that the grants be more flexible in how CBOs could utilize the money.[27] This was a remarkable step forward, and we appreciate this Committee's engagement and desire to find solutions.

And it's working. School Year 2025-2026 is reporting the highest number of schools served and the lowest number of clinician vacancies across both DBH and CBOs. At least 187 schools are connected with a DBH-funded resource, and there are only 7 clinician vacancies across Pilot 1B, CBOs, and DBH.[28] Over the course of this school year, CBO vacancies fell from 19 in November 2025 to just 4 in January 2026.[29] While these numbers speak for themselves in many ways, this Committee will also hear directly from CBOs how the $120,000 grants have impacted recruitment and retention of clinicians.

Just as we are beginning to see the positives of the new grant amounts, DBH has proposed disrupting it all by completely moving the SBBH program in-house. Not only would this destroy the progress we are seeing in School Year 2025-2026 but risks future years as well. Based on DBH's FY2025 (and previous years) performance, we are

concerned about the agency's ability to bring the program in-house.[30] On top of the lack of transparency and stakeholder engagement discussed earlier, we doubt DBH's capacity to take on new and expanded programs.[31] Not only has the agency repeatedly failed to meet SBBH deadlines for deliverables, but also, we believe they have completely overestimated their capacity and the timeline for hiring and onboarding the number of clinicians needed to run SBBH fully in-house.

Slow Down

Given the info-gathering and reporting by DBH has been both late and incomplete, we encourage this Committee to show down the massive changes to the program. First, as we have noted extensively in previous testimonies, DBH misses critical deadlines.[32] Just in the realm of SBBH, we waited two plus years for DBH to conduct and publish a rate study that largely confirmed what we had long suspected – that grant amounts were insufficient for CBOs. Compared to the years-long wait for the cost study, DBH's delay in releasing the Comprehensive Plan was modest– only 10 days. And now, the Agency has missed a self-imposed November 30 deadline for releasing the implementation plan and the Environmental Scan – sharing the information the Friday before today's hearing.[33]

Moreover, and as previously noted in testimony, last year DBH undertook an Environmental Scan of all available behavioral health resources in the 253 public schools in the District.[34] The Environmental Scan was meant to assess how District schools

navigate this complicated system and the degree to which these various programming options were meeting the needs of DC students. Children's Law Center provided DBH with a suggested template to help guide this data collection.

Unfortunately, the 2025 Comprehensive Plan presented opaque data that did not delineate the specifics for each school. DBH received significant feedback on the concerns with the Environmental Scan during the September Coordinating Council meeting, during the November 5, 2025, hearing, and the November 2025 feedback sessions. DBH has repeatedly been asked to release the methodology including the questions, to identify who was interviewed at each school, and to share how interview notes were translated into quantitative metrics used to categorize schools by level of need. In November 2025, DBH stated that they would release the Environmental Scan data, the data was released on January 30, 2026. The raw data needs to be organized and reviewed – we specifically will be reviewing the data in conjunction with our work described below as we asses new z-scores to better understand distribution of available clinicians.

DC must leverage all available data to make informed decisions on how to best utilize existing workforce and investments and to ensure schools with the highest needs are receiving sufficient and appropriate behavioral health services. This should mean working with the Office of the State Superintendent on Education (OSSE) to review the information collected by the Healthy Schools Act as well as releasing information on the School Strengthening Tool and Work Plan.[35] This may also include DBH looking back on

any available data on school readiness for SBBH.[36] The right data likely already exists to conduct a meaningful assessment of how to best distribute existing resources for SBBH while mitigating disruption but that information must be made readily available in a timely manner.

DBH's inability to share information in a timely manner raises further concerns about the aggressive timeline proposed in the Comprehensive Plan. DBH plans to begin their aggressive shift to in-house next school year but just released an implementation plan. The implementation indicates that all the work for School Year 2026-2027 is still not started. More alarming, DBH has indicated that they will select CBOs for School Year 2026-2027 by June 30, 2026.[37] This provides very little notice to CBOs who will either have to layoff or shift a significant number of clinicians. It also does not explain how DBH will cover the significant gap for the first half of School Year 2026-2027.[38]

We ask DBH to meet deadlines and more readily, transparently share critical decision-making information. We ask this Committee to hold the agency accountable to following through on their implementation plan and meaningful engage with stakeholders including on understanding and analyzing the data analysis to inform next steps. And in order to meet these asks, the agency must slow down to ensure data and community informed decisions that are on a realistic timeline.

Stabilize

The 2025 Comprehensive Plan seems to rely on DBH's 25 years of hiring experience, their retention rates (unsupported by data), the ability to foster a supportive work environment (based on anecdotal testimony from one hearing), and that they could poach clinicians from the CBOs after their SBBH grants end (per the Comprehensive Plan).[39] The 2025 Comprehensive Plan does not meaningfully grapple with the feasibility of shifting from the current funding model to one that requires DBH to hire 113 new FTEs.

We are deeply skeptical of DBH's ability to hire the necessary workforce to support an in-house SBBH program. For Fiscal Year 2026 DBH has funding to bring on 24 FTEs – 15 licensed clinicians, 6 prevention specialists, and 3 program managers.[40] As of January 2026, DBH has hired only 2 clinicians and 1 supervisor.[41] DBH also has two current vacancies.[42] Therefore, DBH in Fiscal Year 2026 has netted no progress on hiring the 24 FTEs it reported it could hire this year.

Then, according to the Comprehensive Plan, DBH will need to hire 59 FTEs in FY27. There are only two ways for DBH to fund these 59 FTEs – either a significant new investment of funding in SBBH or to take money from existing program funds. DBH has repeated that they do not need additional funds in FY27 to make this change. Instead, they will cut ties with 8-9 CBOs – an estimated reduction of 90 clinicians – and repurpose the existing grant funding to cover the additional 59 FTEs. At the most basic level, this

plan proposes that 59 DBH employees will absorb the workloads of 90 CBO clinicians. Worryingly, DBH's aggressive timeline will disrupt an already strained workforce.

Moreover, the misalignment between School Year and Fiscal Year complicates hiring timelines and, most importantly, will cause significant disruption to services in SY26-27. While the FY26 SBBH grants do not expire until September 30th, if the clinicians know their role is being cut, we can expect that many will leave at the end of SY25-26 seeking a more permanent role. While DBH expects to hire from this pool of newly unemployed clinicians, job offers are not guaranteed. Moreover, DBH cannot start hiring for their new positions until FY27 funds are available on October 1, 2026 – already two months into the school year. Based on DBH's hiring timeline for Fiscal Year 2026, new jobs were not posted until mid-November 2025 and, as of January 2026, no one has been hired for the 24 new FTEs. We truly believe at the earliest a school may have a clinician in place by January, but likely later, if at all in SY26-27.

Not only are schools likely to experience vacancies for much of the start of SY26-27, but many will also see reductions in clinician coverage. DBH's plan seems to propose that most, if not all, of the new hires in FY27 will cover 2-4 schools. So, even if the new DBH clinicians are hired and onboarded quickly, schools that lost a full-time CBO clinician may only get a part-time DBH clinician going forward. Additionally, even if clinicians come to a school by January 2027, it takes time for clinicians to build relationships with school leadership, staff, and students.

Overall, we are looking at huge disruptions for School Year 2026-2027 – a loss of workforce, a loss of services, and no actual improvements in SBBH access for students. DBH's aggressive timeline will disrupt an already strained workforce. It would be irresponsible to cut CBOs in Fiscal Year 2027 based on a promise that DBH is going to backfill the lost clinicians despite evidence of their inability to do so thus far in Fiscal Year 2026. Therefore, we would ask that this Committee determine whether DBH has a reasonable plan to mitigate this level of disruption. While we understand changes are necessary, we have identified some opportunities below to minimize harm to students and build on the progress in Fiscal Year 2026.

Mitigate

The Comprehensive Plan negates the work CBOs are doing and proposes a blanket statement, with little to no evidence, that DBH could better accomplish this program.[43] Rather than accept DBH's proposal for the future of SBBH, we urge the Committee to consider proposals from SBBH stakeholders. This would allow the Committee to both mitigate harm to this fragile workforce while still evaluating the impact of the increased grant amounts and identify what schools need what

Particularly given the lack of transparency and engagement noted above, the unnecessarily rapid pace at which DBH proposes to move forward with the Comprehensive Plan raises concern. The Comprehensive Plan should also consider the existing workforce. We currently have 164 frontline worker positions across DBH, CBO,

and Pilot 1B. The plan would shift many of these existing positions away from SBBH and cause significant disruption.

The Comprehensive Plan appears to post that there are just two choices for SBBH: (1) bring SBBH fully in-house or (2) continue with the status quo of CBOs, DBH, and Pilot 1B. But in reality, there is a spectrum of choices that would minimize disruption. For example, the DC Behavioral Health Association (DCBHA) submitted a letter to both DBH and this Committee on reconsiderations of the proposed school behavioral health models and financing. Plainly put through their own modeling DCBHA identified that about 108 schools could be covered by model 1 (one clinician per school) and 144 schools could be covered by model 2 (one clinician split between two schools). This would require 180 clinicians and 36 supervisors – we currently have 164 clinicians (7 of which are vacant) and 30 supervisors (no vacancies). Therefore, we are close to being able to fill the remaining positions and move forward with the two proposed models as outlined in DCBHA's letter.

This is just one example of a way to navigate mitigating disruption to the existing workforce and relationships. We are also currently working on modeling updated z-scores which were originally used to determine cohorts. Doing this modeling will help us understand the distribution of the two models between 252 schools (noting that one school continuously chooses not to participate).

We again want to emphasize that even this year, we have moved away from the status quo of SBBH – by increasing the grant amounts to $120,000. We have seen tremendous improvements as noted above. Allowing these changes to continue to work to hire and retain the SBBH workforce is also a step in the right direction of both taking action, moving away from the status quo and minimizing disruption. There is an array of options that DBH, this Committee, and SBBH stakeholders can take to continue progress and forward momentum. We ask that this Committee continue to lead in this work and ensure true partnership to reach actual solutions for SBBH implementation in the District.

The City's Only Youth Mobile Crisis Team Has Been Intentionally Hampered by DBH's Decision-Making

The Child and Adolescent Mobile Psychiatric Service (ChAMPS) began in 2009, providing emergency response services to youth ages 6-17 who are experiencing a behavioral health crisis.[44] They operated 24/7 until FY23, when DBH revised their contract and cut their hours of operation to 8:00am-8:00pm on weekdays, with DBH's Community Response Team (CRT), typically dedicated to adult crisis response, responding to youth crises in those off hours.[45] The FY26 budget destabilized ChAMPS, with their funding being reduced by nearly fifty percent without any prior notice from DBH.[46]

DBH's reasoning for reducing ChAMPS' funding was that most of ChAMPS' deployments were to schools that already have mental health teams, so the service

ChAMPS provides is duplicative. Meaning DBH believes schools can handle student behavioral health crises on their own. This argument ignores the crisis protocol developed by OSSE wherein a flowchart depicts the circumstances under which DC public and public charter schools should reach out to ChAMPS for assistance.[47] The protocol explains that when a student experiences a crisis at school, the mental health professionals in the school should assess, de-escalate, and intervene such that the crisis can be resolved with a safety plan in place. If the crisis does not resolve through this intervention, then ChAMPS is called for further assistance.[48] So, it follows that if most ChAMPS deployments are to schools, it is because they are needed to provide that further assistance; they are not duplicating a service. At minimum, any major funding changes should have been supported by evidence from DBH that ChAMPS is being called before schools intervene themselves or that the protocol is not being followed in some way. This funding cut shows that DBH understands neither schools' capacity to manage all student crises nor the full scope of ChAMPS' work.

Alongside the funding cut, DBH planned to provide school-based clinicians with additional training on crisis intervention to support their ability to manage student crises. CBOs involved in the SBBH program were already unsure if they would be allowed to call ChAMPS this school year or if the team would even be available based on the comments made by DBH leadership in last year's performance oversight and budget hearings. Some CBOs have shared that the DBH-provided trainings explicitly

told school-based clinicians not to call ChAMPS for support with student crises. Some reported being told that ChAMPS could be called but only if there was no consensus amongst school clinicians on a plan of action for a student. Many also remained confused about ChAMPS' hours of operations, unsure if they were giving families accurate information if they needed to call for help outside of school hours. Inconsistent communication from DBH has led to this uncertainty, hurting ChAMPS' efficacy and in turn the schools and students in need of additional support.

DBH's lack of commitment to working with CBOs showed up again in their testimony for the SBBH Comprehensive Plan where they shared that they are planning to create a DBH-operated youth mobile crisis team, akin to a "ChAMPS plus."[49] No details were given on how this in-house team would function. If DBH feels as though they could staff a new in-house team, that suggests they can assist ChAMPS with staffing. Instead, current funding limits ChAMPS to two teams of two responders to deploy for crisis calls. This, in turn, limits their ability to respond to all calls, increases response time, and destabilizes staffing as employees fear job instability as funding continues to decrease.

If DBH continues this pattern, ChAMPS will not be able to function going forward. Not only would the District lose over a decade of specialized expertise in youth crisis intervention; the city would move backward from the vision of how a crisis response system is supposed to operate. The Substance Abuse and Mental Health

Services Administration's (SAMHSA) guidance on crisis response systems makes clear that a system is incomplete without the three components of "someone to contact, someone to respond, and a safe place to go," and that children are best helped by trained professionals dedicated solely to working with their age group.[50] It would be a grave mistake to allow DC's crisis response system to be destabilized in this way. We urge the Council to convene a roundtable on the youth crisis response system in order to exercise oversight of DBH's decisions in this area and allow a deeper exploration of what the crisis system needs to function well.

DBH Should Focus on Long-term Strategic Decision-making Rather Than Short-term, Reactive Choices

The problems in DC's behavioral health system have persisted for years. DBH struggles to define a vision for what the behavioral health system for children should look like. Too often, DBH approaches issues with an eye on short-term impact. Instead, DBH should act with the understanding that meaningful, lasting transformation of the behavioral health system takes time.

Children Need Access to a Full Continuum of Care to Meet Their Varying Needs

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.[51] The District does not have all the types of behavioral health services that children need,[52] leaving our public system unresponsive to the varying acuity and course progressions of children's behavioral health needs.[53] The gaps in our system are either

stagnating or getting worse.[54] It is DBH's responsibility to make sure children have access to quality care.[55]

We testified last year about the shrinking availability of Community-Based Intervention (CBI), a time-limited, intensive service intended to keep children with significant behavioral health needs from utilizing out-of-home placements for treatment.[56] The availability of CBI has only gotten worse in the past year. According to DBH's service utilization dashboard, in FY25, 167 children received CBI, down from 198 in FY24.[57] With only four providers,[58] capacity is severely limited. A snapshot from July 2025 shows that there were only four vacancies, or spots available for a child to begin CBI services, amongst the providers.[59] There has been no communication of a plan from DBH on how to facilitate the growth of CBI service availability. If CBI availability continues to diminish, children with intensive needs will be more likely to see their condition worsen and have to receive out-of-home care, typically in another state.

As detailed above, DC's crisis response system has been hampered by cuts to ChAMPS. A component still missing from DC's crisis response system is a crisis stabilization unit for children. Currently, the only place a child in crisis can go is the hospital, which is not designed or equipped for the observation and intervention needed in crisis situations. Establishing 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.[60] With the future of mobile crisis through ChAMPS uncertain and the remaining gap without a crisis stabilization center, children experiencing behavioral health crises in the District are put even more at risk. DBH is not putting in the effort to support them and is instead taking away resources. A long-term vision for enhancing crisis response for children would place emphasis on maintaining the effective components of our system and prioritize filling the gaps.

In intermediate level services, there seems to have been some advancement, but the impact is unclear. The Psychiatric Institute of Washington (PIW) began a Partial Hospitalization Program (PHP) and an Intensive Outpatient Program (IOP) for youth late last year. This Committee held a roundtable in 2024 about inpatient psychiatric facilities that raised some concerns about the quality of care that patients received at PIW,[61] so we suggest the Committee seek data from PIW about the outcomes of these programs thus far.

For acute services, there has long been a demand to establish a local Psychiatric Residential Treatment Facility (PRTF) to provide that level of care in the District rather than sending youth to other states. The desire for a PRTF was mentioned last year, but in a concerning context that raises questions about what purpose such a facility would serve. In a September 2025 hearing before the House Oversight Committee, Mayor Bowser and Attorney General Schwalb suggested that if Congress wanted to help the

District address the issue of youth crime, they could provide $60 million to fund a 100-bed PRTF.[62] No explanation was given for the number of beds or how the cost was determined. To our knowledge, DBH has not publicly addressed this proposal, but the line of thinking presented to federal legislators raises concerns about the Executive's, position on what a PRTF could or should provide the District. Developing a PRTF will not be justified if it will serve simply as a remedy to the Youth Service Center's (YSC) longstanding overcrowding issue. It must provide effective treatment in a safe environment. A 2020 systematic review on behavioral health interventions in PRTFs concluded that existing research on PRTFs and the treatment provided in these facilities is not sufficient to determine effectiveness, thus it can't reliably guide policy decisions.[63] This is an issue DBH should be leading on to ensure discussions about resources for youth are well-informed and prioritize meaningful treatment outcomes.

DBH Should Commit To The Managed Care Carve-In Of Behavioral Health Services

In our DHCF performance oversight testimony, we testified about the District's need to integrate all behavioral health services into the managed care plans through a process referred to as a "carve-in."[64] The current Medicaid financing structure separates MHRS and SUD services from the rest of the system, creating data gaps, complicated referral processes, and leaving Managed Care Organizations (MCO) without the ability to "see" all the care that their beneficiaries receive. Within the current structure, DBH also takes on the key function of responding to suspected billing fraud. The process to

de-certify a provider for billing fraud is multifaceted, involving multiple investigative entities, and can take years to get to the final result. With the carve-in, MCOs would be able to de-panel and stop doing business with a provider when there is evidence of billing fraud in a far more streamlined manner. We have had recent meetings with Budget Director Jenny Reed and Deputy Mayor Wayne Turnage in which viable steps to making the carve-in happen were determined. We ask the Committee to talk with both officials before FY27 budget hearings to understand what steps can be taken this year to begin implementation of the carve-in.

Conclusion

Opportunities to improve the behavioral health system for children will not be realized if DBH continues operating as it has over the past year. We urge the Committee to push DBH to articulate what the agency needed to truly build a continuum of behavioral health care in the District – whether that be greater investments, a larger workforce, etc. We need true partnership with the agency, this Committee, and stakeholders to see the much-needed progress. Thank you for the opportunity to testify, and I welcome any questions you may have.

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[1] Internal Children's Law Center Data Collection, "GAL Deep Dive," October 1, 2024 through September 30, 2025.

[2] Children, Youth and Family Services, *available at*: https://dbh.dc.gov/service/children-youth-and-family-services.

[3] M.J. v. District of Columbia, *available at*: https://www.bazelon.org/mj-v-district-of-columbia/.
M.J. v. District of Columbia Court Reporter Transcript, p. 168-169.

[6] 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/BH.System.Transformation.2023.Update.Round4_.pdf.
[7] Data gathered from performance oversight responses, on file with Children's Law Center.
[8] 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.
[9] D.C. Law 22-179. Birth-to-Three for All DC Amendment Act of 2018.
[10] DBH, FY2024 Oversight Responses, response to Q62, *available at*: https://lims.dccouncil.gov/Hearings/hearings/637.
[11] *Id.*
[12] Department of Behavioral FY20 Health Performance Oversight Responses, response to Q54, attachment 1 of 3, *available at*: https://dccouncil.us/wp-content/uploads/2021/06/dbh.pdf.
[13] Tami Weerasingha-Cote, Children's Law Center Testimony before the DC Council Committee on Health, (March 21, 2022), *available at*: https://childrenslawcenter.org/wp-content/uploads/2022/06/T-Weerasingha-Cote_DBH-Budget-Oversight-Testimony_3.21.22_updated-5.24.22.pdf; DRAFT Report and Recommendations of the Committee on Health on the Fiscal Year 2023 Budget for Agencies Under Its Purview, (April 20, 2022), *available at*: https://dccouncil.gov/wp-content/uploads/2022/04/DRAFT-COH-FY23-Budget-Report-_v3.pdf.
[14] FY2024 Department of Behavioral Health Performance Oversight Responses, response to Q61, *available at*: https://lims.dccouncil.gov/Hearings/hearings/637.
[15] Chris Gamble, Children's Law Center Testimony before the DC Council Committee on Health, (May 30, 2025), *available at*: https://childrenslawcenter.org/resources/fy26-budget-testimony-department-of-behavioral-health/.
[16] *Id.*
[17] FY2023 Department of Behavioral Health Performance Oversight Responses, response to Q53, *available at*: https://lims.dccouncil.gov/Hearings/hearings/247.
[18] *Id.*
[19] Leah Castelaz, Children's Law Center Testimony before the DC Council Committee on Health, (November 5, 2025), *available at*: https://childrenslawcenter.org/resources/testimony-roundtable-on-dbhs-comprehensive-plan-for-the-school-based-behavioral-health-program/.
[20] Committee on Health, Hearing Record for Department of Behavioral Health's Comprehensive Plan for the School-Based Behavioral Health Program, (November 5, 2025), *available at*: https://lims.dccouncil.gov/Hearings/hearings/1978.
[21] Coordinating Council Slides, January 2026, on file with Children's Law Center; Evaluation Reports for School Behavioral Health Expansion, DBH Coordinating Council Website, *available at*: https://dbh.dc.gov/page/coordinating-council-school-behavioral-health.
[22] The Children's Plan, *available at*: https://dbh.dc.gov/page/childrens-plan.
[23] Brief mention that it was a brief discussion 11/5 hearing.

[24] Committee on Health, Hearing Record for Department of Behavioral Health's Comprehensive Plan for the School-Based Behavioral Health Program, (November 5, 2025), *available at*: https://lims.dccouncil.gov/Hearings/hearings/1978.
[25] Coordinating Council Slides, January 2026, on file with Children's Law Center
[26] *See* End 4 from Leah Castelaz, Testimony before the DC Council Committee on Health, (November 5, 2025), *available at*: https://childrenslawcenter.org/wp-content/uploads/2025/11/L.-Castelaz__Testimony-SBBH-Comprehensive-Plan__11.5.2025.pdf.
[27] Fiscal Year 2026 Budget Support Act of 2025. Subtitle R. SCHOOL-BASED BEHAVIORAL HEALTH STRENGTHENING.
[28] Internal Children's Law Center Data Tracking. *See also* FY2025 Department of Behavioral Health Performance Oversight Responses, response to Q88, *available at*: https://lims.dccouncil.gov/Hearings/hearings/2126.
[29] The way DBH reports their data is always perplexing. For example in reviewing their performance oversight responses, DBH reports "And there are no vacancies with LEA-funded schools." When we first read that we were surprised because in their January reporting DBH reported one LEA-funded school had a vacancy, however, that same school with an LEA vacancy has a DBH clinician in place. Therefore, it would be more accurate to report that there is one LEA vacancy, however, that school has a DBH clinician covering, therefore, there is no gap in access at this time. Also DBH continuously references the 54 schools it needs to partner with but appears to ignore the other 17 schools that need to be partnered with. We believe that is because DBH is considering them for the telehealth program. *See* FY2025 Department of Behavioral Health Performance Oversight Responses, response to Q88, *available at*: https://lims.dccouncil.gov/Hearings/hearings/2126.
[30] CBOs currently have 116 schools being served by 114 behavioral health professionals. DBH has reported that it will let go 90 CBO clinicians in SY26-27. Leaving 24 CBO BH professionals to serve the 116 schools. Based on DBH's current modeling, those CBO BH professionals could serve 48 schools meaning a disruption to 68 schools. DBH plans to fill those schools by hiring 59 new FTEs. However, DBH has reported that they are very delayed in their hiring for the current school year (SY25-26) – DBH has currently hired 2 clinicians and 1 supervisor as of February 2026. DBH also has two vacancies at currently partnered schools. Therefore, DBH has made no progress in hiring the 24 new FTEs this year. Furthermore, DBH explained they were only making progress on approximately 16 positions – a little over half of what their goal is. Therefore, how does DBH foresee their ability to hire 59 clinicians without causing disruption to SY26-27 given the significant delays in hiring or this year. *See* Department of Behavioral Health Fiscal Year 2026 School Behavioral Health Program Comprehensive Plan, (October 29, 2025), *available at:* https://lims.dccouncil.gov/Legislation/HN26-0088; Committee on Health FY2025 DBH Performance Oversight Hearing Government Witnesses, YouTube (February 4, 2026), *available at*: https://www.youtube.com/live/bGQxe_SbzJ4?si=R90IgY1lXvg8GN6r.
[31] As describe above DBH significantly lacks the ability and the timing to hire sufficient workforce to ensure no to minimal disruption.
[32] Examples include the Department of Behavioral Health (DBH) School-Based Behavioral Health Program Implementation and Funding Analysis Report, which was released on June 4, 2025, even though DBH finished it two years prior in 2023. DBH also self-imposed a deadline of November 30, 2025, on the implementation plan that was partially released with performance oversight responses in February 2026. *See* endnote 27.
[33] Performance Oversight Responses were released on January 30, 2026.
[34] Leah Castelaz, Children's Law Center Testimony before the DC Council Committee on Health, (November 5, 2025), *available at*: https://childrenslawcenter.org/resources/testimony-roundtable-on-dbhs-comprehensive-plan-for-the-school-based-behavioral-health-program/.
[35] *Id.*

[36] Leah Castelaz, Children's Law Center Testimony before the DC Council Committee on Health, (November 5, 2025), *available at*: https://childrenslawcenter.org/resources/testimony-roundtable-on-dbhs-comprehensive-plan-for-the-school-based-behavioral-health-program/.
[37] FY2025 Department of Behavioral Health Performance Oversight Responses, response to Q95, available at: https://lims.dccouncil.gov/Hearings/hearings/2126.
[38] *Id.*
[39] Department of Behavioral Health Fiscal Year 2026 School Behavioral Health Program Comprehensive Plan, (October 29, 2025), *available at:* https://lims.dccouncil.gov/Legislation/HN26-0088.
[40] Although there was some reporting from DBH through budget they would only be hiring for 22 FTEs. Budget table on file with Children's Law Center.
[41] Coordinating Council Slides, January 2026, on file with Children's Law Center
[42] FY2025 Department of Behavioral Health Performance Oversight Responses, response to Q88, available at: https://lims.dccouncil.gov/Hearings/hearings/2126.
[43] Leah Castelaz, Children's Law Center Testimony before the DC Council Committee on Health, (November 5, 2025), *available at*: https://childrenslawcenter.org/resources/testimony-roundtable-on-dbhs-comprehensive-plan-for-the-school-based-behavioral-health-program/. DBH's proposed plan calls for service disruption to at least 68 school, likely more, instead of a more targeted approach to address the mere 71 schools that do not currently have a DBH-funded resource. DBH should focus on how to fill the existing gaps.
[44] ChAMPS, *available at*: https://www.catholiccharitiesdc.org/program/champs-child-and-adolescent-mobile-psychiatric-service/.
[45] DBH FY2023 Performance Oversight Responses, response to Q44h, *available at*: https://dccouncil.gov/wp-content/uploads/2024/08/FY-23-Oversight-Pre-Hearing-Responses.-DBH_UPDATED.pdf
[46] Chris Gamble, Children's Law Center Testimony before the DC Council Committee on Health, (May 30, 2025), *available at*: https://childrenslawcenter.org/resources/fy26-budget-testimony-department-of-behavioral-health/.
[47] Office of the State Superintendent of Education, Responding to a School Crisis, *available at*: https://osse.dc.gov/page/responding-school-crisis.
[48] The protocol also says that if there is no MH professional in the school, to call ChAMPS.
[49] Roundtable on DBH's Comprehensive Plan for the School-Based Behavioral Health Program, YouTube (November 5, 2025), available at: https://www.youtube.com/watch?v=ME4Gc0Mx5Og.
[50] Substance Abuse and Mental Health Services Administration, 2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care, (January 2025), *available at*: https://library.samhsa.gov/sites/default/files/national-guidelines-crisis-care-pep24-01-037.pdf.
[51] Beth A. Stroul, *et al., The Evolution of the System of Care Approach for Children, Youth, and Young Adults with Mental Health Conditions and Their Families*, The Institute for Innovation and Implementation, School of Social Work, University of Maryland, (2021), *available at*: https://e1.nmcdn.io/assets/cmhn/wp-content/uploads/2021/05/The-Evolution-of-the-SOC-Approach-FINAL-5-27-20211.pdf.
[52] "These gaps include insufficient access to community-based 3 behavioral health services, inadequate crisis response systems, poor discharge planning and post-discharge services, and lack of both intermediate and long-term intensive treatment programs in DC." See: Kim Daulton, Children's Law Center Testimony before the DC Council Committee on Health, (October 28, 2024), *available at*: https://childrenslawcenter.org/wp-content/uploads/2024/11/K.-Daulton___Childrens-Law-Center-Testimony-before-the-DC-Council-Committee-on-Health___10.28.24.pdf

[53] George C. Patton, et al. *The prognosis of common mental disorders in adolescents: a 14-year prospective cohort study*, The Lancet, (2014), *available at*: https://www.medecin-ado.org/addeo_content/documents_annexes/pronostica14ans-ado-patton-lancet-2014.pdf.

[54] " 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."
"According to DBH's service utilization dashboard, 198 children received CBI services in FY24, a 19% decrease from the previous fiscal year. The decrease in children receiving CBI has occurred year after year since FY20 when 500 children received the service. Further, the number of organizations providing CBI services has decreased - from seven CBI providers in FY23 to five in FY25." See:
Chris Gamble, Children's Law Center Testimony before the DC Council Committee on Health, (February 3, 2025), *available at*: HYPERLINK "https://childrenslawcenter.org/wp-content/uploads/2025/02/DBH-Performance-Oversight-2025-Childrens-Law-Center-Written-Testimony-2.3.25.pdf" https://childrenslawcenter.org/wp-content/uploads/2025/02/DBH-Performance-Oversight-2025-Childrens-Law-Center-Written-Testimony-2.3.25.pdf.

[55] "Fostering the development of high quality, comprehensive, cost effective, and culturally competent mental health services and mental health supports, based on recognized local needs, especially for persons with serious mental illness and children or youth with serious emotional disturbances" See: D.C. Code, § 7–1131.03. Establishment and purposes of the Department of Mental Health, *available at*: https://code.dccouncil.gov/us/dc/council/code/sections/7-1131.03.

[56] https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/TL148.pdf

[57] https://dbh.dc.gov/page/dbh-service-utilization-dashboard-people-served-text

[58] Hillcrest, Umbrella Therapeutics, Better Morning, Maryland Family Resources are the current CBI providers.

[59] Data obtained from DBH.

[60] A Path Forward: Transforming the Public Behavioral Health System for Children and their Families in the District, p. 93, (December 2021), available at: https://childrenslawcenter.org/wpcontent/uploads/2021/12/BH.System.Transformation.2023.Update.Round4_.pdf.

[61] Kim Daulton, Children's Law Center, Testimony Before the District of Columbia Council Committee on Health, (October 28, 2024), *available at*: https://childrenslawcenter.org/wp-content/uploads/2024/11/K.-Daulton___Childrens-Law-Center-Testimony-before-the-DC-Council-Committee-on-Health___10.28.24.pdf.

[62] FULL REMARKS: DC Mayor Muriel Bowser, Phil Mendelson and AG Brian Schwalb speak at House Oversight Committee, (September 18, 2025), *available at*: https://www.wusa9.com/article/news/crime/dc-crime-house-oversight-committee-hearing-full-remarks-bowser-schwalb-mendelson/65-e6081485-b22d-4dbe-bc12-24112bd57645.

[63] Paul Lanier, et al., *A systematic review of the effectiveness of children's behavioral health interventions in psychiatric residential treatment facilities*, Children and Youth Services Review, (June 2020), *available at*: https://www.sciencedirect.com/science/article/abs/pii/S019074091931326X.

[64] Chris Gamble, Children's Law Center, Testimony Before the District of Columbia Council Committee on Health, (January 27, 2026), *available at*: https://childrenslawcenter.org/wp-content/uploads/2026/01/C.-Gamble_DHCF-Performance-Oversight-2026_CLC-Written-Testimony_1.27.26.pdf.