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Testimony Before the District of Columbia Council
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 citywide solutions that benefit hundreds of thousands more.

Thank you for the opportunity to testify today about the proposed FY27 budget for the Department of Behavioral Health (DBH). The economic pressures facing the District not only impact the city's budget; families feel the strain as well. The effects of a stressed economy on people's well-being are well documented. Financial hardship and economic downturns are associated with higher rates of suicide[1] and can affect children's mental health through the stress put on their parents.[2] For those living in poverty, negative mental health outcomes can appear across the lifespan.[3]

For Children's Law Center's clients, the difficulty with accessing behavioral health resources has been persistent and will only get worse without necessary

investment in the behavioral health system. Consistently, our clients' treatment is delayed by waitlists, disrupted by clinician turnover, and left lacking by provision of low-quality services.[4] This past year, half of our clients who were recommended particular services such as Community-Based Intervention (CBI), Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), and Functional Family Therapy (FFT) did not receive the service.[5] Without major adjustments to the proposed budget, access to behavioral health services will remain difficult.

We were therefore alarmed to see so many cuts to DBH – every single activity in DBH's Child/Adolescent/Family Services Program saw cuts (-$6.9 million total) and the overall DBH budget was cut by over $19 million. With this proposed budget, the Mayor has chosen not to invest in the well-being of District youth. Recent public rhetoric around the behavior of teens and young adults has frequently pointed to the need for supportive services—programs like School-Based Behavioral Health, youth crisis services, and the aforementioned therapies are all examples of ways to provide care that addresses youth needs. We encourage this Committee to seize the opportunity to rebalance this budget toward investing in the health of young people in DC. Frankly, the only positive in the Mayor's FY27 Proposed Budget is a minimal cut to the Healthy Futures program. Healthy Futures 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 – the program continues to serve more children each year, in FY24 Healthy Futures served 3,836 children and in FY25, the program served 5,172 children.[6] During performance oversight, this Committee heard the positives of this program for DC children and their educators.[7] We, therefore, are glad to see this program continue to operate at close to FY26 funding levels and ask the Council to maintain funding.

My testimony today will focus on the cuts and lack of investment across DBH and their impact on District children and families including: the elimination of Children and Adolescent Mobile Psychiatric Services (ChAMPS) and decreased funding across the continuum of care. These core components of the behavioral health system need adequate funding, so all children and families have access to affordable, high-quality, and culturally responsive care. I will also highlight an opportunity to streamline the financing of behavioral health services through a managed care carve-in.

Eliminating ChAMPS Jeopardizes the Well-being and Safety of District Children and Families

We were initially concerned about FY27 funding for ChAMPS because a mistake in the budget book made it unclear if the team was being flat funded or having their funding significantly reduced. Through advocacy partners repeatedly reaching out to DBH for answers, it was confirmed on Friday, April 17, 2026 by DBH leadership that in fact the ChAMPS contract was being completely eliminated with plans to bring that work in-house. Catholic Charities, who operates ChAMPS, was not notified about this

drastic decision beforehand. Before addressing all the problems with eliminating the District's only youth-specialized mobile crisis team, Children's Law Center must speak to what the decision says about DBH's responsibility as a government agency.

The proposed FY27 budget shows ChAMPS as being flat funded at $135,000 from FY26 to FY27. The problem here is that in the FY26 DBH government witness budget hearing, agency leadership acknowledged that the $135,000 indicated for the contract with ChAMPS in the budget was incorrect.[8] Actual FY26 funding for ChAMPS was $680,000. Apparently, the mistake was never corrected in the budget books. Carrying over an acknowledged mistake in the budget book is enough of a problem, but for it to take repeated contact to get clarity from agency leadership that ChAMPS is actually being eliminated is unacceptable. The District government's behavioral health authority should be competent enough to make it abundantly clear when it is planning to eliminate a critical service for children. It should also be responsible for clearly communicating to Catholic Charities (or any other provider of vital services to District residents) that their contract is being eliminated. The same lack of communication occurred with last year's cut to ChAMPS, demonstrating that DBH had no interest in maintaining a respectful working relationship with a years-long contractor.

Mobile crisis response is not an option to put up for debate every year. Nationally, investment in mobile crisis response has expanded over the past few years, but the concept is not new.[9] Across the country, jurisdictions are rightfully resourcing

these teams as a critical part of the first response apparatus.[10] And, it is best practice for crisis services to be developmentally appropriate, providing youth with specialized support that recognizes their unique needs.[11] One particular youth crisis intervention model practiced in various jurisdictions,[12] Mobile Response and Stabilization Services (MRSS), is designed around a core principle that services are customized specifically for children, youth, and families through a workforce trained and dedicated to doing so.[13]

ChAMPS has existed since 2009, and across those seventeen years has demonstrated specialized expertise that warrants secure, consistent funding. The refusal to increase funding maintains the impact of cuts over the past few years that have gradually reduced ChAMPS' hours of operations, decreased staffing, and limited its ability to fulfill its duties. Currently, ChAMPS only has five Crisis Specialists, one Team Lead, one Clinical Supervisor and a Director. DBH introduced the argument last year that ChAMPS provides duplicative services because most of their deployments are to schools where school-based clinicians supposedly could manage student crises on their own. Based on this logic, DBH proposed in their Comprehensive Plan to create an in-house youth mobile crisis team akin to a "ChAMPS plus."[14] This plan now seems to be coming to fruition, but there is no indication in the budget how DBH will fund or staff this new in-house team.

DBH's argument clashes with the experiences of school-based clinicians and continues to ignore 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.[15] 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 is not resolved through this intervention, then ChAMPS is called for further assistance.[16] 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. DBH has not provided any evidence that ChAMPS is being called before schools intervene or that the protocol is not being followed in some way. Eliminating funding shows that DBH understands neither schools' capacity to manage all student crises nor the full scope of ChAMPS' work.

Another effect of eliminating ChAMPS is that police will respond to more crises. This is reflected in the experiences of Children's Law Center's clients who have had interactions with police in part due to ChAMPS' low capacity. These interactions will only increase without ChAMPS. We have clients who in the past year had the police called during crises multiple times; for two clients, the police were called on thirteen and nine different occasions, respectively.[17] Not only do the youth who receive a police response during a crisis lose out on the behavioral health expertise developed by ChAMPS over its seventeen-year existence, they are also made susceptible to the trauma of being handcuffed if the police transport them to the hospital.[18]

We strongly urge that ChAMPS, have its contract restored and increased to $1.3 million in order for the team to increase staffing, which will help reduce response times and result in better overall service. We also urge the Committee to seek answers from DBH about how in the event of ChAMPS' elimination CRT would be able to respond to all crises across the city, regardless of age, with a proposed $2 million cut.[19] CRT has also struggled with vacancies, and does not have the specialized expertise to provide quality crisis response services to children.

A 988 Telecommunications Fee Will Support the Growth of the Crisis Response System

In November 2025, the Committee on Health introduced the 988 Lifeline Support and Sustainability Establishment Amendment Act of 2025.[20] This legislation would establish a $0.76 per phone line per month fee that would generate an estimated $12.5 million a year,[21] giving the District a predictable supplemental funding source to expand and improve our crisis response system. In addition to eliminating ChAMPS and the cut to the CRT, there is a $716,000 cut to the AHL with an addition of 10 FTEs. We ask the Committee to clarify how the funding cut and increased staffing are spread across AHL and 988 functions. With precise legislative framing, money from the 988 fee could be used across the crisis response system from call center functions to mobile crisis teams and crisis stabilization units.

In an economic environment that will continue to put constraints on DC's budget, a funding source like the 988 fee is crucial for future growth in crisis response

capacity. It's important to note, however, that the fee should not serve to replace available local dollars but rather offer an additional source of funds to meet needs that local dollars don't reach. We urge the Committee to continue working on passing the legislation so that our crisis response system can receive the sustained support needed to operate effectively.

The Continuum of Care Will Continue to Deteriorate Without Appropriate Investment

The proposed FY27 budget does nothing to strengthen the continuum of care or fill the gaps with the services youth need. Without access to the right type of care at the right time, children will continue to receive inadequate services and cycle in and out of crises with increased potential of having contact with the child welfare and juvenile justice systems. Also, maintaining the trend of under-resourcing the provider network will serve to weaken it as providers struggle financially and ultimately have to stop providing the services so essential to children's behavioral health. We highlighted these issues in 2021 in *A Path Forward: Transforming the Public Behavioral Health System for Children, Youth, and their Families in the District of Columbia*,[22] yet funding continues to fall short of developing an effective behavioral health system that has a range of services that can meet the varied needs of children in DC.[23] Again, there is not one area of Child, Adolescent, and Family Services that received increased funding in this year's proposed budget.

As we testified for performance oversight, 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.[24] With only four providers,[25] 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.[26] There has been no communication of a plan from DBH on how to facilitate the growth of CBI service availability, and this budget amplifies the lack of direction.

Our crisis system still does not have 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.[27] This is a resource money collected through the 988 fee can help fund.

Accurate Data and Medical Necessity Should Guide Considerations for a Local Psychiatric Residential Treatment Facility

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. We shared our concern in performance oversight that much of the recent conversation around a local PRTF has focused on it as a resource to address youth crime and the overcrowding of the Youth Services Center

(YSC).[28] 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.[29] While the source and justification for the referenced cost and number of beds remain elusive, a February 2026 report by the Criminal Justice Coordinating Council (CJCC) provided illuminating relevant information.[30]

First, as to the cost of a local PRTF, the CJCC report references a 2023 report titled *Check In: Psychiatric Residential Treatment Facility for Youth,* released by the Office of Budget and Performance Management (OBPM) and DBH.[31] The OBPM and DBH report used an assumption of 45 youth placed annually to project an initial capital cost of $50 million and annual operating costs of $18,422,380.[32] As for the number of beds, there is a critical data set that likely explains why the Mayor would request a 100-bed facility even though the projected cost is based on 45 placements. The data typically referenced in discussions about whether to establish a local PRTF come from what the Department of Health Care Finance reports annually in performance oversight, listing the number of beneficiaries placed and which Managed Care Organization (MCO) paid for their placement. In FY24, there were 23 youth placed in a PRTF through these means.[33] What the CJCC report reveals, which is not reported elsewhere, is that in FY24 there were 107 youth referred to PRTFs with a total of 73 being placed.[34] That is, the 23 whose placements were paid by MCOs, and an additional 50 whose placements were paid

through Human Care Agreements (HCA), direct contracts between the placing agency[35] and the PRTF.

As considerations around establishing a local PRTF continue, the total number of youth referred and placed, regardless of funding source, has to be kept in mind. The "demand" for a PRTF is clearly much higher than performance oversight data suggests, thus shifting the conversation from whether there are enough youth available to fill beds to whether the presence of a PRTF would serve a useful function. Developing a PRTF will not be justified if it will serve simply as a remedy to YSC's longstanding overcrowding issue. Placement must be based on medical necessity, and the PRTF 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.[36] Based on the information contained in the CJCC report, we recommend that the Committee:

1) Request that the *Check In: Psychiatric Residential Treatment Facility for Youth* report be released publicly to analyze cost projections.
2) Require agencies to report on PRTF referrals and placements (regardless of funding source) in performance oversight responses.

Investing Now in the Managed Care Carve-in of Behavioral Health Services Will Cut Costs Over Time and Strengthen Oversight of the Provider Network

The District's 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. DHCF shared in their performance oversight hearing that they're continuing to evaluate the financial implications of the carve-in.[37] The last estimate given for the annual cost of the carve-in was in early 2024, stated to be $13.7 million.[38] While this cost may have changed in the past couple years, we propose that to initiate the carve-in, a quarter of the funding be provided as needed across DBH and DHCF for a July 1, 2027 start date. This will allow for implementation processes to begin and push the bulk of initial funding into the out years.

Conclusion

The District's children's behavioral health system is struggling, and delaying investment will only erect more barriers to quality care. The longer the city waits to invest, the more money will be required to fill significant gaps in care and rebuild an effective provider network. Not only will stakeholders continue to lose trust in DBH's ability to manage the behavioral health system; children and families will lose opportunities to have their needs met. Thank you for the opportunity to testify today, and I welcome any questions you may have.

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[1] Mark Sinyor, et al., The effect of economic downturn, financial hardship, unemployment, and relevant government responses on suicide, The Lancet, (2024), available at: https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(24)00152-X/fulltext.

[2] Joyce Lee, et al., Family Stress Processes Underlying COVID-19–Related Economic Insecurity for Mothers and Fathers and Children's Internalizing Behaviour Problems, Child & Family Social Work, (2024), available at: https://onlinelibrary.wiley.com/doi/10.1111/cfs.13188.

[3] "Socioeconomic disadvantage is a fundamental determinant of mental health outcomes over the life course… According to structural explanations, social stratification creates unequal access to resources – such as wealth and knowledge – that help individuals avoid exposure to harmful stressors"
James B. Kirkbride, et al., *The social determinants of mental health and disorder: evidence, prevention and recommendations,* World Psychiatry, (2024), *available at*: https://onlinelibrary.wiley.com/doi/pdf/10.1002/wps.21160.

"Poverty and its associated sequelae diminish human potential and increase the risk for chronic conditions, including mental disorders, that can last a lifetime."
Christopher S. Monk and Felicia A. Hardi, *Poverty, Brain Development, and Mental Health: Progress, Challenges, and Paths Forward*, Annual Review of Developmental Psychology, (2023), *available at*: https://www.annualreviews.org/docserver/fulltext/devpsych/5/1/annurev-devpsych-011922-012402.pdf.

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

[5] *Id*.

[6] In FY 25, there were two expulsions of the 5,172 children served from child development facilities where the Healthy Futures Program was implemented. In FY 24 there were two expulsions of the 3,836 children served from child development facilities where the Healthy Futures Program was implemented See DBH, FY2025 Oversight Responses, response to Q72, *available at*: https://dccouncil.gov/wp-content/uploads/2026/02/FY-25-Oversight-Question-Response.-Final-one-document_updated-.pdf; 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. Strengthening Families Coalition, Healthy Futures One Pager, (2026), *available at*: https://www.strengtheningfamiliesdc.org/budget-advocacy.
[7] See hearing record for Committee on Health Performance Oversight Hearing for Department of Behavioral Health, February 3, 2026, *available at*: https://lims.dccouncil.gov/Hearings/hearings/2126.
[8] While $617,000 was stated in the hearing, ChAMPS actual FY26 funding ended up being $680,000. *Budget Oversight of the Department of Behavioral Health (Government Witnesses)*, YouTube, (May 2025), available at: https://www.youtube.com/watch?v=UawhlkTTfek.

[9] The CAHOOTS (Crisis Assistance Helping Out On The Streets) team in Oregon began in 1989. "Although the term 'community responder program,' is relatively new, the concept of sending trained health professionals as first responders has been around for decades."
Emerging Practices to Elevate and Replicate Community Responder Programs Nationwide, The Council of State Governments Justice Center, (May 2024), *available at*: https://csgjusticecenter.org/publications/emerging-practices-to-elevate-and-replicate-community-responder-programs-nationwide/
[10] There are various team makeups as far as the types of professionals, but they share a mission of approaching behavioral health crises as a public health, not public safety issue, reducing the involvement of law enforcement.
Directory of Alternative Crisis Response Programs, (2023) *available at*: https://bpb-us-w2.wpmucdn.com/voices.uchicago.edu/dist/e/2911/files/2024/05/Directory-of-Alternative-Crisis-Response-Programs-v2.1.9.pdf
[11] "Crisis staff should be trained in the unique needs of and best practices for working effectively with children, youth, families, caregivers, and supporters in crisis."
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
[12] Maryland, Ohio, and Rhode Island are each at various stages of implementing MRSS.
[13] Mobile Response and Stabilization Services (MRSS): Best Practice Installation, UConn School of Social Work Innovations Institute, (2024), *available at*: https://innovations.socialwork.uconn.edu/mrss/

https://innovations-socialwork.media.uconn.edu/wp-content/uploads/sites/3657/2024/07/MRSS-Best-Practice-Readiness-Companion.pdf' .
[14] 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.
[15] Office of the State Superintendent of Education, Responding to a School Crisis, available at: https://osse.dc.gov/page/responding-school-crisis.
[16] The protocol also says that if there is no MH professional in the school, to call ChAMPS.
[17] Internal Children's Law Center Data Collection, "GAL Deep Dive," October 1, 2024 through September 30, 2025.

[18] MPD General Order 305.01: Interacting with Juveniles, (September 2023), available at: https://go.mpdconline.com/GO/GO_305_01.pdf.
[19] CRT will maintain the same number of FTEs, so it is unclear what the $2 million cut will affect.
[20] B26-0462 988 Lifeline Support and Sustainability Establishment Amendment Act of 2025, *available at*: https://lims.dccouncil.gov/Legislation/B26-0462.
[21] This estimation is based on the 911 fee that is set at the same amount.
[22] A Path Forward: Transforming the Public Behavioral Health System for Children and their Families in the District, (December 2021), available at: https://childrenslawcenter.org/our-impact/health/behavioral-health/a-path-forward-for-dcs-public-behavioral-health-system/.
[23] 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/wpcontent/uploads/2021/05/The-Evolution-of-the-SOC-Approach-FINAL-5-27-20211.pdf.

[24] DBH Service Utilization Dashboard, *available at:* https://dbh.dc.gov/page/dbh-service-utilization-dashboard-people-served-text.

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

[26] Data obtained from DBH.

[27] 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/our-impact/health/behavioral-health/a-path-forward-for-dcs-public-behavioral-health-system/.

[28] Chris Gamble, Children's Law Center, Testimony Before the District of Columbia Council Committee on Health, (February 2, 2026), *available at*: https://childrenslawcenter.org/wp-content/uploads/2026/02/C.-Gamble_DBH-Performance-Oversight-2026_CLC-Written-Testimony-2.2.26-1.pdf.

[29] 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-remarksbowser-schwalb-mendelson/65-e6081485-b22d-4dbe-bc12-24112bd57645.

[30] *Benefits and Costs of a D.C.-based Psychiatric Residential Treatment Facility*, Criminal Justice Coordinating Council, (February 2026), *available at*: https://cjcc.dc.gov/page/cjcc-research-and-reports-0.

[31] This report does not seem to be available anywhere online.

[32] *Benefits and Costs of a D.C.-based Psychiatric Residential Treatment Facility*, Criminal Justice Coordinating Council, (February 2026), *available at*: https://cjcc.dc.gov/page/cjcc-research-and-reports-0.

[33] FY2024 Department of Health Care Finance Performance Oversight Responses, response to Q85, *available at*: https://dccouncil.gov/wp-content/uploads/2025/02/DHCF-FY24-25-Performance-Oversight-Responses.pdf.

[34] "In FY24, there were 107 youth referred to a PRTF in D.C. The District placed 23 youth in out-of-state PRTF placements funded by a Level of Care (LOC) approved through D.C. Medicaid and the Children's Health Insurance Program (CHIP), costing a total of $1,062,334. The Office of the State Superintendent for Education (OSSE) is responsible for paying the educational costs of youth placed in residential settings if they have an Individualized Education Plan (IEP). The educational costs paid by OSSE in FY24 for the 23 youths whose PRTF placements were funded by LOC were $938,653. An additional 50 children and youth were placed in PRTFs through HCAs; the cost of placements under HCAs is currently not available." *Benefits and Costs of a D.C.-based Psychiatric Residential Treatment Facility*, pg. 2, Criminal Justice Coordinating Council, (February 2026), *available at*: https://cjcc.dc.gov/page/cjcc-research-and-reports-0.

[35] The report includes DYRS, CFSA, and OSSE.

[36] 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.

[37] DHCF Performance Oversight Hearing Presentation, *available at*: https://lims.dccouncil.gov/Hearings/hearings/2125.

[38] Amber Rieke, Children's Law Center Testimony before the DC Council Committee on Health, (April 29, 2024), available at: https://childrenslawcenter.org/wp-content/uploads/2024/05/A-Rieke_Committee-onHealth_DHCF-FY25-Budget-Testimony_April-2024.pdf.