DC Council Committee on Health
Councilmember Christina Henderson, Chair
Fiscal Year 2025 Performance Oversight Pre-Hearing Questions
Department of Behavioral Health

*Please submit written responses in **one** Word document. Excel, PDF, and PowerPoint responses may be submitted as separate attachments. Please send the final responses in one zip file.*

Organization and Performance

1. Please provide the current organizational chart for the agency, with information to the activity level. In addition, please identify the number of full-time equivalents (FTEs) at each organizational level and the employee responsible for the management of each program and cost center. If applicable, please provide a narrative explanation of any organizational changes made during FY 2025 and FY 2026, to date.

2. Please provide a list of all FY 2026 full-time equivalent positions for DBH, broken down by department and title. In addition, for each position please note whether the position is filled (and if filled, the name of the employee) or vacant.

3. What was the vacancy rate for DBH for FY 2025 and FY 2026 to date, broken down by division? What was the average time to fill vacant positions in each division?

4. Please provide a list of DBH employees who received bonuses, special pay, additional compensation, or hiring incentives in FY 2025 and FY 2026, to date, including the amount and reason.

5. Please provide a complete, up-to-date list of contract workers working directly for your agency, by program and cost center, including the following information for each position:
    a. Title of position;
    b. Indication that the position is filled or vacant;
    c. Date employee began in the position;
    d. Whether the position must be filled to comply with federal or local law;
    e. If applicable, the federal or local law that requires the position be filled;
    f. The entity from which they are contracted; and
    g. Annual cost of contract worker.

6. Please provide the names of the primary and alternative Sexual Harassment Officers.
    a. List and describe any allegations of sexual harassment or misconduct committed by or against its employees received by the agency in FY 2025, and FY 2026 to date, and whether those allegations were resolved.
    b. Has DBH received any requests from staff in an otherwise prohibited dating, romantic, or sexual relationship for a waiver of provisions of the Sexual Harassment Order?
        i. What was the resolution of each request?
        ii. If a request was granted, are there limitations on the scope of the waiver?

7. How many performance evaluations did the agency complete in FY 2025? For each question, provide the total number and the percentage of total employees.
    a. How many performance improvement plans were issued in FY 2025?
    b. How many employees have submitted SMART Goals or other relevant workplans in FY 2026?

8. Please provide the following for each collective bargaining agreement that is currently in effect for agency employees:
    a. The bargaining unit (name and local number);
    b. The start and end date of each agreement;
    c. The number of employees covered;
    d. Whether the agency is currently bargaining;
    e. If currently bargaining, anticipated completion date;
    f. For each agreement, the union leader's name title and contact information; and
    g. A copy of the ratified collective bargaining agreement.

9. Please provide the Committee with a list of all vehicles owned or leased by the agency; the purpose of the vehicle; the division the vehicle is assigned to, if applicable; and whether the vehicle is assigned to an individual employee.

10. Please list all pending lawsuits in which the agency, or its officers or employees acting in their official capacities, are named as defendants, and for each case provide the following:
    a. The case name;
    b. Court where the suit was filed;
    c. Case docket number;
    d. Case status; and
    e. A brief description of the case.

11. Please provide in Microsoft Excel, the amount budgeted and spent for FY 2025 and FY 2026, to date, for the agency. In addition, please describe any significant variance between the amount budgeted and spent.
    a. At the agency level, please provide information broken out by source of funds and by Account Group and Account;
    b. At the program level, please provide the information broken out by source of funds and by Account Group and Account; and
    c. At the cost center level, please provide the information broken out by source of funds and by Account Group.

12. Please provide a complete accounting of all interagency projects that the agency was a buyer or seller for during FY 2025 and FY 2026, to date. For each, please provide a narrative description as to the purpose of the transfer and which fund detail, programs, cost center, and account within the agency the reprogramming affected.

13. Please provide a complete accounting of all reprogrammings received by or transferred from the agency in FY 2025 and FY 2026, to date. For each, please provide a narrative description as to the purpose of the transfer and which fund detail, programs, cost center, and account within the agency the reprogramming affected.

14. Please provide the following information for grants/sub-grants awarded to and by the agency in FY 2025 and FY 2026, to date, broken down by program and cost center:
    a. Grant Number/Title;
    b. Approved Budget Authority;
    c. Funding source;
    d. Expenditures (including encumbrances and pre-encumbrances);
    e. Purpose of the grant;
    f. Organization or agency that received the grant;
    g. Grant amount;
    h. Grant deliverables;
    i. Grant outcomes, including grantee/subgrantee performance;
    j. Any corrective actions taken or technical assistance provided;
    k. Agency program and activity supported by the grant;
    l. Agency employee responsible for grant deliverables; and
    m. Any grants that were reduced in FY 2026, and by how much.

15. Please provide the following information for all contracts, including modifications, active during FY 2025 and FY 2026, to date, broken down by program and cost center:
    a. Contract number;
    b. Approved Budget Authority;
    c. Funding source;
    d. Expenditures (including encumbrances and pre-encumbrances);
    e. Purpose of the contract;
    f. Name of the vendor;
    g. Original contract value;
    h. Modified contract value (if applicable);
    i. Whether it was competitively bid or sole sourced;
    j. Final deliverables for completed contracts;
    k. Any corrective actions taken or technical assistance provided;
    l. Agency employee(s) serving as Contract Administrator; and
    m. Any contracts that were reduced in FY 2026, and by how much.

16. Please provide a complete accounting of all grant lapses in FY 2025, including a detailed description of why the lapse occurred and any variance exceeding 5%. Please indicate if the funds can still be used and/or whether they carried over into FY 2026.

17. Please provide a complete accounting of all DBH's Special Purpose Revenue Funds for FY 2024, FY 2025, and FY 2026 to date. Please include the following:
    a. Revenue source and code;
    b. Source of the revenue for each special purpose revenue fund;

c. Total amount of funds generated by each source or program in FY 2025 and in FY 2026, to date;
d. DBH activity that the revenue in each special purpose revenue source fund supports; and
e. The FY 2025 and FY 2026, to date, expenditure of funds, including purpose of expenditure.

18. Please list and explain any Memos of Understanding entered into by DBH during FY 2025 and FY 2026, to date.

19. Please provide a list of all Department of General Services work orders submitted in FY 2025 and FY 2026, to date, for facilities operated by the agency. Please include the date the work order was submitted, whether the work order is completed or still open, and the date of completion (if completed). Please do a separate breakdown for Saint Elizabeths Hospital.

20. Please provide copies of any investigations, reviews or program/fiscal audits completed on programs and activities within DBH during FY 2025 and FY 2026, to date. This includes any reports of the DC Auditor, the Office of the Inspector General, or the Office of Accountability. In addition, please provide a narrative explanation of steps taken to address any issues raised by the program/fiscal audits. Please include a chart with the following:
    a. Name of the provider;
    b. Date complaint was received;
    c. Type of complaint;
    d. Referral source;
    e. Type of report;
    f. Summary or complaint or allegations;
    g. Conclusion(s);
    h. Recommended outcomes or actions; and
    i. Date completed.

21. Please provide a narrative description of what actions DBH undertook to meet the key performance indicators. For any performance indicators that were not met please provide a narrative description for why they were not met, and any remedial actions taken.
    a. Please indicate which FY 2025 KPIs have been extended, amended, or removed in FY 2026.

22. Please provide DBH's capital budgets for FY 2025 and FY 2026, including amount budgeted and actual dollars spent. In addition, please provide an update on all capital projects undertaken in FY 2025 and in FY 2026, to date.

23. For each Mayoral Board, Commission, or Council overseen by DBH, please provide an updated list of members, including when their terms started and end, and their contact information. Please indicate any vacant positions, and include links to the meeting minutes.
    a. Please include the status, list of members, and meeting minutes from FY 2024, and FY 2025, and FY 2026, to date, for the Behavioral Health Planning Council.

24. Please provide a list of all FTE positions detailed **to** DBH, broken down by program and activity for FY 2025 and FY 2026, to date. Include a narrative on specific role the detailed staff took at DBH during their detail. In addition, please provide which agency the detailee originated from and how long they were detailed to DBH.
    b. Please provide a list of all FTE positions detailed **from** DBH to another agency in FY 2025 and in FY 2026, to date. In addition, please provide which agency the employee was detailed to, what work they took on, and for how long.

Provider and Network Oversight

25. Please provide a list and description of all grievances filed against DBH providers and DBH during FY 2025 and FY 2026, to date, including:
    a. Number of external reviews filed;
    b. Number of external reviews found in favor of the consumer; and
    c. Number of external review determinations in favor of the consumer that were approved by the DBH Director.

26. How does DBH coordinate with DHCF to ensure consistency in authorization policies and oversight of Medicaid-funded behavioral health services, including monitoring provider spending? What systems or processes are in place to identify significant increases in provider billing or service utilization, and what triggers a review or follow-up with the provider?

27. In FY 2024, FY 2025, and FY 2026 to date, has DBH observed any significant increases in utilization or billing for specific services? If so, which services experienced the largest increases?
    a. What steps did DBH take to assess whether these increases were appropriate and supported by service delivery data?
    b. Were any providers found to be billing inappropriately? If so, how many, what was the amount of improper billing, and what corrective actions were taken?

28. What is DBH's current authorization process for Community Support Services (CSS), Recovery Support Services (RSS), and Assertive Community Treatment (ACT)?
    a. What documentation is required for initial authorization of each service type?
    b. How does DBH determine medical necessity and service intensity?
    c. How often must ACT services be reauthorized, and what criteria are used to determine continued eligibility?

29. What are the unit limits for CSS and RSS services, and at what point is additional authorization required?
    a. How many units are typically authorized per consumer per month or year?
    b. What is the process for requesting additional units beyond the standard threshold?

30. What was the total amount billed for CSS, RSS, and ACT services in FY 2024, FY 2025, and FY 2026, to date? Please break down by year and type of service.
    a. What utilization or billing trends for these services during this period has DBH observed?
    b. Which services saw the largest increases, and what actions did DBH take to assess whether those increases were appropriate and supported by service delivery data?

31. Please provide a list of providers who were decertified by DBH in FY 2024, FY 2025, and FY 2026 to date. For each provider, please include:
    a. The reason for decertification;
    b. The date the decertification was initiated and completed; and
    c. The services the provider was previously authorized to deliver.

32. What steps does DBH take to notify consumers and ensure continuity of care when a provider is decertified?

33. How many DBH-certified providers were investigated for billing fraud in FY 2024, FY 2025, and FY2026, to date?
    a. For each fiscal year, how many providers were found to have committed Medicaid fraud? Please describe the nature of the fraud and any resulting actions (e.g., decertification, legal referral, repayment).
    b. How many DBH-certified providers are currently under active investigation for Medicaid fraud, with outcomes still pending? Please describe the types of allegations and the status of those investigations.

Providers, Core Service Agencies (CSAs), & Agency Partnerships

34. Please provide a list, in Microsoft Excel, of all DBH providers and Core Service Agencies (CSAs) that serve children, youth, and adults. Include the following information:
    a. Name of provider;
    b. Location(s) (including ward) where services are provided;
    c. Treatment modalities (including whether virtual, in-person, or hybrid);
    d. Populations served (ages, LGBTQ+, seniors, justice involved, experiencing homelessness, newly arrived migrants, returning citizens, etc.); and
    e. Number of individuals served in FY 2025 and FY 2026, to date.

35. Please provide a list and narrative description of any DBH partnerships with District agencies in FY 2025 and FY 2026, to date, to support employment for DBH consumers. Please include the following:
    a. The number of individuals served, the types of employment placements available, and the employee(s) responsible for coordinating the partnership; and
    b. The number of participants who entered post-secondary or occupation training program, apprenticeships, or District employment programs.

36. Regarding the MOU with the Department of Human Services Economic Security Administration to provide Supported Employment services to individuals with serious mental illness who receive Temporary Assistance for Needy Families (TANF), how many individuals participated in this program in FY 2025 and in FY 2026, to date?

37. Please provide the list of services currently available as part of the Mental Health Rehabilitation Services (MHRS) system. Please include:
    a. A description of each service, noting any new services;
    b. Whether it is available as part of the Medicaid MHRS program, the non-MHRS program, or both; and
    c. The FY 2026 reimbursement rate for each service.

38. Please provide the monthly MHRS utilization data for FY 2025 and to FY 2026, to date. Please include:
    a. A breakdown of Medicaid MHRS vs. non-Medicaid MHRS;
    b. For Medicaid MHRS, provide a breakdown by managed care vs. fee-for-service (and include a breakdown by specific managed care organization); and
    c. For non-Medicaid MHRS enrollees, indicate whether the individual had coverage via private insurance, DC Healthcare Alliance, or was uninsured.

39. Please provide for FY 2025 and FY 2026, to date, the name of all certified MHRS providers. For each provider, please indicate whether the provider utilizes the Medicaid MHRS program, the locally-funded MHRS program, or both.

40. Please provide the following information for all housing programs administered by DBH:
    a. Name of the program, services provided, and eligibility requirements;
    b. Number of individuals served in FY 2025 and FY 2026, to date;
    c. Capacity of the program;
    d. If it has changed since FY 2025, a detailed overview of the application process, eligibility requirements, and necessary documentation for each housing program, including the individuals (DBH staff, case workers, etc.) responsible for each step;
    e. Performance measures and associated outcomes for each program;
    f. The name and title of the DBH employee responsible for administering the program; and
    g. The average wait time for a consumer to access housing through the program.

41. How many Mental Health Community Residential Facilities (MHCRFs) closed in FY 2023, FY 2024, FY 2025, and FY 2026, to date?
    a. How many are expected to close in FY 2026?
    b. What is the current number of actively running MHCRFs in the District?

42. In the FY 2025, and FY 2026 budgets, how much funding did DBH allocate to assist individuals transitioning from institutional settings to community placements using PUSH bridge funds?
    a. How many individuals did DBH assist with such transitions in FY 2025 and FY 2026, to date, using PUSH bridge funds?

b. How much of the allocated funding was actually spent on these transitions in FY 2025, and FY 2026, to date?

43. In FY 2025 and FY 2026, to date, what services and supports has DBH provided to consumers experiencing homelessness, including children, youth (under 18), transition-age youth (ages 18–24), and adults?
    a. Of the total number of youth (0–24) served by DBH during this period, how many and what percentage were experiencing homelessness? Please disaggregate by age group and provide a breakdown of the types of services received.
    b. What outcomes has DBH reported for homeless individuals, including housing placements, in FY 2024, FY 2025, and FY 2026 to date? Please disaggregate by age group where possible.

44. In FY 2025 and in FY 2026, to date, what services and support did DBH provide to consumers who identify as LGBTQIA+? Please indicate what services are for children and youth.

45. Which DBH division and staff are responsible for monitoring the quality of care at Core Service Agencies (CSAs), specifically for minors/youth/transition-age youth (under 18 and 22-24yo)?
    a. How does DBH track whether youth referred to CSAs are being connected to therapy services vs medication prescription/management vs both?
    b. What quality-monitoring strategies is DBH using to track whether youth are receiving appropriate therapeutic care? What metrics of success are available for FY 2025 and FY 2026, to date?
    c. How is DBH ensuring that youth, especially transition aged youth (18-24), are connected to developmentally appropriate clinicians at a Core Services Agency, rather than only being connected to adult-focused providers and prescribers?

46. What steps is DBH taking to strengthen the quality-of-care CSA clinicians provide to youth and youth-appropriate clinical connections within the CSA system?
    a. Please provide all data or metrics collected on training completion rates, youth satisfaction scores, or clinical outcomes that demonstrate progress or impact in these areas.
    b. What steps is DBH taking to help CSAs grow their supply of clinicians specially trained to provide developmentally appropriate and affirming care to youth?
    c. Provide data on the number of youth-specialized clinicians added to the CSA system in FY 2024, FY 2025, and FY 2026, to date, and anticipated growth for the remainder of FY 2026.

47. What is DBH's projected timeline, criteria, and process for certifying TAY Choice Providers?
    a. Will DBH implement a standardized training curriculum or requirement for providers serving TAY to qualify as a "Choice Provider?" If so, what is the status of the development or implementation of these trainings?
    b. How many clinicians have completed TAY-specific training modules to date? Provide a count for completions in FY 2025 and, FY 2026, to date.

c. How many providers does DBH anticipate will qualify as Choice Providers in FY 2026?

48. Please provide a list of Community-Based Intervention (CBI) providers, reflecting active providers in FY 2024, FY 2025, and FY 2026.

49. How many Assertive Community Treatment (ACT) providers are currently certified by DBH, and how many of them can accept new referrals? Please provide a list of those providers currently accepting new referrals.

50. Comagine took over as the third-party authorizer for MHRS Community Support Services (CSS) on October 6, 2025.
    a. What oversight is DBH providing to ensure that Comagine complies with its contractual obligations to the District? Please describe DBH's role in reviewing Comagine's decisions regarding MHRS Community Support Services (CSS) authorization.
    b. How many unique consumers who were previously authorized for CSS have now had their CSS terminated?
    c. How many have since been authorized for a higher level of care, such as ACT?

51. Please provide an update on DBH's Intensive Care Coordination (ICC) and High Fidelity Wraparound (HFW) program. For FY 2024, FY 2025, and FY 2026, to date, include the following:
    a. Links to any DBH policies or guidance documents developed to implement the new ICC regulations;
    b. Description of how DBH monitors provider compliance with ICC standards, including staff caseloads and adherence to required timelines;
    c. Current capacity of DBH and other District agency providers to deliver ICC/HFW services;
    d. Description of how ICC/HFW is currently delivered by DBH and other agency providers;
    e. How individuals access ICC/HFW services through DBH and other agencies;
    f. Number of individuals who received ICC/HFW through DBH and other agencies (broken down by agency);
    g. Any short-term or long-term plans to expand flex funding for youth receiving ICC;
    h. Total flexible funding spent in FY 2024, FY 2025, and FY 2026, to date, (per D.C. Mun. Regs. Subt. 22-A, § 3436.17), and what services or supports were covered;
    i. Number of children or youth in FY 2024, FY 2025, and FY 2026, to date, who requested or were referred for placement at a Psychiatric Residential Treatment Facility (PRTF) or non-PRTF residential placement, and how many received such placements; and
    j. Any outcome evaluations or reports from FY 2024, FY 2025, and FY 2026, to date, with links if available.

Opioid Abatement Advisory Commission & Opioid Abatement Fund

52. Please provide a detailed accounting of all Opioid Settlement Funds that have been received by the District, including:
    a. The total amount of Opioid Settlement Funds received to date;
    b. The specific amount of funds transferred to DBH and the dates of these transfers;
    c. If any portion of the funds is being held by other District agencies, please specify the amount and the agency responsible for managing these funds; and
    d. An estimate of the amount of Opioid Settlement Funds the District anticipates receiving in FY 2026.

53. Please provide a detailed list in spreadsheet format of all Opioid Settlement Funds that have been expended to date. For each expenditure, please include the following information:
    a. Recipient name;
    b. Amount awarded;
    c. Grant or contract period;
    d. Specific purpose or project for which the funds were allocated; and
    e. Metrics or outcomes that will determine success of the expenditure.

Children and Youth Services (Non-School Based Behavioral Health)

54. Please describe how DBH will serve as a consulting agency to DC Health as required in B25-0759, the Child Behavioral Health Services Dashboard Act of 2024.
    a. Will DBH incorporate the Behavioral Health Resource Link into LinkU to streamline navigation services for DC residents?
    b. How will DBH incorporate behavioral health resources through DBH's School-Based Behavioral health program into LinkU (the directory)?

55. How many children and youth (age 0-21) received a service through MHRS during FY 2025 and FY 2026, to date? Please include a breakdown by service, age, race, gender, ethnicity, and ward.

56. For FY 2024, FY 2025, and FY 2026, to date, please provide the amount budgeted and spent on each DBH program, service, or cost center that serves children and youth (ages 0-21). If the program, service, or cost center serves both children, youth, and adults, please share the funding spent specifically on children (ages 0-21).
    a. For each program, service, or cost center, please provide a breakdown of the amount of local, federal, private, and special revenue funding for FY 2024, FY 2025, and FY 2026 to date, and a narrative description of the program, cost center, or service, including the specific age group(s) served.

57. How many unique youth received inpatient behavioral health treatment at either the Psychiatric Institute of Washington (PIW), Children's National Hospital or other inpatient hospitals during FY 2024, FY 2025, and FY 2026, to date?

58. For those children and youth about whom DBH receives notification of discharge, please list the following information for FY 2025, and FY 2026, to date, for each hospital:
    a. The number of children and youth who were discharged within (a) one to 10 days, (b) 11 to 30 days, (c) 31 to 60 days (d) more than 60 days;
    b. The number of times a child or youth was readmitted two or more times during the past three year to either one or any of the hospital;
    c. The number of Youth who were connected to a CSA within (a) 5 days of discharge from the institution, (b) 10 days of discharge, (c) more than 10 days of discharge, (c) more than 20 days of discharge, (d) more than 40 days of discharge, (e) more than 60 days;
    d. The number of Youth who were assessed or evaluated by a CSA within (a) 5 days of discharge from the institution, (b) 10 days of discharge, (c) more than 20 days of discharge, (d) more than 40 days of discharge, (e) more than 60 days; and
    e. The number of Youth who received mental health treatment from a CSA within (a) 5 days of discharge from the institution, (b) 10 days of discharge, (c) more than 20 days of discharge, (d) more than 40 days of discharge, (e) more than 60 days.

59. Please provide a breakdown of the number of children and youth seen at 821 Howard Road in FY 2024, FY 2025, and FY 2026 to date. Include the number of Medicaid-eligible clients and the total Medicaid billing amount for each fiscal year.

60. Please provide a breakdown of the complaints, grievances, or concerns received by DBH from or on behalf of youth during FY 2024, FY 2025, and FY 2026, to date. What were the most common issues raised?

61. Please provide a list of DBH providers that offered or will offer the following services to youth in FY 2025, and FY 2026, to date?
    a. Community-Based Intervention (CBI) – Levels I, II, III, IV;
    b. Functional Family Therapy (FFT);
    c. Assertive Community Treatment (ACT);
    d. Transitional Assertive Community Treatment (TACT);
    e. Transition to Independence Program (TIP); Intensive Care Coordination (ICC) and/or High Fidelity Wraparound (HFW);
    f. Therapeutic Foster Care (TFC);
    g. Respite Services (RS);
    h. Community Support (CS); and
    i. Other evidence-based treatments for youth provided under the Medicaid State Plan.

62. For each of the services listed in Q61, please provide the following data for FY 2025 and FY 2026:
    a. Number of unique youth who requested the service
    b. Number of unique youth referred to the service;
    c. Number of unique youth who received the service;

d. Average wait time from request to receipt and from referral to receipt in FY 2025;
e. Number of youth who received more than one of these services; and
f. Duration of service received:
    i. Less than 90 days;
    ii. Between 91 and 180 days; and
    iii. More than 180 days.

63. For each of the services listed in Q61, please provide the number of youth under the custody of CFSA who:
    a. Received the service (disaggregated by service and CBI level);
    b. Requested but did not receive the service;
    c. Number of youth committed to DYRS who;
    d. Received the service (disaggregated by service and CBI level); and
    e. Requested but did not receive the service.

64. Please provide the following information for the Children and Adolescent Mobile Psychiatric Service (ChAMPS):
    a. Number of staff that administer the program; and their roles, specifying education level and clinical licensure. describe the composition of the two-person teams deployed on calls, including their qualifications and responsibilities;
    b. Hours of operation in FY 2025, and 2026, to date;
    c. Number of individuals served by ChAMPS in FY 2025 and in FY 2026, to date, including their race, gender, and ward data;
    d. Number of calls received and the number of deployments (along with the location of deployments, i.e. school, home, etc) by ChAMPS in FY 2025 and in FY 2026, to date;
    e. The number of times that MPD was called to assist ChAMPS in FY 2025 and in FY 2026, to date;
    f. The response time for deployable calls including the longest and shortest response times that occurred in FY 2025 and FY 2026, to date, as well as the average;
    g. The number of mobile crisis teams;
    h. Any updates regarding how calls are triaged to ensure that a team is available upon request;
    i. Updates to the relationships and coordination between the 911 call-takers, Access Helpline, 988 call center, and ChAMPS teams;
    j. Updates on CRT's performance in responding to evening and weekend calls since the change in ChAMPS' contract, including the number of calls responded to during those hours and the associated response times;
    k. How the new exclusion of evening and weekend hours has impacted potential users of the service as well as the capacity of the other services that respond to calls during these hours instead of ChAMPS;
    l. All languages in which ChAMPS services are provided; and
    m. The findings of any review or evaluation of these services. Please attached any relevant reports.

65. Please provide the information requested in Q64 for the Community Response Team's response and transport of children and youth aged 18 and under.

66. For individuals served by ChAMPS, how many times did receipt of service result in psychiatric hospitalization in FY 2025 and in FY 2026, to date? Of the individuals who were hospitalized, how many of those hospitalizations were involuntary (FD-12) and what agency, if any, had custody? Of the individuals who were hospitalized, how many had a diagnosis of "serious emotional disturbance"?
    a. Please provide the same information for the Community Response Team's response and transport of children and youth aged 18 and under.

67. During FY 2024, FY 2025. and FY 2026, to date, how many calls to ChAMPS and any other Youth Mobile Crisis providers were initiated by:
    a. MPD;
    b. DCPS or a public charter school;
    c. Family members;
    d. The child or youth affected; and
    e. Others.

68. Is DBH considering transitioning the ChAMPS program from a contracted or grantee model to an in-house operation?
    a. What factors are being considered in evaluating whether to continue with a contractor/grantee versus internalizing the program?
    b. How would such a transition impact staffing, service delivery, and program oversight?

69. Please explain the work DBH is doing with Child and Family Services Agency to better serve the behavioral health needs of foster children and their families in the District. Please provide the following information for FY 2025 and FY 2026, to date:
    a. The number of children/youth in out-of-home placements DBH served;
    b. The number of children/youth in in-home care DBH served;
    c. The percentage of children/youth who were screened within 30 days of entering or re-entering care;
    d. The number of days it took for a child who has been identified as needing behavioral health services to be connected to those services;
    e. The services DBH provides to parents and guardians whose children are being served through in-home or out-of-home care;
    f. The number parents and guardians that received services;
    g. The services DBH provides to resource providers;
    h. The number of resource providers who received services from DBH; and
    i. Documentation that children are receiving timely services and what DBH is doing to improve timeliness of services.

70. For DBH's early childhood mental health projects, please provide the following information for FY 2025 and FY 2026, to date:

a. For the Parent Child Infant Early Childhood Enhancement Program, please provide:
    i. The provider(s);
    ii. Description of the services provided
    iii. Type(s) and numbers of clinicians employed;
    iv. Capacity and number of children served; and
    v. The number and percentage of outcomes for cases (e.g. successful completion, closure for lack of attendance, etc.
b. For the Early Childhood Mental Health Consultation Project, Healthy Futures:
    i. Provider(s);
    ii. List of childcare centers, homes, and schools that are participating;
    iii. Services each site has received and any progress/outcome measure available;
    iv. The number of teachers, administrators, families, and children being served each year;
    v. Amount of funding DBH has allocated to subsidize other costs associated with early childhood mental health consultation (ECMHC), such as certification and training in early ECMHC; and
    vi. Please provide an update on the evaluation of Health Futures.

71. For FY 2024, FY 2025, and FY 2026, to date, please provide the amount budgeted and spent on Healthy Futures, including a cost breakdown. Include a breakdown of the amount of local, federal, philanthropic, and special revenue funding across all sites. Please include:
    a. Evaluation data of Healthy Futures; and
    b. Updates on hiring for Healthy Futures.

72. Please share early childhood expulsion rates in FY 2025, and FY 2026, to date, across the District and by ward and race.

73. Please provide an update on the DC MAP program, including the transition to a new provider in the previous fiscal year. Please include for FY 2024, FY 2025, and FY 2026, to date:
    a. Number of referrals made to the DC MAP program;
    b. The most common diagnoses for referrals;
    c. Number of patients served;
    d. Cause of any discrepancy between the number of referrals and the actual services delivered;
    e. Average number of days between when a referral is issued and the patient receives services, including the longest wait time experienced in FY 2024, FY 2025, and FY 2026, to date;
    f. Number of practicing clinicians in DC MAP's current provider, including their credentials and number of vacancies; and
    g. Summary of findings of any review or evaluation of these services. Please attach any relevant reports, including feedback related to the quality and delivery of services from patients and referring providers.

74. Please describe efforts in FY 2025 and FY 2026, to date, to establish the full continuum of psychiatric care for children, including acute care, crisis stabilization, intensive outpatient care,

and Intensive Community-Based Interventions in the District, including the following services specifically for children less than 18 years:

a. Crisis stabilization unit or pediatric CPEP, with an extended observation unit;
b. Bridging Clinic for youth who are being discharged from inpatient psychiatric units;
c. Therapeutic group home/community residence;
d. Intensive outpatient programs;
e. Partial hospitalization or day hospital;
f. A local Psychiatric Residential Treatment Facility (PRTF), particularly whether there has been any communication with the Mayor regarding the plan required by the ROAD Act; and a
g. Substance Use Disorder treatment inpatient or outpatient facility.

75. How many youth were reviewed through the PRTF Medical Necessity Determination process in FY 2025 and FY 2026, to date? What was the rate of approval?

76. According to DBH policy 200.7, the PRTF Review Committee is supposed to produce an annual report on PRTF referrals and post it to their website. Please provide the annual reports starting from the year the policy was established to now. If these reports have not been produced, please explain.

77. Please describe all substance abuse services offered to children and youth and the process for obtaining these services. Please include:
    a. The total number of children and youth who received substance abuse services in FY 2024, FY 2025 and FY 2026, to date. Please breakdown by age, home ward, ward where services took place, how many were in-person/virtual/hybrid, and the types of services;
    b. The total number of agencies or organizations that provided substance abuse services to children and youth. Please provide (via Excel spreadsheet) a list of the agencies and organizations that provide substance abuse services to children and youth. Include their grant/contract amount, location, Ward, how many children and youth they served in FY 2025 and FY 2026 to date, the format of their services (virtual/in-person/hybrid), what services they provided, and contact information (staff contact, email address, phone number, and website);
    c. Plans in FY 2026 to expand the types of substance abuse services offered to children and youth; and
    d. The number children and youth who received services through the Adolescent Community Reinforcement Approach (A-CRA) in FY 2025 and FY 2026, to date.

78. Please provide the following information for the DC Prevention Centers in FY 2025 and FY 2026, to date:
    a. Locations of centers (if any changed);
    b. Number of youth served at each Center, broken down by age, grade, race/ethnicity, ward, and gender;
    c. Number of youth participating in the DC Prevention Center Leadership Councils (please provide the names of the schools they attend); and

d. Activities and programs provided by each DC Prevention Centers, including but not limited to Narcan training, community events, and school related initiatives.

79. How many teachers or other personnel in FY 2025 and FY 2026, to date, completed the online behavioral health training program for child development facilities and public schools that was launched in FY 2015?

80. What is the current status of the community-based Level 3.5 SUD treatment facility for youth that was funded through Opioid Abatement Settlement dollars? If the facility is already open, please provide data for FY 2025, and FY 2026, to date, on its utilization, including the number of youth served, referral sources, and average length of stay.

81. Please provide an update on the collaborative efforts between DBH and Dr. Sivabalaji Kaliamurthy, at Children's National Medical Center, including the number of youth seen in FY 2025 and FY 2026, to date, including their demographics (age, race, gender and ward) and the outcomes achieved.

82. Please provide the following information for SUD services in FY 2025 and FY 2026, to date, for youth ages 18-24:
    a. Number of consumers who used detox, outpatient, and residential services;
    b. Number of service providers providing services to this age group, including their names, respective capacities, and locations;
    c. Average wait times to begin services; and
    d. DBH's strategies for expanding both capacity and accessibility of services, and addressing barriers to this age group.

83. Please provide an update on the creation of the District's comprehensive "Children's Plan," which was last updated in May 2012 and DBH indicated would be published by the end of FY 2025, and has yet to be published.

84. How many Peer Navigators did DBH certify in FY 2025 and FY 2026, to date? How many of these navigators are ages 18-24? How many youth ages 18-24 have been engaged by DBH-certified Peer Navigators (of any age)? Please provide a count of the different types of services peer navigators have helped youth receive or connect to.

85. What funding did DBH expend for FY 2025 and allocate in FY 2026 to grow the youth behavioral health workforce, including training, recruitment, retention, credentialing/continuing education, or the development of the "TAY Choice Provider" model or Peer Navigator program?

86. What mental and behavioral health counseling, referral, or outreach services does DBH provide specifically for youth aging out of foster care or youth ages 18–24 with prior involvement in the foster care system?
    a. With the recent closure of Wayne Place, what alternative services or placements are currently being used to meet the needs of youth with prior CFSA involvement?

b. Please provide data for FY24 and FY25, to date, on the number of youth served through these targeted services, including:
    i. Number of youth referred and number who received services;
    ii. Types of services accessed (e.g., counseling, substance use treatment, housing-related support);
    iii. Average duration of service engagement; and
    iv. Outcomes tracked, if available (e.g., housing stability, reduced substance use, improved mental health).

School Based Behavioral Health

87. Please provide an update regarding the type of assessments in place for screening students. How many students were assessed in FY 2024, FY 2025, and FY 2026, to date?

88. Please provide an update on DBH's School Behavioral Health Program including a list of all schools that as of December 1, 2025 have DBH clinicians, CBO clinicians, or both. Please include:
    a. How much clinician time has been spent on Tier 1, Tier 2, and Tier 3 services;
    b. How many and what percentage of schools have one or more CBO or DBH clinician currently in place;
    c. How many schools have been matched by do not have an active DBH or CBO clinician;
    d. How many schools have not been matched with a CBO (Please identify schools without a CBO clinician and provide the reason why one has not been hired);
    e. How many schools in each cohort have a School Behavioral Health Coordinator, and what type of position/role do they hold at the school;
    f. A list of all of the schools in each cohort; and
    g. Any DBH plans to change the type of professionals that can be involved in the provision of Tier 1 and 2 services.

89. Individual School Breakdown: For each school with a DBH or CBO clinician in place during FY 2024, FY 2025, and FY 2026, to date, please provide the following information in an Excel spreadsheet:
    a. The number of students who met with a clinician;
    b. The number of students who were referred to care;
    c. The student to clinician ratio for the school, and the average caseloads of CBO clinicians;
    d. The most common diagnoses or concerns;
    e. The percentage of each referral source (walk-in, teacher, parent, etc.);
    f. The prevention programs and services (Tier 1 or 2) that were offered;
    g. The number of students who participated in prevention programs;
    h. Name and contact information for their clinician(s) and School Behavioral Health Coordinator;

i. Percentage of clinician's time that was billed to Medicaid, Alliance, or private insurance;
j. Relevant links for clinician websites, social media pages, or other materials; and
k. A list of current programs that are meeting the existing need for services, and if not, what is being done to meet the total need.

90. How many of the schools in Cohorts 1, 2, 3, and 4 have started or completed the SBBH School Strengthening Tool and Work Plan for the 2025-26 school year? Please provide the template for the School Strengthening Tool.

91. Please provide the following information on the SBBH funding model:
    a. Why the findings of the Rate Study were not updated to reflect current cost given the two-year delay of the study;
    b. Status of program evaluations conducted by Child Trends including the timeline for publication, the reason for delay, and how the findings will be shared;
    c. Percentage of total CBO and DBH clinician services, broken down by type of service, that have been able to be billed to Medicaid, private insurance, or other sources in FY 2025 and FY 2026, to date;
    d. What is the total amount billed per school by the CBOs during school years 2024–2025 and 2025–2026, to date? Please provide the same information, broken down by school, for DBH clinicians;
    e. Plans for re-evaluating the financial model and the data DBH will use to make decisions;
    f. How did DBH factored in the rate study when considering their new comprehensive plan?

92. Please provide an update on the pilot programs that were launched and implemented in FY 2025 and FY 2026, to date. Include all details for each pilot program, including the number of applications received, the number of schools participating, compensation levels, and any obstacles encountered during the implementation of each individual pilot. Include how the pilots will be evaluated to determine whether DBH will continue in school year 2026-27.

93. Please provide a breakdown of all DBH administrative positions that support the SBBH program. Include the following information for each position:
    a. Role and responsibilities;
    b. Whether the position provides technical assistance, supervision, program oversight, or other support to DBH clinicians and CBO grantees;
    c. Number of FTEs assigned to each role; and
    d. Funding source(s) for each position.

94. Since school year 2012, please identify all schools where DBH has placed DBH clinicians (excluding CBO clinicians). For each school and school year (from SY 2012 to the present), please provide:
    a. Billing data;
    b. Average caseload per clinician;

c. Number of student drop-ins;
d. Please list any schools where DBH has removed DBH-employed clinicians, along with the reasons for their removal.

95. Provide an update on the status of DBH's comprehensive plan to improve the School-Based Behavioral Health program, including, but not limited to the following:
    a. What major revisions have been made since the plan was released, and what prompted those changes?
    b. Which elements of the plan remain under development, and what is the anticipated timeline for finalizing them?
    c. How has DBH incorporated feedback from school leaders, clinicians, CBOs, families, and advocates into the revised plan?
    d. Please describe plans to contract with an expert in school based behavioral health to complete a case study evaluation that will identify effective practices in high performing SBHP CBOs.
    e. The Comprehensive Plan makes no reference to the School Based Behavioral Health Coordinator role – how does the agency foresee implementing this in the Comprehensive Plan?
    f. Please provide the implementation plan for the SBBH comprehensive plan that DBH indicated would be completed by November 30, 2025.
    g. Please provide the raw data collected as part of the School-Based Behavioral Health (SBBH) Environmental Scan.

Adult Substance Abuse Services

96. Please provide the following information on DBH's work to promote access to a continuum of quality substance abuse prevention, treatment, and recovery support services for FY 2025 and FY 2026, to date:
    a. List of providers and number of consumers served by DBH's outpatient methadone maintenance treatment programs and clinics; and
    b. Number of prescriptions, per month, reported to the Prescription Drug Monitoring Program.

97. For the Safe Syringe Program, please provide the following information for FY 2025 and FY 2026, to date:
    a. Number of syringes distributed, per vendor per month, for the Safe Syringe Exchange program;
    b. Targeted geographic areas for each vendor; and
    c. The number of sharps collected by each vendor.

98. Please provide the following information for LIVE.LONG.DC 3.0 for FY 2024, FY 2025 and FY 2026, to date:
    a. The number of DBH staff dedicated to opioid prevention and response, including grades and titles;

b. An updated list and map of locations (including ward) where the public can get Naloxone;
c. The number of Naloxone that was distributed in FY 2024, FY 2025, and FY 2026, to date. If possible, provide a list of the locations and the number of Naloxone that was distributed at each location;
d. The number of Naloxone trainings conducted in FY 2024, FY 2025, and FY 2026, to date; and
e. A spreadsheet listing the faith-based institutions receiving grants on opioid prevention and treatment, including grant amount and description of services.

99. How many calls the Access Helpline received related to opioid addiction in FY 2024, FY 2025, in FY 2026, to date? Please provide the following information for the Assessment and Referral Center (ARC) in FY 2024, FY 2025 and FY 2026, to date:
    a. Number of clinicians and other staff conducting assessments;
    b. Number of assessments conducted; and
    c. List of places where consumers were referred, including number referred to each center, description of services, and length of type between referral, intake, and first appointment.

100. Please provide the following information for the DBH Peer Specialist Certification Program FY 2024, FY 2025, and FY 2026, to date:
    a. Number of peers trained and certified;
    b. Duration of the program and any significant enhancements or modifications introduced; and
    c. Number of certified peer specialists working in the District, including roles and activities.

101. Please provide the following information regarding substance abuse services that are offered to adults in FY 2025 and FY 2026, to date:
    a. The total number (via spreadsheet) of adults who received substance abuse services, broken down by age, home ward, ward where services took place, format (in-person/virtual/hybrid), and the types of services provided;
    b. Please provide (via spreadsheet) a list of all agencies and organizations that provide substance abuse services to adults, including location, Ward, how many adults served, the format of their services (virtual/in-person/hybrid), what services they provided, and contact information (staff contact, email address, phone number, and website); and
    c. Plans in FY 2026 to expand the types of substance abuse services offered to adults.

Stabilization Centers

102. Please provide the following information on the Stabilization Center since it opened in October 2023:
    a. The total number of individuals served, disaggregated by race, age, gender, ward of residence, and housing status (broken down by FY);

b. Percentage of individuals served who have come to the Center more than 1, 5, and 10 times;
c. Types of services provided; and
d. Numbers of referrals made to other agency programs and organizations, broken down by program/service.

103. Please provide a detailed narrative on the second Stabilization Center project, including:
   i. Environmental remediation;
   ii. Construction contractor selection;
   iii. Construction commencement;
   iv. Expected completion date;
   v. Planned capacity, including what factors informed the decision;
   vi. Operations contractor selection;
   vii. Anticipated opening date for accepting individuals; and
   viii. A copy of the Good Neighbor Agreement associated with the second stabilization center, or indicate whether one is being developed.

Inpatient Care

104. Please provide the following information for Saint Elizabeths[1] Hospital in FY 2024, FY 2025, and FY 2026, to date:
   a. Types of services and interventions offered;
   b. Number of adult admissions;
   c. Number of adult walk-ins;
   d. Number of FTEs (broken down by type and certification/license);
   e. Number of open work orders; and
   f. Major facility upgrades and renovations (including plans for FY 2025).

105. In FY 2024, FY 2025 and FY 2026, to date, how many children were discharged from inpatient psychiatric hospitalization or psychiatric residential treatment facilities and received in-home and community-based mental health services?
   a. Please include CBI, intensive care coordination, and intensive case management services—within 30 days, 60 days, or 90 or more days of their discharge.

106. What is the rate of readmissions to inpatient psychiatric hospitals for FY 2024, FY 2025, and FY 2026, to date? Please provide a breakdown by adults and youth.

107. For those adults about whom DBH receives notification of discharge, please list the following information for FY 2025 and FY 2026, to date (for each hospital or inpatient facility):
   a. How many individuals were discharged within (a) one to 10 days, (b) 11 to 30 days, (c) 31 to 60 days (d) more than 60 days;
   b. How many individuals were readmitted two or more times during the past three years to either any hospital;

[1]

c. How many individuals were connected to a CSA within (a) 5 days of discharge from the institution, (b) 10 days of discharge, (c) more than 10 days of discharge, (c) more than 20 days of discharge, (d) more than 40 days of discharge, (e) more than 60 days;
d. How many individuals who were assessed or evaluated by a CSA within (a) 5 days of discharge from the institution, (b) 10 days of discharge, (c) more than 20 days of discharge, (d) more than 40 days of discharge, (e) more than 60 days; and
e. How many individuals who received mental health treatment from a CSA within (a) 5 days of discharge from the institution, (b) 10 days of discharge, (c) more than 20 days of discharge, (d) more than 40 days of discharge, (e) more than 60 days.

108. Describe DBH's current routine oversight process at PIW.
    a. How is DBH ensuring that the Psychiatric Institute of Washington (PIW) is adhering to its incident reporting requirements under D.C. law and DBH policy?
    b. How many incident reports did DBH receive from PIW in FY 2024, FY 2025 and FY 2026 to date?
    c. How many investigation reports did DBH receive from PIW in FY 2025 and FY 2026 to date? How many investigations did DBH conduct based on complaints of abuse and neglect at PIW in FY 2025 and FY 2026, to date?

Violence Prevention and Response, Department of Corrections & Behavioral Court Diversion

109. Please provide the following information for the Behavioral Court Diversion program in FY 2025 and FY 2026, to date:
    a. The number of youth who participated, including the type of status offense they were alleged to have committed, the referral source (i.e., judge, probation officer, prosecutor, etc.) and the outcomes for youth in the program;
    b. The number of youth who received Community Based Intervention (CBI) services through the Juvenile Behavioral Diversion Program;
    c. The number of youth who received CBI services through the Family Court Social Services Division;
    d. The average and median wait time for a first appointment with a psychiatrist after referral from the Juvenile Behavioral Diversion Program and the Family Court Social Services Division; and
    e. The recidivism rate of the youth participants and an explanation of how recidivism rates are measured.

110. Please provide an update on the DBH services to consumers under the custody of the Department of Corrections, including services provided in the READY Center. Please specify the number of individuals served, types of services provided, and any measurable outcomes or improvements in mental health and substance use treatment for this population in FY 2024, FY 2025 and FY 2026, to date.
    a. How does DBH provide age and developmentally specific services for transitional age youth (18-26) entering/exiting the jail?

b. What data does DBH currently collect to monitor and evaluate continuity of mental health care for individuals transitioning between jail, community supervision, and community-based settings?

DBH Crisis Response

111. Please provide the following information for the Community Response Team in FY 2024, FY 2025 and FY 2026, to date:
    a. DBH policies or procedures that describe standards for the District's mobile crisis system;
    b. Number of calls from 911 diverted to DBH;
    c. Types and percentages of services billed to insurance or Medicaid;
    d. Number of Community Response Team FTEs (indicate whether staff are full or part-time);
    e. Number of vacancies on the Community Response Team;
    f. Community Response Team budget and spending;
    g. Number of calls received and responded to;
    h. The locations where the team was dispatched, by ward;
    i. Breakdown of how many calls related to children and youth or adults; and
    j. Top 5 types of crises addressed.

112. Please provide the following on the DBH 9-8-8 Suicide & Crisis Lifeline:
    a. Number of FTEs for 9-8-8, number of vacancies (please indicate which staff are contractors), and where they are located;
    b. Number of calls received through 9-8-8, by month with the total listed for the entire year;
    c. How 9-8-8 is operating with/within the Access Helpline;
    d. The average response time for calls, and the longest and shortest wait times that occurred to date;
    e. Data showing that the implementation of 9-8-8 has replaced calls for mental health-related issues to 911;
    f. How many calls from OUC 911 call takers that were not answered by 9-8-8 call takers and transferred back to OUC;
    g. Any changes to the protocol for service, follow-up, or referral;
    h. Description and number of each call type;
    i. Please summarize the findings of any review or evaluation of these services and attach any relevant reports;
    j. Please share any updates to how DBH collaborates with the Office of Unified Communications or other public safety cluster agencies to implement this program; and
    k. Please describe the marketing/outreach strategy for 9-8-8 services (billboards, digital, commercials, etc.) and how much funding is used for this purpose.

113. Please provide a detailed narrative on any changes to the Access Helpline that have taken place in FY 2025 and FY 2026, to date, including:
    a. Changes to key functions of the Access Helpline;

b. Changes to staffing levels; and
c. Training or preparation for Access Helpline staff.

114. Please provide detailed information for FY 2024, FY 2025, and FY 2026, to date, about the DBH Access Helpline. Please include:
    a. Total number of FTE assigned to the Access Helpline (broken down by type or level);
    b. Number of FTEs by shift;
    c. Location of each FTE (e.g., remote, centralized call center, other);
    d. Number of vacancies and roles currently unfilled (broken down by type or level);
    e. Breakdown of staff roles (e.g., clinicians, call takers, supervisors, contractors);
    f. Average number of calls handled per FTE per month;
    g. Average response time and call duration;
    h. Call volume by month and total for each fiscal year;
    i. Hours of operation and any changes to availability over time; and
    j. Any recent or planned efforts to expand staffing, training, or infrastructure to meet demand.

115. Please provide the following information on the Access Helpline for FY 2025, and FY 2026, to date: (Jana)
    a. The number of days, on average, between when a family or child calls the Access Helpline and when they are referred to a CSA;
    b. The number days, on average, between when a family or child is enrolled and their intake appointment with a CSA;
    c. The number of days, on average, between when a family or child is enrolled and when they receive a diagnostic needs assessment;
    d. The number of days, on average, between when a family or child is enrolled and when they receive their first service as part of a treatment plan;
    e. Please provide a breakdown of (e) by service type, including medication management, CBI, community support, counseling, and psychiatrist appointment;
    f. All languages in which Access Helpline services are provided; and
    g. The number of children who were moved around to more than one CSA.

Q1. Please provide the current organizational chart for the agency, with information to the activity level. In addition, please identify the number of full-time equivalents (FTEs) at each organizational level and the employee responsible for the management of each program and cost center. If applicable, please provide a narrative explanation of any organizational changes made during FY 2025 and FY 2026, to date.

DBH Response:
Please see attachment 1 of 1.

Q2. Please provide a list of all FY 2026 full-time equivalent positions for DBH, broken down by department and title. In addition, for each position please note whether the position is filled (and if filled, the name of the employee) or vacant.

DBH Response:
Please see Attachment 1 of 1. FTE Report

Q3. What was the vacancy rate for DBH for FY 2025 and FY 2026 to date, broken down by division? What was the average time to fill vacant positions in each division?

DBH Response: Please see attachment 1 of 1.

Q4. Please provide a list of DBH employees who received bonuses, special pay, additional compensation, or hiring incentives in FY 2025 and FY 2026, to date, including the amount and reason.

DBH Response:
171 psychiatric nurses received a $1,500.00 retention bonus totaling the amount $256,500.00 for FY 2025 pursuant to the collective bargaining agreement.

In FY 25, three residents at Saint Elizabeths each received a $2,500.00 hiring incentive pursuant to the collective bargaining agreement. In FY 26, four residents each received a $2,500.00 hiring incentive pursuant to the collective bargaining agreement.

Q5. Please provide a complete, up-to-date list of contract workers working directly for your agency, by program and cost center, including the following information for each position:

a. Title of position;
b. Indication that the position is filled or vacant;
c. Date employee began in the position;
d. Whether the position must be filled to comply with federal or local law;
e. If applicable, the federal or local law that requires the position be filled;
f. The entity from which they are contracted; and
g. Annual cost of contract worker

DBH Response:
Please see document, "FY 25 Oversight Question 5. Attachment 1 of 1. Contract Workers."

Q6. Please provide the names of the primary and alternative Sexual Harassment Officers.

h. List and describe any allegations of sexual harassment or misconduct committed by or against its employees received by the agency in FY 2025, and to date, and whether those allegations were resolved.

i. Has DBH received any requests from staff in an otherwise prohibited dating, romantic, or sexual relationship for a waiver of provisions of the Sexual Harassment Order?

i. What was the resolution of each request?

ii. If a request was granted, are there limitations on the scope of the waiver?

DBH Response:

Please provide the names of the primary and alternative Sexual Harassment Officers.

- Lisa Tapp, EEO Manager and Sexual Harassment Officer (SHO)
- Mary Campbell, Risk Manager and Special Services Coordinator, Alternate, SHO

a. *List and describe any allegations of sexual harassment or misconduct committed by or against its employees received by the agency in FY 2025, and to date, and whether those allegations were resolved.*

Type of Case	**Sexual Harassment**	**Fiscal Year**	**Outcome**
Sexual Harassment	Employee alleged a male colleague kissed her on the cheek and then came back and attempted to kiss her again.	FY 25	1st allegation substantiated, 2nd allegation, unsubstantiated Closed
Sexual Harassment	Anonymous allegation that a male employee showed favoritism and flirted with female staff.	FY 25	Closed, unsubstantiated,

b. *Has DBH received any requests from staff in an otherwise prohibited dating, romantic, or sexual relationship for a waiver of provisions of the Sexual Harassment Order?*

DBH has not received any requests.

i. What was the resolution of each request? N/A

ii. If a request was granted, are there limitations on the scope of the waiver? N/A

Q7.How many performance evaluations did the agency complete in FY 2025? For each question, provide the total number and the percentage of total employees.
How many performance improvement plans were issued in FY 2025?
How many employees have submitted SMART Goals or other relevant workplans in FY 2026?

DBH Response:

DBH completed FY25 performance evaluations for 98% of eligible employees for a total of 1,017 employes. Managers are now developing performance improvement plans for employees who received a performance rating of 2 or less. In addition, FY26 performance plans, which includes SMART goals, were completed for 90% of eligible employees for a total of 1028.

Q8. Please provide the following for each collective bargaining agreement that is currently in effect for agency employees:

j. The bargaining unit (name and local number);
k. The start and end date of each agreement;
l. The number of employees covered;
m. Whether the agency is currently bargaining;
n. If currently bargaining, anticipated completion date;
o. For each agreement, the union leader's name title and contact information; and
A copy of the ratified collective bargaining agreement.

DBH Response:

DBH employees are represented by ten labor unions with 15 collective bargaining agreements. Though specific language is not included in each CBA, the agreement remains in effect until a successor agreement is negotiated. DBH is responsible for negotiating non-compensation agreements and the Mayor's Office of Labor Relations and Collective Bargaining negotiates compensation agreements.

1. **1199 National Union of Hospital and Health Care Employees, American Federation of State, County, And Municipal Employees, Chapter 2095 (AFSCME, Chapter 2095) /American Federation of Government Employees Local 383 (AFGE Local 383) and the Department of Behavioral Health**
   The start and end date of each agreement: Effective through September 30, 2016, or until a successor Agreement is negotiated.
   The number of employees covered: 606
   Whether the agency is currently bargaining: No
   If currently bargaining, anticipated completion date: NA
   For each agreement, the union leader's name title and contact information: Sirena Childress, AFSCME, Chapter 205, President sirena.childress@dc.gov -Kenneth Pitts, AFGE Local 383, President Kenneth.pitts@dc.gov ; and
   A copy of the ratified collective bargaining agreement: See attached.

2. **Master Agreement Between the American Federation of Government Employees Local 383, 2737, 2741, 3406, 3444 and 3871 and the Government of the District of Columbia**
   The start and end date of each agreement: September 12,1994 through September 30, 1995.
   *The number of employees covered:*15
   Whether the agency is currently bargaining: No
   If currently bargaining, anticipated completion date: NA

For each agreement, the union leader's name title and contact information: Kenneth Pitts, AFGE Local 383 President Kenneth.pitts@dc.gov ; and
A copy of the ratified collective bargaining agreement. See attached.

3. **1199 SEIU United Health Care Workers East- Social Workers**
The start and end date of each agreement: October 1, 2023 through September 30, 2026.
The number of employees covered: 54
Whether the agency is currently bargaining: No
If currently bargaining, anticipated completion date: NA
For each agreement, the union leader's name title and contact information: Lisa Wallace, Area Vice-President, lisa.wallace@1199.org; and
A copy of the ratified collective bargaining agreement. See attached.

4. **Non-compensation Agreement Between the Department of Behavioral Health and the District of Columbia Nurses Association (DCNA)**
The start and end date of each agreement: October 1, 2007 through September 30, 2017
*The number of employees covered:*186
Whether the agency is currently bargaining: No
If currently bargaining, anticipated completion date: NA
For each agreement, the union leader's name title and contact information: Nancy Boyd, DCNA President, nancy.boyd@dc.gov; and
A copy of the ratified collective bargaining agreement. See attached.

5. **Compensation Agreement Between the District of Columbia Department of Behavioral Health and the District of Columbia Nurses Association (DCNA)**
The start and end date of each agreement: October 1, 2020 through September 30, 2024.
*The number of employees covered:*186
Whether the agency is currently bargaining: No
If currently bargaining, anticipated completion date: NA
For each agreement, the union leader's name title and contact information: Nancy Boyd, President, nancy.boyd@dc.gov; and
A copy of the ratified collective bargaining agreement. See attached.

6. **Non-Compensation Agreement Between Doctors' Council of the District of Columbia and Department of Mental Health (DCDC)**
The start and end date of each agreement: October 1, 2005 through September 30, 2007;
The number of employees covered: 48
Whether the agency is currently bargaining: No
If currently bargaining, anticipated completion date: NA
For each agreement, the union leader's name title and contact information: Jean Villier, DCDC, President jean.villier@dc.gov ; and
A copy of the ratified collective bargaining agreement. See attached

7. **Compensation Agreement Between Doctors' Council of the District of Columbia NUHHCE, AFSCME, AFL-CIO and the Department of Behavioral Health**

The start and end date of each agreement: October 1, 2020 through September 30, 2024
The number of employees covered: 48
Whether the agency is currently bargaining: No
If currently bargaining, anticipated completion date: NA
For each agreement, the union leader's name title and contact information: Jean Villier, DCDC, President jean.villier@dc.gov ; and
A copy of the ratified collective bargaining agreement. See attached

8. **Non-Compensation Collective Bargaining Agreement Between the District of Columbia Department of Behavioral Health and Psychologists Union Chapter 3758, Metropolitan District 1199 DC National Union of Hospital and Health Care Employees, NUHHCE, American Federation of State, County, and Municipal Employees AFL-CIO.**
The start and end date of each agreement: December 27, 2018 through September 30, 2021;
The number of employees covered: 34
Whether the agency is currently bargaining: No
If currently bargaining, anticipated completion date: NA
For each agreement, the union leader's name title and contact information: Kate Croson, President kate.croson@dc.gov; and
A copy of the ratified collective bargaining agreement. See attached

9. **Compensation Collective Bargaining Agreement Between the Department of Behavioral Health and Psychologists Union Chapter 3758, Metropolitan District 1199 DC National Union of Hospital and Health Care Employees, NUHHCE, American Federation of State, County, and Municipal Employees AFL-CIO**
The start and end date of each agreement: October 1, 2020 through September 30, 2025;
The number of employees covered; 34
Whether the agency is currently bargaining: No
If currently bargaining, anticipated completion date: NA
For each agreement, the union leader's name title and contact information: Kate Croson, President kate.croson@dc.gov ; and
A copy of the ratified collective bargaining agreement. See attached

10. **Non-Compensation Collective Bargaining Agreement Between the Department of Behavioral Health and Pharmacist, Metropolitan District 1199 DC National Union of Hospital and Health Care Employees, NUHHCE, American Federation of State, County, and Municipal Employees AFL-CIO.**
The start and end date of each agreement: March 13, 2019 through September 30, 2021
The number of employees covered; 5
Whether the agency is currently bargaining: No
If currently bargaining, anticipated completion date: NA
For each agreement, the union leader's name title and contact information: Wanda Shelton-Martin, Area Director, Metropolitan District 1199DC NUHHCE, AFSMCE, AFL-CIO
wsheltonmartin@nuhhce1199dc.org ; and
A copy of the ratified collective bargaining agreement. See attached

11. Non-Compensation Collective Bargaining Agreement Between District of Columbia Department of Behavioral Health and Committee of Interns and Residents, (CIR) Service Employee International Union, AFl-CIO
The start and end date of each agreement: October 1, 2020 through September 30, 2023
The number of employees covered: 36
Whether the agency is currently bargaining: No
If currently bargaining, anticipated completion date; NA
For each agreement, the union leader's name title and contact information: Russell Warburton, Contract Organizer rwarburton@cirseiu.org ; and
A copy of the ratified collective bargaining agreement. See attached

12. Compensation Collective Bargaining Agreement Between the Department of Behavioral Health and Committee of Interns and Residents, (CIR) Service Employee International Union, AFl-CIO
The start and end date of each agreement: October 1, 2023 through September 30, 2026
The number of employees covered: 36
Whether the agency is currently bargaining: No
If currently bargaining, anticipated completion date: NA
For each agreement, the union leader's name title and contact information: Russell Warburton, Contract Organizer rwarburton@cirseiu.org: and
A copy of the ratified collective bargaining agreement. See attached

13. Compensation Collective Bargaining Agreement Between the Department of Behavioral Health and Public Service Employees Local,572, Laborers Internation Union of North America (LIUNA)
The start and end date of each agreement: October 1, 2021 through October 1, 2025
The number of employees covered: 16
Whether the agency is currently bargaining: No
If currently bargaining, anticipated completion date: NA
For each agreement, the union leader's name title and contact information: Sonia Vasquez Luna, Business Manager sluna@bwldc.org: and
A copy of the ratified collective bargaining agreement. See attached

14. Compensation Collective Bargaining Agreement Between the Department of Behavioral Health and Washington Area Metal Trades Council, AFL-CIO, Public Service Employees Local,572, Laborers Internation Union of North America (LIUNA)
The start and end date of each agreement: October 1, 2013 through October 1, 2017
The number of employees covered:16
Whether the agency is currently bargaining: No
If currently bargaining, anticipated completion date: NA
For each agreement, the union leader's name title and contact information: Lorena Cruz, Business Manager lcruz@bwldc.org ; and
A copy of the ratified collective bargaining agreement. See attached

15. Compensation Collective Bargaining Agreement Between the Department and Compensation Units 1 and 2

The start and end date of each agreement: October 1, 2021 through September 30, 2025
*The number of employees covered:*680
Whether the agency is currently bargaining: Yes
If currently bargaining, anticipated completion date: TBD
For each agreement, the union leader's name title and contact information: Lee Blackmon (NAGE) lblackmon@nage.org, and
A copy of the ratified collective bargaining agreement. See attached

Q9. Please provide the Committee with a list of all vehicles owned or leased by the agency; the purpose of the vehicle; the division the vehicle is assigned to, if applicable; and whether the vehicle is assigned to an individual employee.

DBH response: Please see document "FY 25 Oversight. Question 9. Attachment 1 of 1, DBH Vehicles".

Q10. Please list all pending lawsuits in which the agency, or its officers or employees acting in their official capacities, are named as defendants, and for each case provide the following:

a. The case name;
b. Court where the suit was filed;
c. Case docket number;
d. Case status; and
e. A brief description of the case.

DBH Response:
See attachment. All Pending Lawsuits in Which the Agency is Named as Defendants.

Q11. Please provide in Microsoft Excel, the amount budgeted and spent for FY 2025 and FY 2026, to date, for the agency. In addition, please describe any significant variance between the amount budgeted and spent.

a. At the agency level, please provide information broken out by source of funds and by Account Group and Account;
b. At the program level, please provide the information broken out by source of funds and by Account Group and Account; and
c. At the cost center level, please provide the information broken out by source of funds and by Account Group.

DBH Response:

Please see Attachment 1 of 3. Agency Level
Attachment 2 of 2. Program Level
Attachment 3 of 3. Cost Center Level

Q12. Please provide a complete accounting of all interagency projects that the agency was a buyer or seller for during FY 2025 and FY 2026, to date. For each, please provide a narrative description as to the purpose of the transfer and which fund detail, programs, cost center, and account within the agency the reprogramming affected.

DBH Response:
Please see Attachment 1 of 2. FY 25 Interagency and Attachment 2 of 2. FY 26 Interagency

Q13. Please provide a complete accounting of all reprogrammings received by or transferred from the agency in FY 2025 and FY 2026, to date. For each, please provide a narrative description as to the purpose of the transfer and which fund detail, programs, cost center, and account within the agency the reprogramming affected.

DBH Response:
See Attachment 1 of 1 for a report of reprogrammings in FY 25. There has been no reprogramming in FY 26 to date.

Q14. Please provide the following information for grants/sub-grants awarded to and by the agency in FY 2025 and FY 2026, to date, broken down by program and cost center:

a. Grant Number/Title;
b. Approved Budget Authority;
c. Funding source;
d. Expenditures (including encumbrances and pre-encumbrances);
e. Purpose of the grant;
f. Organization or agency that received the grant;
g. Grant amount;
h. Grant deliverables;
i. Grant outcomes, including grantee/subgrantee performance;
j. Any corrective actions taken or technical assistance provided;
k. Agency program and activity supported by the grant;
l. Agency employee responsible for grant deliverables; and
m. Any grants that were reduced in FY 2026, and by how much.

DBH Response:
Please see attachments "FY 25 Oversight Question 14. Attachment 1 of 2. FY25-26 Grants" and "Attachment 2 of 2. FY 25-26 Subgrants".

Q15. Please provide the following information for all contracts, including modifications, active during FY 2025 and FY 2026, to date, broken down by program and cost center:

a. Contract number;
b. Approved Budget Authority;
c. Funding source;
d. Expenditures (including encumbrances and pre-encumbrances);
e. Purpose of the contract;
f. Name of the vendor;

g. Original contract value;
h. Modified contract value (if applicable);
i. Whether it was competitively bid or sole sourced;
j. Final deliverables for completed contracts;
k. Any corrective actions taken or technical assistance provided;
l. Agency employee(s) serving as Contract Administrator; and
m. Any contracts that were reduced in FY 2026, and by how much.

DBH Response:

Please see attached document, "FY 25 Oversight Question 15. Attachment 1 of 1. FY25 and FY26 to Date Contracts."

Q16. Please provide a complete accounting of all grant lapses in FY 2025, including a detailed description of why the lapse occurred and any variance exceeding 5%. Please indicate if the funds can still be used and/or whether they carried over into FY 2026.

DBH Response:
Please see attachment "FY 25 Oversight Question 16. Attachment 1 of 1. FY 25 Grant Lapses".

Q17. Please provide a complete accounting of all DBH's Special Purpose Revenue Funds for FY 2024, FY 2025, and FY 2026 to date. Please include the following:

a. Revenue source and code;
b. Source of the revenue for each special purpose revenue fund;
c. Total amount of funds generated by each source or program in FY 2025 and in FY 2026, to date;
d. DBH activity that the revenue in each special purpose revenue source fund supports; and
e. The FY 2025 and FY 2026, to date, expenditure of funds, including purpose of expenditure.

DBH Response:

Please see Attachment 1 of 1. Special Purpose Revenue

Q18. Please list and explain any Memos of Understanding entered into by DBH during FY 2025 and FY 2026, to date.

DBH Response:
A Memorandum of Understanding is the legal document and an interagency project is the financial balance/transaction that supports the legal document. The list of interagency projects was provided in response to Question 12.

Q19. Please provide a list of all Department of General Services work orders submitted in FY 2025 and FY 2026, to date, for facilities operated by the agency. Please include the date the work order was submitted, whether the work order is completed or still open, and the date of completion (if completed). Please do a separate breakdown for Saint Elizabeths Hospital.

DBH Response:
Please see attachment "FY 25 Oversight Question 15. Attachment 1 of 1. FY 25 and FY 26 DGS Work Orders".

Q20. Please provide copies of any investigations, reviews or program/fiscal audits completed on programs and activities within DBH during FY 2025 and FY 2026, to date. This includes any reports of the DC Auditor, the Office of the Inspector General, or the Office of Accountability. In addition, please provide a narrative explanation of steps taken to address any issues raised by the program/fiscal audits. Please include a chart with the following:

a.
b. Name of the provider;
c. Date complaint was received;
d. Type of complaint;
e. Referral source;
f. Type of report;
g. Summary or complaint or allegations;
h. Conclusion(s);
i. Recommended outcomes or actions; and
j. Date completed

DBH Response:

Please see Question 20. Attachment 1 of 1. Investigations.

Q21. Please provide a narrative description of what actions DBH undertook to meet the key performance indicators. For any performance indicators that were not met please provide a narrative description for why they were not met, and any remedial actions taken.

f. Please indicate which FY 2025 KPIs have been extended, amended, or removed in FY 2026.

DBH Response

DBH met or nearly met 16 or 18 performance indicators. Below is a description of the actions taken for each indicator.

Measure	**Target**	**FY25 Performance**	**Narrative description of what actions DBH undertook to meet the key performance indicators. For any performance indicators that were not met please provide a narrative description for why they were not met, and any remedial actions taken**
Percent of Intensive Care Coordination (ICC) consumers who were enrolled within 90 days of engagement.	75%	71%	This measure was nearly met[2]. In September 2025, the ICC team participated in a specialized homeless outreach initiative in which the team increased the number of overall engagements. Due to the significant number of engagements (i.e. denominator) and the short time frame to build rapport and establish trust, many consumers did not readily agree to enroll in behavioral health services. DBH anticipates that continued engagement during FY26 Q1 will result in further rapport and trust building, which will consequently result in increased behavioral health service engagement.
Average time from 911 call to Community Response Team (CRT) arrival on the scene of an event for Priority 1 calls.	30 minutes	91 minutes	CRT is working to meet this target by: (1) regularly reviewing existing data to identify gaps, duplications and areas for improvement; and (2) exploring the feasibility of co-locating staff at two Business Improvement Districts in key areas that will better position teams, reduce travel time and improve response times. This measure was not met.
Percent of Community Response Team (CRT) deployment where MPD assistance was requested by CRT.	20%	11%	DBH met this measure.
Percent of unique patients secluded at least once per month.	4.4%	4.1%	DBH met this measure.
Percent of unique patients restrained at least once per month.	8.4%	10.2%	This measure was nearly met. Saint Elizabeths is working to meet this measure by a new pilot program on a high acuity unit which encourages increased engagement of individuals by safety and admission staff and more proactive interdisciplinary meetings between the psychiatry and treatment teams. Also, Saint Elizabeths has

[2] Nearly met is defined as within ten percentage points of the target.

Measure	Target	FY25 Performance	Narrative description of what actions DBH undertook to meet the key performance indicators. For any performance indicators that were not met please provide a narrative description for why they were not met, and any remedial actions taken
			provided staff education on trauma informed care and post trauma history of individuals. Saint Elizabeths is working to meet this measure by a new pilot program on a high acuity unit which encourages increased engagement of individuals by safety and admission staff and more proactive interdisciplinary meetings between the psychiatry and treatment teams. Also, Saint Elizabeths has provided staff education on trauma informed care and post trauma history of individuals.
Percent of individuals from SEH readmitted within 30 days.	2.4%	0.6%	DBH met this measure.
Percent of consumers who remained in the Community Residential Facility (CRF) placement for at least 90 days from move-in date, with no psychiatric hospitalizations, incarcerations, crisis bed placements, or involuntary discharges.	90.0%	94%	DBH met this measure. The Division of Licensure and Residential Support Services are working to meet this metric by: (1) reviewing placement disruptions monthly to identify areas of improvement for transition planning; and (2) ensuring that initial discharge planning meetings occur at least 31 days before planned discharges with both internal and external stakeholders to avoid disruptions in placements.
Percent of DBH operated programs consumers who were satisfied with overall experience.	95%	92%	The target was nearly met. Satisfaction improved between Q3 and Q4.
Percent of consumers surveyed in the Behavioral Health Satisfaction Survey who were satisfied with the person-centered planning process.	80%	72%	The target was nearly met. DBH is working with providers to identify consumer concerns and address them through individual provider technical assistance and network wide trainings.

Measure	**Target**	**FY25 Performance**	**Narrative description of what actions DBH undertook to meet the key performance indicators. For any performance indicators that were not met please provide a narrative description for why they were not met, and any remedial actions taken**
Percent of patients satisfied with Facility/Environment.	60%	50%	The target was nearly met. DBH believes this score is tied to dissatisfaction with meals provided by an outside vendor for a portion of the year while the kitchen was under repair. In addition, the Hospital is ordering new furniture for patients and staff.
Percent of consumers surveyed in the Behavioral Health Satisfaction Survey who were satisfied with Access.	80%	75%	The target was nearly met. DBH will continue to work with providers to ensure that consumers are seen for their first, as well as urgent, appointments within regulatorily established time frames and will increase provider monitoring and treatment chart reviews to ensure that occurs.
Percentage of beneficiaries (ages 18+) who received clinical follow-up within 30 days of discharge for psychiatric hospitalization.	60%	77%	DBH met this metric.
Percent of individuals with improvement on one or more outcome indicators on the adult functional assessment (DLA-20).	35%	22%	This target was not met. Contributors to this missed target include: (1) provider DLA-20 data entry and documentation errors, which led to missing or duplicate entries that skewed reports; (2) DLA-20s not being completed at consistent intervals due to changes in required testing frequency (i.e. every 180 days to every 90 days). Missing reassessment data may have weakened outcome reporting and prevented showing client progress over time. DBH anticipates that this metric will improve in FY 26 as providers are learning a new data platform that is the central depository for data elements, including DLA-20 scores. DBH will offer refresher DLA-20 training and technical assistance to ensure timely and accurate submissions of data.
Average length of stay at DC Stabilization Center.	23 hours	14 hours	DBH met this metric.

Measure	**Target**	**FY25 Performance**	**Narrative description of what actions DBH undertook to meet the key performance indicators. For any performance indicators that were not met please provide a narrative description for why they were not met, and any remedial actions taken**
Percent of school-based behavioral health partnership schools with a school based behavioral health provider.	70%	59%	The target was not met due primarily to workforce challenges. DBH has adopted a comprehensive plan that increases access to services that does not rely on the assignment of a clinician to a school.
Percent of cases who improved on at least one of 3 outcome indicators between initial and most recent children/youth functional assessment (PECFAS/CAFAS).	55%	47%	The target was nearly met. In FY 25, the average total score on initial assessment was 55 (CAFAS) and 52 (PECFAS). The average total score on the most recent assessment was 46 (CAFAS) and 37 (PECFAS). The initial and most recent assessment scores are in the minimal to low moderate range of impairment. Data showed that children/youth's level of functioning improved over time. On average, nearly half of the youth reported improvements in level of functioning even when their initial assessment was low. In FY26, DBH will continue to offer train the trainer trainings and technical assistance with CAFAS/PECFAS implementation per fidelity.
Percent of beneficiaries (age 13+) who received a follow-up service within 30 days after Emergency Department visit for alcohol or other drug use or dependence.	54%	54%	DBH met this metric.
Percentage of beneficiaries (Ages 6 to 17) who received clinical follow-up within 30 days of discharge for psychiatric hospitalization.	75%	86%	DBH met this metric.

Measure	Target	FY25 Performance	Narrative description of what actions DBH undertook to meet the key performance indicators. For any performance indicators that were not met please provide a narrative description for why they were not met, and any remedial actions taken
Percent of vendors not selling tobacco to minors	80%	82%	DBH met this metric.

a. The following KPIs were altered in FY26:

Metric	Status
Percent of consumers who remained in the Community Residential Facility (CRF) placement for at least 90 days from move-in date, with no psychiatric hospitalizations, incarcerations, crisis bed placements, or involuntary discharges	Replaced by metric below
Percent of beneficiaries who received a follow-up visit with any practitioner for mental illness after an emergency department (ED) visit for a diagnosis of mental illness: Age 18 and older (HEDIS)	Added
Percent of beneficiaries who received a follow-up visit with any practitioner for mental illness after an emergency department (ED) visit for a diagnosis of mental illness: Ages 6 to 17 (HEDIS)	Added
Percentage of adolescent (13-17 years) and adult (18+ years) patients with a new diagnosis of alcohol or other drug abuse or dependence who initiated treatment or partial hospitalization, telehealth or medication treatment within 14 days of the diagnosis (HEDIS)	Added
Percentage of beneficiaries aged 16 and older who received at least 180 days of continuous pharmacotherapy for opioid use disorder (buprenorphine, methadone, or naltrexone) (HEDIS)	Added
Percent of visits to DBH urgent care and crisis programs (Adult Urgent Care, Child Urgent Care, CPEP, CRT) where consumers were discharged to the community that had a follow-up service by a community provider (MHRS or FSMH) within seven days.	Added
Percent of individuals from Saint Elizabeths Hospital readmitted within 30 days	Removed

Q22. Please provide DBH's capital budgets for FY 2025 and FY 2026, including amount budgeted and actual dollars spent. In addition, please provide an update on all capital projects undertaken in FY 2025 and in FY 2026, to date.

DBH Response:

Please see Attachment 1 of 2. Capital Budget FY 25
Attachment 2 of 2. Capital Budget FY 26

Q23. For each Mayoral Board, Commission, or Council overseen by DBH, please provide an updated list of members, including when their terms started and end, and their contact information. Please indicate any vacant positions, and include links to the meeting minutes.
Please include the status, list of members, and meeting minutes from FY 2024, and FY 2025, and FY 2026, to date, for the Behavioral Health Planning Council.

DBH Response:

The Department of Behavioral Health manages the Opioid Abatement Advisory Commission which includes members appointed by the Mayor and Council. Please see Attachment 1 of 1. Opioid Abatement Advisory Commission Membership

Please see Attachment 2 of 2. Behavioral Health Planning Council (BHPC) for the list of members and their status. Below are links to the meetings held by the BHPC during this period.

BHPC Meeting-20251212_100208-Meeting Recording

Webex meeting recording: Behavioral Health Planning Council (BHPC) Meeting-20240927 1357-1
Recording link: https://dcnet.webex.com/dcnet/ldr.php?RCID=caf33c521bfac70d3ada0f97a3f17107

Webex meeting recording: Behavioral Health Planning Council October Meeting-20241025 1401-1
Recording link: https://dcnet.webex.com/dcnet/ldr.php?RCID=a143f040db5ddc4bb283701d768755e5

Webex meeting recording: DC DBH Behavioral Health Planning Council Meeting-20250228 1501-1
Recording link: https://dcnet.webex.com/dcnet/ldr.php?RCID=ebf3bb1d6577d24a3c0ed7d430fd96f7

Webex meeting recording: DC DBH Behavioral Health Planning Council Meeting-20250425 1405-1
Recording link: https://dcnet.webex.com/dcnet/ldr.php?RCID=5121be73c1e0aa9301e180f4b51614aa

Webex meeting recording: DC DBH Behavioral Health Planning Council Meeting-20250613 1404-1
Recording link: https://dcnet.webex.com/dcnet/ldr.php?RCID=636bf9f0fd93f5da8274454271afa214

Webex meeting recording: DC DBH Behavioral Health Planning Council Meeting-20250926 1530-1
Recording link: https://dcnet.webex.com/dcnet/ldr.php?RCID=06e5b083d4d4ef8c6c6dff7b07e4ef9e

*Q24. Please provide a list of all FTE positions detailed **to** DBH, broken down by program and activity for FY 2025 and FY 2026, to date. Include a narrative on specific role the detailed staff took at DBH during their detail. In addition, please provide which agency the detailee originated from and how long they were detailed to DBH.*

*b. Please provide a list of all FTE positions detailed **from** DBH to another agency in FY 2024 and in FY 2025, to date. In addition, please provide which agency the employee was detailed to, what work they took on, and for how long.*

DBH Response:

FY 25: Two people were detailed to DBH—one from the Department of Youth Rehabilitation Services to assist with receptionist/clerical support from 11/29/2024 – 01/22/2025 and one from the Department of Corrections to assist with clerical/driving duties at Saint Elizabeths from 10/28/2024 – 12/13/2024 — under the Return to Work program. No Employee was detailed from DBH.

FY 26: There are no details to or from DBH to date.

Q25. Please provide a list and description of all grievances filed against DBH providers and DBH during FY 2025 and FY 2026, to date, including:

a. Number of external reviews filed;
b. Number of external reviews found in favor of the consumer; and
***c.** Number of external review determinations in favor of the consumer that were approved by the DBH Director*

DBH Response:

In FY 25 there were a total of 34 grievances filed. A total of four grievances were filed to date in FY 26. Grievances received from consumers receiving services from community-based providers primarily related to concerns with information noted in their behavioral health records, delivery of services or availability of desired services, and interactions with provider staff. Grievances filed at Saint Elizabeths Hospital mostly related to medication, treatment, and property theft.

d. Number of external reviews filed.
There was a total of seven external reviews filed in FY25. No external reviews have been filed to date in FY26.

e. Number of external reviews found in favor of the consumer; and
There were no external reviews found solely in favor of the consumer. Three of the external review outcomes were in favor of the consumer in part.

f. Number of external review determinations in favor of the consumer that were approved by the DBH Director.
There were no external reviews that fully met this criterion. There was a total of three external review determinations that were partially in favor of the consumer that were approved by the DBH Director.

Q26. How does DBH coordinate with DHCF to ensure consistency in authorization policies and oversight of Medicaid-funded behavioral health services, including monitoring provider spending? What systems or processes are in place to identify significant increases in provider billing or service utilization, and what triggers a review or follow-up with the provider?

DBH Response: In February 2025, the Department of Behavioral Health (DBH) began the process of transitioning the authorization of all specialty services to the Department of Health Care Finance's (DHCF) contracted Quality Improvement Organization (QIO), Comagine Health. The specialty services are:

1) Assertive Community Treatment (ACT)
2) Community Based Intervention (CBI)
3) Crisis Stabilization
4) Rehabilitation Day Services, and
5) Community Support Services (CSS)

DBH provided current policies and regulations pertaining to the services and consulted with DHCF on a streamlined process for the authorization of DBH managed Medicaid reimbursable behavioral health services.

With the transition of each service, review standards were developed based upon DBH's current policies and regulations by the QIO. In addition, new requirements were implemented to monitor service utilization. Documentation requirements as well as level of care requirements are established and agreed upon by DBH, DHCF and the QIO, before each implementation of the review of service requests for DBH certified providers.

The following protocols have been established with the QIO and DHCF to monitor provider reviews:

- Weekly reporting of the number of requests for authorizations submitted
- Post-pay audit reviews by the QIO based on contract requirements with DHCF
- Referral to DHCF's Program Integrity

DBH, DHCF and the Medicaid Fraud Control Unit work collaboratively and closely to address allegations of Medicaid fraud, waste and abuse.

DBH maintains a dashboard with data from paid Medicaid and local claims that shows trends by provider and service type. DBH reviews claim data through the dashboard regularly. When trends or outliers are identified, a multidisciplinary team meets to establish a plan to address the issue, up to and including corrective or adverse action. In addition, DBH staff meet monthly and as needed with DHCF's data manager and program integrity team to discuss trends in service utilization and expenditures and concerns about specific providers. DBH refers cases of suspected Medicaid fraud, waste or abuse to DHCF for investigation. In FY 25, DBH and DHCF partnered to complete joint site visits for providers suspected of committing Medicaid fraud, waste or abuse. DBH also served as a subject matter expert for several DHCF investigations involving behavioral health providers.

Q27. In FY 2024, FY 2025, and FY 2026 to date, has DBH observed any significant increases in utilization or billing for specific services? If so, which services experienced the largest increases?

a. *What steps did DBH take to assess whether these increases were appropriate and supported by service delivery data?*
b. *Were any providers found to be billing inappropriately? If so, how many, what was the amount of improper billing, and what corrective actions were taken?*

DBH Response:

In FY 2024 and FY 2025, DBH saw year over year increases in expenditures and services utilization for: (1) clinical care coordination; (2) recovery support services; and (3) community support services. Clinical care coordination, which is the coordination of care between a licensed behavioral health clinician and the clinical personnel of an external provider, experienced year-over-year increases in both service utilization and expenditures in FY 2024 and FY 2025. These changes were a result of DBH planned implementation of CCC to serve as the foundation to developing a clinically based service system. DBH continues to monitor CCC to ensure that it is provided in an appropriate manner consistent with client clinical care needs.

Recovery support services, which are non-clinical services provided to a SUD client by a DBH-certified RSS provider to assist the client in achieving or sustaining SUD recovery, increased in service utilization and expenditures in FY 2025 from FY 2024. These increases were isolated to two new providers. When identified, DBH staff, in collaboration with DHCF, conducted onsite visits and record reviews, which resulted in corrective actions including statements of deficiency, and payment and referral suspensions.

Community support services, which are mental health rehabilitation services that focus on helping clients conduct activities of daily living to lead fulfilling lives. The service assists a consumer in achieving rehabilitation and recovery goals that focus on building and maintaining a therapeutic relationship with the provider and support network experienced an increase in year-over-year expenditures in FY 2024 with flat utilization. In FY 2025, year over year expenditures decreased, but year over year utilization increased. These changes were a result of updated regulations that decreased the number of allowable community support services per consumer in a 180-day period and established limits on community support services delivered via telehealth.

There are currently eight DBH providers that have been placed on suspended payment due to credible evidence of inappropriate billing on the local payment side. DBH receives a notification to suspend payment from the DHCF for Medicaid payments after transactions have been reviewed and deemed to show evidence of credible inappropriate billing. DBH follows the findings of the DHCF investigation and when payments are suspended by DHCF, DBH also suspends payments. While the suspension is in place, the investigation into the providers' billing practices continues. The provider is also able to appeal the decision. If through the appeals process there is a decision to allow billing to be reinstated, DBH will reinstate the provider's ability to be paid for services. The process begins with the suspension of billing and can include the decertification of a provider. There is no amount of inappropriate billing determined until an investigation is completed.

Q28. What is DBH's current authorization process for Community Support Services (CSS), Recovery Support Services (RSS), and Assertive Community Treatment (ACT)?

h. What documentation is required for initial authorization of each service type?
i. How does DBH determine medical necessity and service intensity?
j. How often must ACT services be reauthorized, and what criteria are used to determine continued eligibility?

DBH Response:

Community Support Services (CSS) has transitioned to the contracted QIO, Comagine Health, for utilization/prior authorization reviews. DBH authorizes Assertive Community Treatment (ACT). Recovery Support Services is based on an evaluation and require prior authorization is not required at this time.

a) Community Support Service prior authorization documentation requirements:
    1. Consumer Choice Form that confirms enrollment with provider. Form must be signed by the consumer and a supervising clinician from the certified provider submitting the request.
    2. Daily Living Activities-20 (DLA-20) assessment for adults or the CAFAS/PECFAS assessment for youth must be completed within 90 days of the date of request.
    3. Community Support Review Assessment. An assessment including the DLA 20 scores submitted in the Comagine Health Provider Portal by a Qualified Practitioner.
    4. Treatment Plan. Must be completed within 180 days of the date of request, must be signed by client and a Qualified Practitioner .
b) Assertive Community Treatment (ACT) prior authorization documentation requirements:
    1. Consumer Choice Form (CCF) confirming enrollment with a certified provider. Must be signed by the client and a supervising Clinician from the provider submitting the request.
    2. Daily Living Activities-20 (DLA-20), Adult completed within 90 days of the date of request.
    3. Comprehensive Psychiatric Evaluation completed by a Qualified Practitioner within 90-days of request.
    4. Treatment Plan completed within 180-days of the date of request, must be signed by client and a Qualified Practitioner.
c) ACT is an intensive, integrated, rehabilitative, crisis, treatment, community-based service for adults with serious and persistent mental illness along with complicating factors such as homelessness, co-occurring substance use disorders, recidivism, and physical health conditions. ACT is a critical component of the District's community-based services to treat individuals at risk of hospitalization in the least restrictive setting. The goal of ACT is to improve consumer functioning and quality of life while supporting community integration.

To meet medical necessity for ACT Services the following shall be demonstrated or required:

1. Consumers must be aged 18 or older

2. Consumer has moderate to severe functional impairment as evidenced by a score of 4 and below utilizing the d functional assessment tool DLA-20 within 90 days.
3. Diagnostic Assessment and/or clinical notes that identifies that consumer has a current diagnosis of a serious and persistent mental illness and that the consumer's demonstrate significant service needs that cannot be met through less intensive outpatient services.
4. Current IRP/ICP (treatment plan) within 180 days that identifies person centered goals to be achieved through the provision of ACT Services.

Intensity of service delivery is person centered and is delivered based on several factors including risk and safety concerns, symptom acuity, and recent psychiatric hospitalizations. ACT Services requires a minimum of five contacts per month.

ACT providers can request reauthorization every 180 days. ACT Services will be reauthorized based on meeting medical necessity criteria and documentation that the consumer has benefited from and/or continues to require this level of services in order to reduce risk factors and improve functional assessment and/or prevent deterioration. Current clinical documentation, treatment plans, functional assessments must be submitted for review to request reauthorization of ACT Services.

Q29. What are the unit limits for CSS and RSS services, and at what point is additional authorization required?

a. How many units are typically authorized per consumer per month or year?
b. What is the process for requesting additional units beyond the standard threshold?

DBH Response: Recovery Support Services (RSS) do not require prior authorization. The RSS service utilizes the recovery support evaluation that must be completed by an approved qualified practitioner in the case of the client in a SUD Treatment program or community setting. Current regulations state for SUD services, RSS must be included in the clients' plan of care. Providers are responsible for monitoring clients' progress on achieving goals and objectives. In a residential setting, providers must review the plan of care upon approval of medical necessity. The client's progress is reviewed every 90 days in a community setting.

Community Support units are authorized for up to 200 units per one hundred eighty (180) days and allows up to 50 supplemental units per 180-day authorization period. These provisions allow for the appropriate use of community supports tailored to an individual and supports our strategic priority to transform the system by increasing utilization of clinical services and evidence-based practices and reducing reliance on Community Support services, a non-clinical service delivered largely by unlicensed staff which is intended to supplement the provision of clinical services.

Q30. What was the total amount billed for CSS, RSS, and ACT services in FY 2024, FY 2025, and FY 2026, to date? Please break down by year and type of service.

a. What utilization or billing trends for these services during this period has DBH observed?
b. Which services saw the largest increases, and what actions did DBH take to assess whether those increases were appropriate and supported by service delivery data?

DBH Response:

a). Please see attachment "FY 25 Oversight Question 30. Attachment 1 of 1. CSS, RSS and ACT for FY 24 FY 25 and FY 26-Q1".

b). Recovery Support Services (RSS) billing from FY 24 to FY 25 jumped from $861,304 to $19,740,567. The increase was due to billing by two new providers. Because of the significant increase, DBH, in collaboration with DHCF, conducted targeted oversight including onsite visits and record reviews which resulted in corrective and adverse actions including statements of deficiency, and payment and referral suspensions.

Community Support Services (CSS) utilization continues to decrease as service unit limits have gone from 600 per 180 days to 200 units per 180 days and telehealth usage has been limited. The decrease in utilization should continue once the clinical authorization process through Comagine Health begins in April 2026.

Assertive Community Treatment (ACT) utilization has remained constant.

Q31. Please provide a list of providers who were decertified by DBH in FY 2024, FY 2025, and FY 2026 to date. For each provider, please include:

a. *The reason for decertification;*
b. *The date the decertification was initiated and completed; and*
c. *The services the provider was previously authorized to deliver.*

DBH Response:

During this period, DBH has decertified eleven providers, of whom five are in the administrative appeal process. For specific information, please see Attachment 1 of 1. Decertified Providers.

Q32. In FY 2024 and in FY 2025, to date, what services and support did DBH provide to consumers who identify as LGBTQIA+? Please indicate what services are for children and youth.

DBH Response

DBH requires that all certified providers offer services (within their scope of practice) to anyone seeking care or to appropriately refer such individuals to a qualified provider, whether or not an individual identifies as LGBTQIA+. DBH emphasizes this mandate in our monthly provider meetings to ensure individuals who identify as LGBTQIA+ do not experience barriers to accessing necessary care.

During FY24 and FY25 to date, DBH has especially focused on providing a range of services to children, youth, and adults who identify as LGBTQIA+. The School Behavioral Health Program (SBHP) clinicians provide prevention, early intervention, and treatment services to children and youth in schools, some of whom identify as LGBTQIA+. SBHP clinicians implemented programming focused on LGBTQIA+ awareness, diversity and inclusion programming for students, parents, and staff. SBHP providers also hosted/host LGBTQIA+ early intervention small groups. SBHP Providers disseminate important information about LGBTQIA+ topics via newsletters to the school community. Additionally,

some report that mental health teams collect and share data for students and faculty surrounding LGBTQIA+ questions (identity, how they feel at school, acceptance, etc.) so all can be informed and feel comfortable and included in the school environment.

The DBH Transitional Age Youth (TAY) Team created several social media posts to provide LGBTQIA+ TAY with behavioral health resources and services. These were posted to the TAY Instagram, Facebook, and Twitter pages. Additionally, the TAY teams outreached to programs specifically geared to the LGBTQ community with the purpose of letting LGBTQ young adult know that many of the TAY providers offered a safe place for them to seek and receive support and treatment.

DBH is also aware of and sensitive to the needs of numerous diverse populations across the District (e.g., racial/ethnic minorities, LGBTQ+, older adults) and their significantly higher rate of substance use, overdoses and deaths across these populations. Therefore, our State Opioid Response (SOR) grant team uses data to inform our intervention strategies, which then drive the planned actions and interventions of the SOR outreach teams.

Our outreach teams specifically target the needs of these diverse population (including LGBTQIA+ individuals) by promoting prevention, treatment, and recovery options while engaging in harm reduction strategies. Social marketing strategies are focused on raising awareness, offering hope, and informing the communities and populations most affected by the opioid crisis about the available services and supports.

DBH has also entered into an MOU with the Mayor's Office of LGBTQA to assist with outreach to diverse populations. This MOU supports prevention and harm reduction outreach activities across the District to expand outreach to LGBTQIA+ residents who are at greater risk of opioid and stimulant use, especially members of the trans community, men having sex with men, and individuals experiencing homelessness.

DBH continues to fund the *Expanding Access and Retention in Care for Opioid and/or Stimulant Use Disorder Treatment* grant to Whitman Walker and HIPS, both organizations which target the LGBTQIA+ population. This initiative brings local providers together to: implement strategies that reduce barriers to accessing treatment for individuals with OUD/STUD; re-engage consumers who have unexpectedly or prematurely discontinued treatment; and support current consumers to promote retention, and whole-person care. By addressing the known barriers to care, this initiative seeks to reduce health disparities within this underserved community by improving access to needed behavioral health services and supports.

Q33. How many DBH-certified providers were investigated for billing fraud in FY 2024, FY 2025, and FY2026, to date?

k. For each fiscal year, how many providers were found to have committed Medicaid fraud? Please describe the nature of the fraud and any resulting actions (e.g., decertification, legal referral, repayment).

l. How many DBH-certified providers are currently under active investigation for Medicaid fraud, with outcomes still pending? Please describe the types of allegations and the status of those investigations.

DBH Response: DBH refers cases of suspected Medicaid fraud to the DHCF and the Office of the Inspector General for investigation.

a. DHCF investigated the following DBH providers for billing fraud by fiscal year:

FY	Number of DBH Providers Investigated for Fraud by DHCF
FY 24	2
FY 25	4
FY 26 To Date	11

Allegations investigated include:

1. Community Support Workers billing for services that were not provided to include billing for services for incarcerated, hospitalized, and/or deceased consumers;
2. Biling for more services than were provided;
3. Community Support Workers utilizing multiple different providers to submit fraudulent claims for services that were not rendered;
4. Tax fraud by Community Support Workers and behavioral health providers, as evidenced by the lack of records related to wage reporting in DC DOES system;
5. Impossible day billing, and billing for unusually high numbers of consecutive days worked, including claims that Community Support Workers worked everyday for more than a year;
6. Reports of illegal inducements being provided to consumers;
7. Overbilling/upcoding schemes (billing for higher reimbursement services than those that were provided);
8. False documentation.

Both DBH and DHCF have suspended payments for all providers for which there are credible allegations of fraud. Further, DHCF has referred these cases to the Medicaid Fraud Control Unit for full investigation. Additionally, DBH has pursued corrective and adverse action for substantiated allegations of fraud, up to and including issuing notices of decertification.

b. DHCF presently has six active investigations of DBH providers.

Q34. Please provide a list, in Microsoft Excel, of all DBH providers and Core Service Agencies (CSAs) that serve children, youth, and adults. Include the following information:

a. Name of provider;
b. Location(s) (including ward) where services are provided;
c. Treatment modalities (including whether virtual, in-person, or hybrid);
d. Populations served (ages, LGBTQ+, seniors, justice involved, experiencing homelessness, newly arrived migrants, returning citizens, etc.); and
e. Number of individuals served in FY 2025 and FY 2026, to date.

DBH Response:

Please see Question 34. Attachment 1 of 1. Providers.

Q35. Please provide a list and narrative description of any DBH partnerships with District agencies in FY 2025 and FY 2026, to date, to support employment for DBH consumers. Please include the following:

a. *The number of individuals served, the types of employment placements available, and the employee(s) responsible for coordinating the partnership; and*
b. *The number of participants who entered post-secondary or occupation training program, apprenticeships, or District employment programs.*

DBH Response:

The Evidence-Based Supported Employment program serves adult consumers for whom competitive employment has been interrupted or intermittent as a result of significant mental health or substance use challenges. Evidence-Based Supported Employment strives to help enrollees obtain part-time or full-time employment. The individual receives support in a competitive employment setting that pays at least the minimum wage. The program offers intake, assessment, job development, treatment team coordination, disclosure counseling, benefits counseling and follow-along support for all participants enrolled in the program.

DBH provides this program in partnership with the Department of Disabilities Services (DDS) through Rehabilitation Services Administration (RSA) via a memorandum of understanding (MOU). As stipulated in the MOU, DDS provides funding to DBH-certified Evidence-Based Supported Employment programs using a "pay for performance" methodology. Providers receive payment for meeting specified milestones for the following services: job development, job placement, and job stabilization for shared consumers. In FY 25 and to date in FY 26, the partnership with DDS/RSA supported three DBH-certified evidence-based Supported Employment programs listed in the table below.

a. *The number of individuals served, the types of employment placements available, and the employee(s) responsible for coordinating the partnership*

Supported Employment programs served a total of 168 consumers in FY 25 and 54 consumers to date in FY 26. In FY 25, 66 consumers received job placement and retention services, and 25 consumers received job placement and retention services to date in FY26. The average hourly income for FY25 placements is $18.79 (above the DC minimum wage of $17.95).

Supported Employment Placements		
Certified-Provider	FY 25	FY 26
MBI	25	12
PSI	8	
Hillcrest	33	13
Total	66	25

Please see Attachment 1 of 1. Placements Report lists the number and types of placements made by each agency during FY25 and FY26.

Employee/s responsible for coordinating the partnership:

Melody Crutchfield, DBH Supported Employment Program Manager
Catherine Pitts, DBH Supported Employment Program Analyst

b. The number of participants who entered post-secondary or occupation training program, apprenticeships, or District employment programs

DBH Evidence-Based Supported Employment: Training and Education

	FY25	To Date in FY26
Participants Entered Post-Secondary Education Programs	6	1
Occupational Training Programs	0	0
Participated in Apprenticeships	0	0
Entered District Employment Programs	0	0

Additionally, DBH has partnerships with the following District agencies to help residents with behavioral health challenges obtain and keep employment with ongoing support.

Department of Employment Services (DOES)

DBH has a memorandum of understanding (MOU) with the Department of Employment Services (DOES) to provide onsite behavioral health support, screening and referral to DC residents who participate in DOES' Job Readiness Programs, specifically DC Career Connections and Project Empowerment. This partnership also supports DC residents, ages 16-24, who participate in the Out-of-School Program which provides occupational skills training, career awareness counseling, work readiness modules, basic education, GED preparation, supported internship experiences, as well as vocational skills training. In addition, the partnership promotes behavioral health wellness and prepares participants to have a comprehensive and well-rounded experience leading to long term employment success and economic stability. During FY25, there were two (2) DBH onsite clinicians who screened and referred 152 participants to behavioral health resources and services. In FY26 the terms of the MOU changed to support one (1) DBH onsite clinician who is to support the DOES programs to include DC Career Connections, Project Empowerment and the Out of School Programs. To date, DBH has screened and referred 0 DC residents as the position is vacant and is in the process of recruitment. It is anticipated that this position will be filled in February 2026.

Office of the Deputy Mayor for Planning and Economic Development (DMPED) New Communities Initiatives

DBH partners with the Office of the Deputy Mayor for Planning and Economic Development (DMPED) New Communities Initiatives (NCI) to support the behavioral health needs of residents living in the following four NCI neighborhoods: Barry Farm, Park Morton, Lincoln Heights/Richardson Dwelling, and Northwest One. DBH provides two onsite Mental Health Clinical Specialists (MHCS) to provide behavioral health support, screenings/assessments, and linkage to supports and services.

During FY25, the two DBH Mental Health Clinical Specialists were co-located at the four NCI Neighborhood designated sites and provided behavioral health support to 93 residents via screening/assessment, referral/enrollment, care coordination and solution focused sessions. They also provided 24 consultations to the case managers and partners working directly with residents impacted by unaddressed behavioral health needs. The MHCS also conducted 19 behavioral health workshops to the residents who reside in NCI neighborhoods.

In FY26 to date, the Mental Health Clinical Specialists have provided behavioral health support to 42 residents via screening, referral care coordination and brief solution focused sessions. The DBH MHCS provided 4 behavioral health consultations to case managers and partners working with residents of the NCI neighborhoods. During FY26 to date, two (2) workshops have been conducted to the residents who reside in NCI neighborhoods.

The employee responsible for coordinating the partnerships with the Department of Employment Services (DOES), and Office of the Deputy Mayor for Planning and Economic Development (DMPED) is Kim Ray.

Q36. Regarding the MOU with the Department of Human Services Economic Security Administration to provide Supported Employment services to individuals with serious mental illness who receive Temporary Assistance for Needy Families (TANF), how many individuals participated in this program in FY 2025 and in FY 2026, to date?

DBH Response:

DBH has a memorandum of understanding (MOU) with the Department of Human Services (DHS), and Economic Security Administration (ESA) to assist and support TANF participants who may be experiencing behavioral health related barriers that may prevent them from engaging in required work-related activities/employment and/or making progress in their path to recovery. In FY25, 694 participants were screened and referred to DBH providers for ongoing behavioral health services. In FY26 to date, 198 TANF participants have been screened and referred for ongoing behavioral health services.

Through our partnership with DHS, DBH administers behavioral health screenings to TANF participants in order to refer and link those in need to appropriate behavioral health services to address mental health related barriers to employment and recovery. Participants are educated regarding strategies to meaningfully engage in work activities, secure employment, and achieve greater degrees of self-sufficiency. In addition, DBH partners with DHS to support the behavioral health needs of TANF participants connected to TANF Employment Programs (TEP), which provides education and

employment training opportunities/programming to support TANF participants' educational and work-related goals.

Q37. Please provide the list of services currently available as part of the Mental Health Rehabilitation Services (MHRS) system. Please include:

a. *A description of each service, noting any new services;*
b. *Whether it is available as part of the Medicaid MHRS program, the non-MHRS program, or both; and*
c. *The FY 2026 reimbursement rate for each service.*

DBH Response:

Please see attachment "FY 25 Oversight Question 37. Attachment 1 of 1. MHRS Services by Payer and Reimbursement Rates".

Q38. Please provide the monthly MHRS utilization data for FY 2025 and to FY 2026, to date. Please include:

a. *A breakdown of Medicaid MHRS vs. non-Medicaid MHRS;*
b. *For Medicaid MHRS, provide a breakdown by managed care vs. fee-for-service (and include a breakdown by specific managed care organization); and*
c. *For non-Medicaid MHRS enrollees, indicate whether the individual had coverage via private insurance, DC Healthcare Alliance, or was uninsured.*

DBH Response:

Please see attachment, "FY 25 Oversight Question 38 Attachment 1 of 1 MHRS Utilization Data FY 25 and FY 26_Q1".

Q39. Please provide for FY 2025 and FY 2026, to date, the name of all certified MHRS providers. For each provider, please indicate whether the provider utilizes the Medicaid MHRS program, the locally-funded MHRS program, or both.

DBH Response:
Please see Question 39. Attachment 1 of 1. Providers by Funding Type.

Q40. Please provide the following information for all housing programs administered by DBH:

a. *Name of the program, services provided, and eligibility requirements;*
b. *Number of individuals served in FY 2025 and FY 2026, to date.*
c. *Capacity of the program.*
d. *If it has changed since FY 2025, a detailed overview of the application process, eligibility requirements, and necessary documentation for each housing program, including the individuals (DBH staff, case workers, etc.) responsible for each step.*
e. *Performance measures and associated outcomes for each program.*
f. *The name and title of the DBH employee responsible for administering the program; and*
g. *The average wait time for a consumer to access housing through the program.*

DBH Response

a. Name of the program, services provided, and eligibility requirements

DC Local Rent Supplement Program (LRSP)/Site-Based Vouchers
The LRSP is administered by the D.C. Housing Authority (DCHA). The program follows the eligibility requirements and rules and regulations of DCHA's federally funded voucher program. DBH makes referrals for initial occupancy and backfills of vacancies for LRSP vouchers attached to newly renovated or developed units funded with DBH capital dollars for 25 years. The LRSP vouchers are attached to single-room occupancy (SRO) units and to apartments.

Home First Housing Voucher Program
The locally funded Home First Program provides housing rental vouchers for individuals and families who live in the apartment or home of their choice and sign their own rental leases. Consumers pay thirty percent (30%) of their household income to the landlord toward their rent, and the Home First Program subsidizes the balance of the rental amount.

Supported Residences (Licensed Mental Health Community Residence Facilities – CRFs):

Intensive Rehabilitative Residence (IRR)
An intensive level of care for individuals enrolled in the DBH behavioral health system who have medical issues that put them at risk of needing nursing home care if they do not receive physical health care nursing supports with the appropriate mental health rehabilitation services.

Supportive Rehabilitative Residence (SRR)
A SRR CRF provides 24-hour, structured housing support for consumers with severe and persistent mental illness who need an intense level of support to live within the community. The specific services offered include: 24-hour awake supervision; assisting the consumer to obtain medical care; providing training and support to assist consumers in mastering activities of daily living; maintaining a medication intake log to ensure that residents take their medications as prescribed; provision of one-to-one support to manage behaviors or perform functional living skills; arrange transportation to doctor's appointments; assistance with money management; and participation in treatment planning, implementation, and follow-up.

Supportive Residence (SR)
A SR CRF provides on-site supervision when residents are in the facility; medication monitoring; maintenance of a medication log to ensure that medication is taken as prescribed; assistance with activities of daily living; arrangement of transportation; monitoring behaviors to ensure consumer safety; and participation in treatment planning, implementation, and follow-up.

b. and c. Number of Individuals Served in FY25 and FY26-1Q and *Capacity of the program*
In FY25, the capacities of the supported housing program and supported residences were adjusted to align with program funding. In FY25 a total of 1,523 housing slots were in use, while 1,538 individuals were served across all programs. In FY26 Q1, a total of 1,420 people received either a site-based or rental voucher or lived in a supported residence.

Supported Housing Program	FY25 Capacity	Consumers Served FY25	FY26 Capacity	Consumers Served FY26- Q1

Site-based Vouchers				
DBH Capital-Funded Housing (LRSP/Site-Based Vouchers)	220	219	220	221
Rental Vouchers				
Home First (Vouchers)	756	761	736	710
Mental Health Community Residence Facilities (MHCRFs)				
Intensive Residence (IR)	8	8	14	8
Supportive Rehabilitative Residence (SRR)	179	173	149	147
Supportive Residence (SR)	360	377	366	334
Total Supported Housing	**1,523**	**1,538**	**1,485**	**1,420**

d. The application process, eligibility requirements, and necessary documentation for the various programs have not changed over the last several years.

e. Performance measures and associated outcomes for each program

DBH Housing Performance Measures /Outcomes for Consumers – FY25

Quality Domain	Performance Measure	Outcome
Housing Tenure/Stability	75% of consumers will maintain community tenure in independent housing for 12 months or longer	96% of consumers in the community maintained community tenure from October 1, 2024 through September 30, 2025 (FY25)
Housing Occupancy	DBH will maintain an 80% or greater occupancy rate within its subsidized housing program	FY25: The housing subsidy program maintained a 100% occupancy rate. FY26-Q1: The housing subsidy program maintained a 96% occupancy rate.
Availability of Housing Services/Supports	80% of consumers in subsidized housing will enroll with a Core Service Agency (CSA) to receive mental health services and supports	83% of consumers in the housing subsidy program were enrolled with a CSA.
CRF Placement Stability	90% of consumers who remained in the CRF placement for at least 90 days from move-in date, with no psychiatric hospitalizations, incarcerations, crisis bed placements, or involuntary discharges.	83% of consumers placed in a CRF in FY24 had no disruptions within the first 90 days.

f. Name and title of the DBH employee responsible for administering the program
Brandi Gladden, Director – Housing Development Division, is the DBH employee responsible for administering the DBH housing programs.
g. The average wait time for a consumer to access housing through the program
DBH does not maintain a waiting list for housing services. The average time elapsed between referral and placement is approximately 8 – 12 weeks, once the consumer has verified income, submitted an application, and all necessary paperwork & documentation.

Q41. How many Mental Health Community Residential Facilities (MHCRFs) closed in FY 2023, FY 2024, FY 2025, and FY 2026, to date?
m. How many are expected to close in FY 2026?
n. What is the current number of actively running MHCRFs in the District?

DBH Response
CRF Closures – FY2023 through FY2026-1Q

Fiscal Year	No. of CRF Closures	No. of Beds
FY2023	9	65
FY2024	6	32
FY2025	8	49
FY2026-1Q	0	0
Totals	**23**	**146**

a. How many are expected to close in FY 2026?
Operators of eight CRFs announced voluntary closures resulting in a loss of 50 beds.

b. What is the current number of actively running MHCRFs in the District?
The table below lists the number of MHCRFs and level of care as of December 31, 2025.

CRF Level of Care	No. of CRF Operators	No. of Beds
Intensive Rehabilitative Residence (IR)	2	14
Supportive Rehabilitative Residence (SRR)	22	149
Supportive Residence (SR)	55	366
Totals	**79**	**529**

Q42. In FY 2025, and FY 2026 budgets, how much funding did DBH allocate to assist individuals transitioning from institutional settings to community placements using PUSH bridge funds?
a. How many individuals did DBH assist with such transitions in FY 2025 and FY 2026, to date, using PUSH bridge funds?
b. How much of the allocated funding was actually spent on these transitions in FY 2025, and FY 2026, to date?

DBH Response
PUSH Funds for individuals transitioning into Mental Health Community Residence Facilities (MHCRFs) are local dollars paid to CRF Operators, through the D.C. Housing Authority (DCHA).

Fiscal Year	PUSH Funds Paid	Consumers Assisted
FY2025	$673,813	70
FY2026-Q1	$173,759	45

Q43. In FY 2025 and FY 2026, to date, what services and supports has DBH provided to consumers experiencing homelessness, including children, youth (under 18), transition-age youth (ages 18–24), and adults?

a. *Of the total number of youth (0–24) served by DBH during this period, how many and what percentage were experiencing homelessness? Please disaggregate by age group and provide a breakdown of the types of services received.*
b. *What outcomes has DBH reported for homeless individuals, including housing placements, in FY 2024, FY 2025, and FY 2026 to date? Please disaggregate by age group where possible.*

DBH Response:

a. *Of the total number of youth (0–24) served by DBH during this period, how many and what percentage were experiencing homelessness? Please disaggregate by age group and provide a breakdown of the types of services received.*

Please review Attachment 1 of 1 for the total number of youth (0-24) served by DBH in FY25 and FY26 and the number and percentage of youth who were experiencing homelessness.

b. What outcomes has DBH reported for homeless individuals, including housing placements, in FY 2024, FY 2025, and FY 2026 to date? Please disaggregate by age group where possible.

During FY25, DBH provided services to adults experiencing homelessness through the SAMSHA funded grant: Projects for Assistance in Transition from Homelessness (PATH). The PATH team consists of three individuals trained in the Critical Time Intervention (CTI) evidence-based practice. This team engages adults in shelters, encampments, and any place such individuals may be in the community. The goal of is to connect unhoused individuals to a CSA for ongoing behavioral health care, help them access benefits they may be entitled to, and help them navigate the process from homeless to permanent housing. PATH Team works in coordination with community based Homeless Outreach teams to further support unhoused individuals with engagement in housing resources. This team also works with the CSA, if one is already engaged with the consumer, to deliver needed care. In FY 25 the PATH team served 352 adults experiencing homelessness. To date in FY26 the team is engaged with approximately 271 unhoused individuals.

Through the Wayne Place Transition Living Program for Transition Aged Youth (TAY), young adults of transition age,18-24.5 years old, are offered, have access to, and receive developmentally appropriate TAY services, supports, and programming, that is specifically designed to prepare them

to transition into adult roles. The program tailors services to meet the unique goals of each participant, with goal setting and planning designed to reflect individual aspirations and enhance self-efficacy. By aligning program activities with the personal objectives of young adults, the TAY not only increase their confidence, but also become equipped with the necessary tools, skills and resources to make informed and empowered decisions about their futures. Of the 10 TAY successfully discharged from Wayne Place in FY 25, 70% (n=7) reported an improved feeling of self–efficacy and an improved ability to navigate adult / independent situations. Of the seven successful transitions, 42% or three TAY were transitioned to their own apartment; 29% or two transitioned to a room in a shared living space, and another 29% or two transitioned to living with family but were placed on the lease to ensure stability.

In FY 24, 522 adult unhoused consumers were enrolled with PATH. Of the consumers, 447 were connected to a CSA or other community mental health provider and 155 achieved temporary or permanent housing.
In FY 25, 352 adult unhoused consumers were enrolled with PATH. Of the consumers, 208 were connected to a CSA or other community mental health provider and 135 achieved temporary or permanent housing.
In FY26 to date, 271 adult unhoused consumers have been engaged by the PATH team. Of the consumers, 66 are connected to a CSA or other community mental health provider and 10 have achieved temporary or permanent housing.

Q44. In FY 2025 and in FY 2026, to date, what services and support did DBH provide to consumers who identify as LGBTQIA+? Please indicate what services are for children and youth.

DBH Response:

DBH requires that all certified providers offer services (within their scope of practice) to anyone seeking care or to appropriately refer such individuals to a qualified provider, regardless of whether an individual identifies as LGBTQIA+. DBH emphasizes this mandate in our monthly provider meetings to ensure individuals who identify as LGBTQIA+ do not experience barriers to accessing necessary care.

During FY25 and FY26 to date, DBH has focused on providing a range of services to children, youth, and adults who identify as LGBTQIA+. The School Behavioral Health Program (SBHP) clinicians provide prevention, early intervention, and treatment services to children and youth in schools, some of whom identify as LGBTQIA+. SBHP clinicians implemented programming focused on LGBTQIA+ awareness, diversity and inclusion programming for students, parents, and staff. SBHP providers also hosted/host LGBTQIA+ early intervention small groups. SBHP Providers disseminate important information about LGBTQIA+ topics via newsletters to the school community. Additionally, some report that mental health teams collect and share data for students and faculty surrounding LGBTQIA+ questions (identity, how they feel at school, acceptance, etc.) so all can be informed and feel comfortable and included in the school environment.

The DBH Transitional Age Youth (TAY) Team created several social media posts to provide LGBTQIA+ TAY with behavioral health resources and services. These were posted to the TAY Instagram, Facebook, and Twitter pages. Additionally, the TAY teams outreached to programs specifically geared to the LGBTQIA+ community with the purpose of letting LGBTQIA+ young adult know that many of the TAY providers offered a safe place for them to seek and receive support and treatment.

DBH is also aware of and sensitive to the needs of numerous populations in high need across the District and their significantly higher rate of substance use, overdoses and deaths across these populations. Our outreach teams specifically target the needs of these populations with high needs by promoting prevention, treatment, and recovery options while engaging in overdose prevention strategies. Social marketing strategies are focused on raising awareness, offering hope, and informing the communities and populations most affected by the opioid crisis about the available services and supports.

Q45. Which DBH division and staff are responsible for monitoring the quality of care at Core Service Agencies (CSAs), specifically for minors/youth/transition-age youth (under 18 and 22-24yo)?

a. *How does DBH track whether youth referred to CSAs are being connected to therapy services vs medication prescription/management vs both?*
b. *What quality-monitoring strategies is DBH using to track whether youth are receiving appropriate therapeutic care? What metrics of success are available for FY 2025 and FY 2026, to date?*
c. *How is DBH ensuring that youth, especially transition aged youth (18-24), are connected to developmentally appropriate clinicians at a Core Services Agency, rather than only being connected to adult-focused providers and prescribers?*

DBH Response:

The Child/Adolescent/Family Services Administration is responsible for monitoring the quality of care at Core Services Agencies along with technical assistance support from Provider Relations and regulatory support from the Data Quality and Compliance Administration. The Child/Adolescent/Family Services Administration develops, implements and monitors a comprehensive array of prevention, early intervention, and community-based behavioral health services and supports children, youth, and their families that are culturally and linguistically competent; and supports resiliency, recovery and overall well-being for District residents who have mental health and substance use disorders.

The Evidence Based Practice (EBP) Division provides oversight of the design, development, implementation, and evaluation of a comprehensive continuum of evidence-based practices offered to children and youth with mental health and substance-related issues. In addition, the division provides oversight and support of Community Based Intervention (CBI) services for youth in crisis up to age 21. The Division also assists in the implementation and monitoring of children's assessment tools, Child and Adolescent Functional Assessment Scale and Preschool Early Childhood Functional Assessment Scale.

The TAY Division coordinates care for young adults ages 16 to 25 with behavioral health needs as they transition into adult roles. Its goal is to ensure individuals are connected to the right services at the right time, without being placed into inappropriate programs based solely on age. The division promotes treatment coordination; educates young adults, communities, and providers on TAY-related issues; and works to adapt and expand evidence-based practices to better meet the unique needs of this population. It supports evidence-based practice (EBP) training and workshops and provides oversight of DBH's independent living transition programs, helping young adults experiencing homelessness access stable housing options. Additionally, the TAY Division works to expand the number of core service agencies focused on transition-age youth by equipping them with specialized evidence-based treatment training and enabling providers to offer targeted interventions for conditions such as first-episode psychosis (FEP) and clinical high risk for psychosis (CHR-P).

The Provider Relations Division provides technical support to providers to support their compliance with Chapter 34 regulations and quality indicators identified by the Department. This includes but is not limited to technical support on Person Centered Planning, Daily Living Activities (DLA-20), Child and Adolescent Functional Assessment Scale (CAFAS) / Child and Preschool and Early Childhood Functional Assessment Scale (PECFAS), and basic administrative operations. In addition, the Division regularly monitors provider treatment plans & encounter note documentation, audit results, and complaints. Technical assistance is provided based on assessment of identified needs. This may require coordination of support from DC government sister agencies (i.e., Department of Health Care Finance, MCOs, Courts and other clinical divisions within DBH).

a. How does DBH track whether youth referred to CSAs are being connected to therapy services vs medication prescription/management vs both?

In FY24 in preparation for integration of behavioral health services into managed care contracts, providers fully exited from DBH systems and implemented their own organization Electronic Health Records (EHR) system. Enrollment processes were updated which included providers enrolling youth in their EHR system. Since provider's enrollment process has changed, DBH does not have access to the date youth were referred to a CSA. DBH uses claims data to track utilization of therapy and/or medication management for youth who were enrolled and received either service.

b. What quality-monitoring strategies is DBH using to track whether youth are receiving appropriate therapeutic care? What metrics of success are available for FY 2025 and FY 2026, to date?

DBH conducts fidelity monitoring which assesses the quality of services and provider's compliance with model standards. In addition, DBH completes a monthly data analysis to assess utilization, capacity, staffing, and outcomes which informs strategies to increase access, customize training that capture the unique needs of population, and targeted outreach.

See table below for DBH's Key Performance Indicators that were used as metrics to evaluate services for youth offered during FY25.

Measure	**Target**	**FY25 Performance**	**Narrative description of what actions DBH undertook to meet the key performance indicators. For any performance indicators that were not met please provide a narrative description for why they were not met, and any remedial actions taken**
Percent of school-based behavioral health partnership schools with a school based behavioral health provider	70%	59%	Resignations and new hire process ongoing.
Percent of cases who improved on at least one of 3 outcome indicators between initial and most recent children/youth functional assessment (PECFAS/CAFAS)	55%	47%	In FY 25, the average total score on initial assessment was 55 (CAFAS) and 52 (PECFAS). The average total score on the most recent assessment was 46 (CAFAS) and 37 (PECFAS). The initial and most recent assessment scores are in the minimal to low moderate range of impairment. Data showed that children/youth's level of functioning improved over time. On average, nearly half of the youth reported improvements in level of functioning even when their initial assessment was low. In FY26, DBH will continue to offer TOT training and technical assistance with CAFAS/PECFAS implementation per fidelity.
Percent of beneficiaries (age 13+) who received a follow-up service within 30 days after Emergency Department visit for alcohol or other drug use or dependence (HEDIS)	54%	54%	Effective collaboration among hospital staff, the patient and family, and the Community Service Agency team members was critical to facilitating appropriate linkages to community behavioral health services.
Percentage of beneficiaries (Ages 6 to 17) who received clinical follow-up within 30 days of discharge for psychiatric hospitalization (HEDIS)	75%	86%	Comprehensive discharge planning, supported by collaboration among hospital staff, the patient and family, and the Community Service Agency team members, was essential to ensuring appropriate linkage to community-based behavioral health services.

For FY26, DBH will continue to use the measures identified in FY25 and added two additional indicators to measure success. Specifically, data will be collected on the percentage of families whose first contact was within 10 days of referral to Intensive Care Coordination (ICC) and the percentage of children newly admitted to a Mental Health Rehabilitative Services (MHRS) provider who had their first clinical service within 30 days of enrollment.

c. How is DBH ensuring that youth, especially transition aged youth (18-24), are connected to developmentally appropriate clinicians at a Core Services Agency, rather than only being connected to adult-focused providers and prescribers?

While engagement in services remains a personal choice, DBH's Transition-Age Youth (TAY) Division prioritizes educating the community, professionals, and referral sources on the unique needs of the TAY population. The Division provides presentations on the developmental characteristics of transition-age youth and the services available within the District at least quarterly. In addition, the Transition to Independence Process (TIP), the Division's core training required for all TAY providers, is offered biannually.

All other training sponsored by the TAY Division are open to any agency serving transition-age youth. The overarching goal is to ensure that even if an agency elects not to establish a dedicated TAY program, clinicians will still possess developmentally appropriate skills to effectively engage and support young adults.

To date, agencies not formally included in the OurTime service array (agencies with a specific TAY focus) have received training in the following evidence-based and recovery-oriented practices:

- **Seeking Safety** – An evidence-based treatment model addressing co-occurring post-traumatic stress disorder (PTSD) and substance use disorders.
- **Motivational Enhancement Therapy/Cognitive Behavioral Therapy-5 (MET/CBT-5)** – A brief intervention for adolescents with cannabis use disorders consisting of two individual MET sessions followed by three group CBT sessions.
- **Enhanced Illness Management and Recovery (E-IMR)** – A recovery-focused approach designed to support individuals with mental illness in managing symptoms and achieving personal recovery goals.
- **Trauma Recovery and Empowerment Model (TREM)** – A fully manualized, 24- to 29-session group intervention for male or female groups that addresses the impact of trauma.
- **Recovery-Oriented Cognitive Therapy (CT-R)** – A person-centered, strengths-based approach that promotes empowerment, recovery, and resilience by emphasizing individuals' values, aspirations, and capabilities rather than solely focusing on symptom reduction.

Q46. What steps is DBH taking to strengthen the quality-of-care CSA clinicians provide to youth and youth-appropriate clinical connections within the CSA system

a. Please provide all data or metrics collected on training completion rates, youth satisfaction scores, or clinical outcomes that demonstrate progress or impact in these areas.

b. What steps is DBH taking to help CSAs grow their supply of clinicians specially trained to provide developmentally appropriate and affirming care to youth?

c. *Provide data on the number of youth-specialized clinicians added to the CSA system in FY 2024, FY 2025, and FY 2026, to date, and anticipated growth for the remainder of FY 2026.*

DBH Response:

DBH provides a comprehensive menu of Evidence-Based Practices (EBPs) for early childhood through young adulthood to include Attachment Biobehavioral Catch-Up (ABC); Child Parent Psychotherapy (CPP); Parent Child Interaction Therapy (PCIT); Trauma-Focused Cognitive Behavioral Therapy (TF-CBT); Trauma Systems Therapy (TST); Functional Family Therapy (FFT); Multi-Systemic Therapy (MST); Intensive Home and Community-Based Services (IHCBS); Motivational Enhancement Treatment- Cognitive Behavioral Therapy (MET-CBT); and Transition to Independence Process (TIP). DBH contracts with a vendor to provide implementation support which includes training, consultation, fidelity monitoring, and data analysis. Training courses are offered to enhance and sustain the current workforce. In addition, fidelity monitoring assesses the quality of services and provider's compliance with model standards. Lastly, DBH completes a monthly data analysis to assess utilization, capacity, staffing, and outcomes which is used to customize training to meet the unique needs of youth and youth-appropriate clinical connections within the CSA system.
a. In FY24, 20 new clinicians were trained in EBP models. In FY25, 19 new clinicians were trained, and in FY26, two new clinicians completed training. Additionally, in FY26, two new child and youth providers were certified as Core Service Agencies who provide therapy, medication management, and community support. DBH has also scheduled additional evidence-based trainings for new clinicians and anticipates continued growth.

DBH collaborates with the Consumer and Family Affairs Division to collect feedback regarding community mental health and substance use services. Caregivers completed the Youth Services Survey for Families (YSS-R). Results from the FY24 YSS-R survey indicate that about 73% of caregivers were satisfied with services whereas 69% of caregivers were satisfied in FY25. During FY25, 80% of caregivers reported they would recommend their provider to a friend or family member.
To monitor outcomes of children and youth receiving services, DBH requires all providers to utilize the Preschool and Early Childhood Functional Assessment Scale (PECFAS), which is used for children ages 3-5 years old and the Child and Adolescent Functional Assessment Scale (CAFAS), which is used for ages 6-20 years old. The PECFAS/CAFAS is used to guide treatment planning, support cross system collaboration, and to provide information on the effectiveness of various services for children and youth. In FY 25, the average total score on initial assessment was 55 (CAFAS) and 52 (PECFAS). The average total score on the most recent assessment was 46 (CAFAS) and 37 (PECFAS). Scores decreased from initial assessment to most recent assessment indicating improvement in functioning across domains.
b. As noted above, DBH continues to offer evidence-based training for new and current Clinicians. DBH also has an internship program within the School Behavioral Health Program and maintains affiliation agreements with 10 universities and colleges. They include: Catholic University, Columbia University, Howard University, George Mason University, Salisbury University, Tulane University, University of Maryland, University of New England, Virginia Commonwealth University, and Yeshiva University.

During FY26, DBH's internship program supported nine graduate level students (four from Columbia University, three from Catholic University, one from Howard University and one from Salsbury

University). Working with interns to support their professional development helps to strengthen the workforce pipeline.

In addition to supporting interns, DBH and OSSE staff are working with the Advancing the Recruitment and Retention of our Workforce (ARROW) grant to provide additional training and support to young behavioral health professionals. Young professionals may apply to be part of the First Year Cadre, which provides behavioral health professional development opportunities for individuals new to delivering services in school settings. Clinicians attend trainings, connect with peers, and receive resources. The additional support is intended to help retain clinicians.

c. DBH does not currently track the total number of youth-specialized clinicians added to the CSA system.

Q47. What is DBH's projected timeline, criteria, and process for certifying TAY Choice Providers?

a. *Will DBH implement a standardized training curriculum or requirement for providers serving TAY to qualify as a "Choice Provider?" If so, what is the status of the development or implementation of these trainings?*
b. *How many clinicians have completed TAY-specific training modules to date? Provide a count for completions in FY 2025 and, FY 2026, to date.*
c. *How many providers does DBH anticipate will qualify as Choice Providers in FY 2026?*

DBH Response:

The criteria for certifying Transition-Age Youth (TAY) Choice Providers has been established. At a foundational level, all TAY Choice Providers will be trained in the Transition to Independence Process (TIP), operate from a trauma-informed framework, and offer evidence-based treatments such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and/or the Trauma Recovery and Empowerment Model (TREM). Providers will also be equipped to address dual-diagnosis needs among TAY through Motivational Enhancement Therapy/Cognitive Behavioral Therapy–5 (MET/CBT-5).
In addition, a subset of providers will offer specialized services targeting specific clinical needs, including First Episode Psychosis (FEP) and individuals at Clinically High Risk for Psychosis (CHR-P). All TAY Choice Providers will support teams of TAY-focused, certified peer support workers who assist youth and young adults in navigating complex service systems.
The certification process is currently under development and is expected to be modeled after the Children's Choice Provider process. A timeline for implementation will be established once the certification framework is finalized.

a. The Transition to Independence Process (TIP) is one of the evidenced based practices specifically developed for young adults and serves as the minimum requirement for providers serving transition aged youth. The TIP approach is designed to support young adults from age 14 to 29 with emotional and behavioral difficulties as they transition into adult roles. It focuses on TAY engagement and futures planning with the aim of helping TAY achieve self-sufficiency across transition domains including Employment and Career; Education; Living Situation; Personal Effectiveness/Well-being; and Community Life Functioning. Training for this EBP has been offered two times per year.

b. Please see the table below for the number of individuals (not clinicians) who have completed TAY-specific training modules in FY 2025 and, FY 2026:

Model	Number in FY 25	Number in FY 26 (YTD)
Transition to Independence Process (TIP)	15	6
Cognitive Behavioral Therapy for Psychosis (CBT-P)	6	n/a
Enhanced Illness Management and Recovery (E-IMR)	13	10

c. Pending the finalization and approval of the certification framework, DBH anticipates two providers immediately qualifying as a TAY Choice Provider.

Q48. Please provide a list of Community-Based Intervention (CBI) providers, reflecting active providers in FY 2024, FY 2025, and FY 2026.

DBH Response:

Below is the list of CBI providers in FY 2024, FY 2025, and FY 2026.

FY24	**FY25**	**FY26**
Better Morning	Better Morning	Better Morning
Hillcrest Children's Center	Hillcrest Children's Center	Hillcrest Children's Center
Maryland Family Resources, Inc.	Maryland Family Resources, Inc.	Maryland Family Resources, Inc.
MBI Health Services	**MBI Health Services	N/A
*Life Enhancement Services	N/A	N/A
Umbrella Therapeutic Services	Umbrella Therapeutic Services	Umbrella Therapeutic Services

*In FY24, Life Enhancement Services closed its CBI program.
**In FY25, MBI closed its CBI program.

Q49. How many Assertive Community Treatment (ACT) providers are currently certified by DBH, and how many of them can accept new referrals? Please provide a list of those providers currently accepting new referrals.

DBH Response:

There are currently eight DBH-certified Assertive Community Treatment (ACT) providers delivering ACT services in the network, with 21 distinct ACT teams among them. Each ACT team has the capacity to potentially serve approximately 100 consumers. All ACT providers are currently accepting referrals.

Provider	**Number of ACT Teams**	**Number of Current Consumers**	**Availability**
Anchor	2	118	7 additional consumers may be accepted based upon their current staffing
City Care	2	136	64
Community Connections	5	469	31
Hillcrest	3	231	69
Lifecare	1	108	5 - additional consumers may be accepted based upon their current staffing
MBI	5	396	104
Pathways	2	139	61
Prestige	1	75	25

Q50. Comagine took over as the third-party authorizer for MHRS Community Support Services (CSS) on October 6, 2025.

a. *What oversight is DBH providing to ensure that Comagine complies with its contractual obligations to the District? Please describe DBH's role in reviewing Comagine's decisions regarding MHRS Community Support Services (CSS) authorization.*
b. *How many unique consumers who were previously authorized for CSS have now had their CSS terminated?*
c. *How many have since been authorized for a higher level of care, such as ACT?*

DBH Response*:*

Beginning October 2, 2025, DBH certified providers began to register clients and submit requests for community support services through Comagine Health. For dates of service beginning November 1, 2025, providers must include a prior authorization number with the claim in order for the services to be reimbursed.

a. DHCF manages the contract with Comagine Health. DBH and DHCF agreed to engage Comagine Health for CSS because of their experience working in utilization management and

quality improvement of services. The expected benefit of the contract includes improved safeguards against unnecessary or inappropriate use of Medicaid services, ensuring provision of appropriate care through prospective, concurrent, and retrospective reviews of services, improved data gathering and reporting, and the identification of fraud, waste, and abuse.

DBH meets regularly with DHCF and Comagine Health to monitor provider progress, review data and provide feedback.

b. MHRS Providers are required to request authorization for all clients for whom they provide community support services. If the documentation requirements are met, an administrative authorization will be issued to the provider. The prior authorization process does not and has not resulted in the termination of services for clients, rather a provider must ensure that the required materials have been submitted so that services can be authorized.

c. Beginning in April 2026, the authorization review requirements will incorporate the DLA 20 functional assessment score. This change will align community support utilization with standards that ensure consumers receive the appropriate level of care based on their current behavioral health needs.

Q51. Please provide an update on DBH's Intensive Care Coordination (ICC) and High Fidelity Wraparound (HFW) program. For FY 2024, FY 2025, and FY 2026, to date, include the following:

o. Links to any DBH policies or guidance documents developed to implement the new ICC regulations;
p. Description of how DBH monitors provider compliance with ICC standards, including staff caseloads and adherence to required timelines;
q. Current capacity of DBH and other District agency providers to deliver ICC/HFW services;
r. Description of how ICC/HFW is currently delivered by DBH and other agency providers;
s. How individuals access ICC/HFW services through DBH and other agencies;
t. Number of individuals who received ICC/HFW through DBH and other agencies (broken down by agency);
u. Any short-term or long-term plans to expand flex funding for youth receiving ICC;
v. Total flexible funding spent in FY 2024, FY 2025, and FY 2026, to date, (per D.C. Mun. Regs. Subt. 22-A, § 3436.17), and what services or supports were covered;
w. Number of children or youth in FY 2024, FY 2025, and FY 2026, to date, who requested or were referred for placement at a Psychiatric Residential Treatment Facility (PRTF) or non-PRTF residential placement, and how many received such placements; and
x. Any outcome evaluations or reports from FY 2024, FY 2025, and FY 2026, to date, with links if available.

DBH Response:

a. *Links to any DBH policies or guidance documents developed to implement the new ICC regulations*

Please see Attachment 1 which includes the Chapter 34 Regulations- Section A3436- Intensive Care Coordination and describes ICC services. Attachment two is an ICC Bulletin issued in June 2026 which provides information regarding ICC Flex Funds.

b. *Description of how DBH monitors provider compliance with ICC standards, including staff caseloads and adherence to required timelines;*

DBH currently has a contract with NWIC/UCONN to provide coaching. DBH staff are in the process of obtaining local coach certification which includes training, coaching, and fidelity monitoring. Once certification is received, DBH will not need to maintain the existing coaching contract to support the monthly coaching sessions with ICC provider leadership and the model expert where staffing updates are shared, documentation is reviewed, and model standards are discussed. In addition, DBH monitors monthly reports that include utilization, program data, and fidelity adherence data. Lastly, DBH facilitates monthly provider meetings to review policies and procedures.

c. Current capacity of DBH and other District agency providers to deliver ICC/HFW services;

ICC provider	FY 24 (Capacity)	FY25 (Capacity)	FY26 YTD (Capacity)
Mecca	60	50	N/A
MBI	120	202	57
Better Morning	N/A	20	20

Mecca discontinued ICC services in February 2025, and Better Morning was certified as an ICC provider in May 2025.

d. Description of how ICC/HFW is currently delivered by DBH and other agency providers;

Intensive Care Coordination uses the High Fidelity Wraparound model and is delivered through a Wraparound Team Meeting (WTM) process. ICC supports a child and youth and their family in establishing a family vision and identifying goals. The Wraparound Team works collaboratively with the child or youth and their family (including biological, kin, foster, adoptive, and fictive kin) to develop, implement, monitor, and adapt a family-driven and youth-guided individualized plan of care (IPC) that identifies goals and the strategies needed to achieve them.

DBH has certified two providers to deliver the ICC model to children or youth and their families.

e. How individuals access ICC/HFW services through DBH and other agencies;

To access ICC services, individuals contact ICC providers to discuss the family's needs and determine eligibility. The ICC referral packet is submitted directly to the ICC providers. Completed referrals are reviewed within 48 hours of submission. Upon approval, the ICC provider assigns an ICC Care Coordinator within 72 hours. Families are contacted within 48 hours of the Care Coordinator's assignment to begin services.

f. Number of individuals who received ICC/HFW through DBH and other agencies (broken down by agency);

ICC provider	FY24	FY25	FY26 YTD
Mecca	19	28	N/A
MBI	101	174	138
Better Morning	N/A	10	2

Mecca discontinued ICC services in February 2025, and Better Morning became certified as an ICC provider in May 2025.

g. Any short-term or long-term plans to expand flex funding for youth receiving ICC;

DBH currently has two providers certified to provide ICC services. As a certified provider, each child or youth receiving ICC services may receive up to a one thousand dollar ($1,000) flexible funding allotment per calendar year as needed for non-Medicaid reimbursable services and supports that are included in their treatment plan. At this time there are no short-term or long-term plans to expand flex funding for youth receiving ICC; however, DBH will continue to monitor the need and review and analyze data on a quarterly basis to inform future decisions.

h. Total flexible funding spent in FY 2024, FY 2025, and FY 2026, to date, (per D.C. Mun. Regs. Subt. 22-A, § 3436.17), and what services or supports were covered;

In FY24 and FY25, flex funding expenditures totaled $11,770 and $9,995, respectfully. In FY26, $1,000 in flexible funding has been expended to date. Flex funding supported services and supports such as transportation, recreational activities, and emergency housing.

i. Number of children or youth in FY 2024, FY 2025, and FY 2026, to date, who requested or were referred for placement at a Psychiatric Residential Treatment Facility (PRTF) or non-PRTF residential placement, and how many received such placements; and

In FY24, two youth were referred for placement at a PRTF and one youth received a PRTF placement. In FY25, five youth were referred for placement at a PRTF and one youth received the placement. The remaining referrals are currently pending placement. In FY26 YTD, there were no referrals or placements.

j. Any outcome evaluations or reports from FY 2024, FY 2025, and FY 2026, to date, with links if available.

In FY24, 47 youth were discharged from ICC. Of the 47 youth, 33 youth (70%) were discharged successfully and 14 youth (30%) discharged unsuccessfully. In FY25, 244 youth were discharged from ICC. Of the 244, 169 youth (69%) were discharged successfully and 72 youth (30%) discharged unsuccessfully. In FY26 YTD, 15 youth were discharged from ICC and all youth were discharged successfully.

Q52. Please provide a detailed accounting of all Opioid Settlement Funds that have been received by the District, including:

a. *The total amount of Opioid Settlement Funds received to date;*
b. *The specific amount of funds transferred to DBH and the dates of these transfers.*
c. *If any portion of the funds is being held by other District agencies, please specify the amount and the agency responsible for managing these funds; and*
d. *An estimate of the amount of Opioid Settlement Funds the District anticipates receiving in FY 26.*

DBH Response

a. *The total amount of Opioid Settlement Funds received to date:*

The Office of Attorney General reports deposits of $32,973,554.02 to date.

b. The specific amount of funds transferred to DBH and the dates of these transfers:

Opioid Abatement Fund Deposits as of January 1, 2026		
Defendant	**Payment Date**	**Amount Received**
McKinsey	4/1/2021	$897,620.83
McKinsey	4/1/2022	$46,334.23
McKesson	5/31/2022	$1,838,652.11
McKesson	9/15/2022	$2,082,409.82
Johnson & Johnson	10/18/2022	$6,638,061.12
McKinsey	4/3/2023	$46,334.23
Mallinckrodt	5/24/2023	$275,365.55
Johnson & Johnson	6/16/2023	$75,705.79
McKesson	8/2/2023	$2,055,574.13
Mallinckrodt	11/9/2023	$323,959.47
Allergan Payment 1	1/31/2024	$555,142.32
CVS Payment 1	1/31/2024	$618,190.36
Teva Payment 1	1/31/2024	$500,960.07
Walgreens Payment 1	1/31/2024	$715,166.18
Walgreens Payment 2	1/31/2024	$481,099.72
Walmart Payment 1	1/31/2024	$1,871,257.28
Walmart	2/29/2024	$2,992,707.92
Manufacturers & Trust	3/15/2024	$940,237.95

Publics Health LLC	3/27/2024	$617,322.76
Publics Health LLC	4/1/2024	$5,000.00
McKinsey	4/3/2024	$46,334.23
Manufacturers & Trust-Janssen	6/17/2024	$70,298.23
CVS Payment 2	7/31/2024	$494,600.34
Manufacturers & Trust	7/31/2024	$2,136,187.97
Allergan Payment 2	7/31/2024	$560,217.20
Teva Payment 2	8/2/2024	$553,542.44
Endo Public Opioid Trust	10/10/2024	566,957.24
Endo Public Opioid Trust	10/10/2024	24,792.10
National Opioids Trust Walgreens	1/15/2025	9,042.27
Kroger Section IV.C (ref 2504301302577)	3/31/2025	201,578.86
Kroger Section IV.C (ref 2504301302578)	3/31/2025	201,578.86
Walgreens #3	3/31/2025	472,057.46
McKinsey	4/3/2025	46,334.23
Mallinckrodt	4/30/2025	83,349.57
Manufacturers & Trust	8/8/2025	1,922,569.17
National Opioid Trust CVS	8/8/2025	935,719.36
National Opioid Trust Allergan	8/8/2025	504,195.48
National Opioid Trust Teva	8/8/2025	498,188.20
National Opioids Trust Walgreens	9/15/2025	68,908.97
Total		**$32,973,554.02**
Source: Reported by the Office of the Attorney General		

c. *If any portion of the funds is being held by other District agencies, please specify the amount and the agency responsible for managing these funds:*
No portion of the funds ($0) is being held by other District agencies.

d. *An estimate of the amount of Opioid Settlement Funds the District anticipates receiving in FY 26:*
The Office of Attorney General has projected that the Opioid Abatement Fund will receive $5,054,254.33 by the end of FY 26.

Q53. Please provide a detailed list in spreadsheet format of all Opioid Settlement Funds that have been expended to date. For each expenditure, please include the following information:

a. Recipient name.
b. Amount awarded.
c. Grant or contract period.
d. Specific purpose or project for which the funds were allocated; and

e. Metrics or outcomes that will determine success of the expenditure.

DBH Response

This award list reflects initiatives that have been awarded to date (February 15, 2024 to January 16, 2026). There are a total 43 awardees with a total award amount of $19,803,046 to date. This includes awards made in FY24, FY25, and new awards that have been made in FY26 to date. More initiatives are currently under review for award-making in FY26.

Please see FY25 Oversight Q 53, Attachment 1 of 1, Opioid Settlement Fund Details

Q54. Please describe how DBH will serve as a consulting agency to DC Health as required in B25-0759, the Child Behavioral Health Services Dashboard Act of 2024.

a. Will DBH incorporate the Behavioral Health Resource Link into LinkU to streamline navigation services for DC residents?
b. How will DBH incorporate behavioral health resources through DBH's School-Based Behavioral health program into LinkU (the directory)?

DBH Response:

DBH is actively involved in collaboration and consultation with DC Health regarding the Child Behavioral Health Services Dashboard and LinkU directory integration. DC Health is working with DBH to implement all of the required components of the Child Behavioral Health Services Dashboard legislation. DBH has completed a spreadsheet that will be used by the vendor's Curation Team to upload the required information into the system.

a. Currently, under the South Capitol Street Memorial Amendment Act of 2012, DBH is legislatively mandated to maintain an online resource directory. However, DBH is open to exploring the integration of the resource directory into the LinkU dashboard. DBH supports streamlining the navigation of services for DC residents to identify and access available resources and is interested in structuring this integration in a manner that does not risk noncompliance with existing statutory mandates.

b. During January 2026, DBH will provide DC Health and its vendor with information to support search functionality for school behavioral health resources across schools. This will include filters for age of population served, services provided, types of therapy offered, and languages spoken by DBH-funded resources in DC public and public charter schools. DBH will also explore the feasibility of including a hyperlink from each school's dashboard page to the corresponding DBH website location where DBH-funded resource listings are updated monthly.

Q55. How many children and youth (age 0-21) received a service through MHRS during FY 2025 and FY 2026, to date? Please include a breakdown by service, age, race, gender, ethnicity, and ward.

DBH Response:

Please see the attachment for the total number of children and youth (ages 0-21) who received a service through MHRS during FY25 and FY26 YTD.

Q56. For FY 2024, FY 2025, and FY 2026, to date, please provide the amount budgeted and spent on each DBH program, service, or cost center that serves children and youth (ages 0-21). If the program, service, or cost center serves both children, youth, and adults, please share the funding spent specifically on children (ages 0-21).

a. *For each program, service, or cost center, please provide a breakdown of the amount of local, federal, private, and special revenue funding for FY 2024, FY 2025, and FY 2026 to date, and a narrative description of the program, cost center, or service, including the specific age group(s) served.*

DBH Response:

Below is a description of the Child/Adolescent Family Services Administration (CAFS) and programs:

Child/Adolescent/Family Services Administration –develops, implements and monitors a comprehensive array of prevention, early intervention, and community-based behavioral health services and supports for children, youth, and their families that are culturally and linguistically competent; and supports resiliency, recovery and overall well-being for District residents who have mental health and substance use disorders.

Behavioral Health Services MH/SUD – oversees development, implementation and monitoring of a comprehensive array of community-based mental health and substance use disorders services including evidenced-based and promising practices, implemented within the behavioral health provider network to address the needs of adults, children, youth, and their families. Leads the oversight and management of the agency's integrated community-based, prevention, early intervention, and specialty behavioral health programs.

SUD Prevention and Treatment –ensures comprehensive prevention systems by developing policies, programs, and services to prevent the onset of illegal drug use, prescription drug misuse and abuse, alcohol misuse, and abuse, and underage alcohol and tobacco use. Oversees the provision of substance use treatment for children and adolescents and transition-aged youth by ASTEP providers.

School Based Behavioral Health Services – provides school-based, primary prevention services to students and school staff, early intervention and treatment services to students and parents, and consultation to individual teachers and school administrators in public and public charter schools within the District.

Crisis Services– through the ChAMPS contract provide crisis intervention and stabilization services to residents and visitors who are experiencing psychiatric crisis in the community or at home; services include linkage to DBH, psycho education, treatment compliance support, and grief and loss services to individuals after atraumatic event.

Court Assessment – provides the Superior Court of the District of Columbia with court-ordered, high-quality, comprehensive, and culturally competent mental health consultation, and psychological and psychiatric evaluations, for children and related adults with involvement in child welfare, juvenile justice, and family court.

Early Childhood Services – provides in home and center-based early childhood mental health supports and child and family-centered consultation to child development center staff and families to build their skills and capacity to promote social/emotional development and to prevent, identify, and respond to mental health issues among children in their care.

Specialty Services – provides centralized coordination and monitoring of placement, continued stay, and post-discharge of children and youth in psychiatric residential treatment facilities (PRTF). Oversees the coordination of the PRTF medical necessity review process. Supports Juvenile Court by providing Juvenile Behavioral Diversion Program and Hope Court that conduct mental health and substance use disorder screening, assessments, and referrals for youth, and families involved with the courts ensuring they have easy access to a full continuum of quality behavioral health services and supports. DC MAP supports the provision of screening and psychiatric consultation in pediatric practices. Co-Located Services oversees the co-location of DBH clinician at CFSA to facilitate early behavioral health screenings, assessments, and consultations with CFSA social work staff and to make service referrals to the behavioral health provider network.

Government Operated Services - Howard Road – provides early childhood treatment services through the Parent Infant Early Childhood Enhancement Program (PIECE) program for children ages 0-7. Provides same day Urgent Care Psychiatric Evaluations for youth ages 0-18 years of age.

Evidence Based Practice (EBP)– provides oversight of the design, development, implementation, and evaluation of a comprehensive continuum of evidence-based practices offered to children and youth with mental health and substance-related issues. In addition, the division provides oversight and support of Community Based Intervention (CBI) services for youth in crisis up to age 21. The Division also assists in the implementation and monitoring of children's assessment tools, Child and Adolescent Functional Assessment Scale and Preschool Early Childhood Functional Assessment Scale.

See Attachment 1 of 1. FY 24, FY 25, and FY 26 budget for the CAFS Administration.

Q57. How many unique youth received inpatient behavioral health treatment at either the Psychiatric Institute of Washington (PIW), Children's National Hospital or other inpatient hospitals during FY 2024, FY 2025, and FY 2026, to date?

DBH Response:

Please see Attachment 1 of 1 for the number of unique youth who received inpatient behavioral health treatment at either PIW or Children's National Hospital or other inpatient hospitals during FY24, FY25, and FY26 YTD.

Table 1 reports the total number of unique youth who received inpatient treatment across hospitals.
Table 2 lists the youth who received inpatient services at each individual hospital.
The higher total in Table 2 reflects that some youth received services at multiple hospitals within the same fiscal year.

Q58. For those children and youth about whom DBH receives notification of discharge, please list the following information for FY 2025, and FY 2026, to date, for each hospital:

a. *The number of children and youth who were discharged within (a) one to 10 days, (b) 11 to 30 days, (c) 31 to 60 days (d) more than 60 days;*
b. *The number of times a child or youth was readmitted two or more times during the past three year to either one or any of the hospital;*
c. *The number of Youth who were connected to a CSA within (a) 5 days of discharge from the institution, (b) 10 days of discharge, (c) more than 10 days of discharge, (c) more than 20 days of discharge, (d) more than 40 days of discharge, (e) more than 60 days;*
d. *The number of Youth who were assessed or evaluated by a CSA within (a) 5 days of discharge from the institution, (b) 10 days of discharge, (c) more than 20 days of discharge, (d) more than 40 days of discharge, (e) more than 60 days; and*
e. *The number of Youth who received mental health treatment from a CSA within (a) 5 days of discharge from the institution, (b) 10 days of discharge, (c) more than 20 days of discharge, (d) more than 40 days of discharge, (e) more than 60 days.*

DBH Response:

Please see Attachment 1 of 1 that describes information regarding children and youth inpatient discharges.

Q59. Please provide a breakdown of the number of children and youth seen at 821 Howard Road in FY 2024, FY 2025, and FY 2026 to date. Include the number of Medicaid-eligible clients and the total Medicaid billing amount for each fiscal year.

DBH Response:

During FY 24, 260 children were served at 821 Howard Road. In FY 25, 325 youth were served, and 162 youth have been served in FY 26 to date. All children seen at 821 Howard Road were Medicaid-eligible clients.

Q60. Please provide a breakdown of the complaints, grievances, or concerns received by DBH from or on behalf of youth during FY 2024, FY 2025, and FY 2026, to date. What were the most common issues raised?

DBH Response:

In FY24, DBH's Ombudsman Office received six complaints related to services provided to youth. In FY25, five complaints were received by DBH. To date in FY 26, DBH has not received any youth-related complaints. The most common issue was access to care. Some youth and families reported challenges with understanding how to access and engage in services. The second most common issue identified was challenges related to discharges. Youth and families noted that sometimes discharges were initiated without notification and others noted that there was a failure to honor a discharge request.

To promote available services and encourage treatment, DBH uses multiple opportunities to engage youth and families about the multiple entry points to access services which include contacting providers directly and contacting the Access Helpline. DBH hosts monthly meetings with providers to discuss concerns to include enrollment and discharge protocols. In addition, DBH hosts and participates in roundtable discussions with sister agencies and community partners to trouble shoot access and engagement concerns. When contacted by families directly, DBH assists with contacting agencies to connect families with services and resolve any staff concerns.

Q61. Please provide a list of DBH providers that offered or will offer the following services to youth in FY 2025, and FY 2026, to date?

a. *Community-Based Intervention (CBI) – Levels I, II, III, IV;*
b. *Functional Family Therapy (FFT);*
c. *Assertive Community Treatment (ACT);*
d. *Transitional Assertive Community Treatment (TACT);*
e. *Transition to Independence Program (TIP); Intensive Care Coordination (ICC) and/or High Fidelity Wraparound (HFW);*
f. *Therapeutic Foster Care (TFC);*
g. *Respite Services (RS);*
h. *Community Support (CS); and*
i. *Other evidence-based treatments for youth provided under the Medicaid State Plan.*

DBH Response:

a. Below is a list of providers who offered Community-Based Intervention (Levels I, II, III, IV) services during FY25 and FY26 YTD:

FY25	**FY26**
Better Morning (CBI II, III)	Better Morning (CBI II, III)
Hillcrest Children's Center (CBI II, III)	Hillcrest Children's Center (CBI II, III)
Maryland Family Resources, Inc. (CBI II, III)	Maryland Family Resources, Inc. (CBI II, III)
MBI Health Service (CBI I, II, III)	
Umbrella Therapeutic Services	Umbrella Therapeutic Services

As of FY23, CBI IV, which utilized the FFT model, was removed from the CBI umbrella and established as a stand-alone service. In FY 25, MBI Health Services closed their CBI I, II, and III programs.

b. Below is a list of providers who offered Functional Family Therapy (FFT) in FY25 and FY26 YTD:

FY25	**FY26**
Better Morning	
Parent & Adolescent Support Services (PASS)	Parent & Adolescent Support Services (PASS)

In FY25, Better Morning discontinued its FFT program.

c. Below is a list of providers who offered Assertive Community Treatment in FY25 and FY26 YTD:

FY25	**FY26**
Anchor	Anchor
City Care	City Care
Community Connections	Community Connections
Hillcrest	Hillcrest
Lifecare	Lifecare
MBI	MBI
Pathways	Pathways
Prestige	Prestige

d. Below is a list of providers who offered TACT during FY25 and FY26 YTD:

FY25	**FY26**
MBI	MBI

e. Below is a list of providers who offered Transition to Independence Process (TIP) in FY25 and FY26:

FY25	**FY26**
Life Enhancement Services	Life Enhancement Services
Umbrella Therapeutic Services	Umbrella Therapeutic Services
MBI	MBI
Parent & Adolescent Support Services (PASS)	Parent & Adolescent Support Services (PASS)

Below is a list of providers who offered Intensive Care Coordination (ICC) during FY25 and FY26:

FY25	**FY26**
Better Morning	Better Morning
MBI	MBI
Mecca	N/A

Mecca discontinued its ICC services in February 2025.

f. DBH does not provide therapeutic foster care for youth. DBH partners with agencies including the Department of Youth Rehabilitative Services (DYRS) and the Child and Family Services Agency (CFSA) that provide therapeutic foster care for youth under their supervision. DBH works with certified providers to ensure service delivery is consistent across community settings for youth and families.

g. DBH does not offer respite services for youth but partners with community partners, including Sasha Bruce Network, Child and Family Services, and Health Services for Children with Special Needs who provide these services.

h. Below is a list of providers who offered Community Support during FY25 and FY26:

FY25	**FY26**
	Gio Health Services
Hillcrest Children's Center	Hillcrest Children's Center
Inner City Family Services	Inner City Family Services
Latin American Youth Center	Latin American Youth Center
Life Enhancement Services	Life Enhancement Services
Maryland Family Resource Inc.	Maryland Family Resource Inc.
MBI Health Services	MBI Health Services
New Hope Health Services	New Hope Health Services
Preventive Measures	Preventive Measures
PSI	PSI
Spring Leaf Solutions	Spring Leaf Solutions
Umbrella Therapeutic Services	Umbrella Therapeutic Services

Gio Health Services obtained certification to provide Community Support Services in FY26.

i. Other evidence-based treatments for youth provided under the Medicaid State Plan include Child Parent Psychotherapy (CPP), Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), and Trauma Systems Therapy (TST).

Below is a list of providers who offered Child Parent Psychotherapy (CPP) during FY25 and FY26:

FY25	**FY26**
Mary's Center	Mary's Center
DBH	DBH

Below is a list of providers who offered Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) during FY25 and FY26:

FY25	**FY26**
Latin American Youth Center	Latin American Youth Center
Hillcrest	Hillcrest
Maryland Family Resource	Maryland Family Resource

Below is a list of providers who offered Trauma Systems Therapy (TST) during FY25 and FY26:

FY25	**FY26**
Latin American Youth Center	Latin American Youth Center
Hillcrest	Hillcrest
Maryland Family Resource	Maryland Family Resource

Q62. For each of the services listed in Q61, please provide the following data for FY 2025 and FY 2026:

a. Number of unique youth who requested the service
b. Number of unique youth referred to the service;
c. Number of unique youth who received the service;
d. Average wait time from request to receipt and from referral to receipt in FY 2025;
e. Number of youth who received more than one of these services; and
f. Duration of service received:
    i. Less than 90 days;
    ii. Between 91 and 180 days; and
    iii. *More than 180 days.*

DBH Response:

a. In FY24, in preparation for integration of behavioral health services into managed care contracts, providers fully exited from DBH systems and implemented their own organization Electronic Health Records (EHR) system. Enrollment processes were updated to where youth and families enrolled directly with providers. In addition, youth and families contacted providers directly to request services; therefore, DBH does not have data regarding the number of youth who requested a specific service.

b. Services requiring prior authorization, including CBI and ACT, require referrals and are submitted directly to DBH for processing. The other listed services are accessed directly through providers, and DBH does not maintain referral data on those services.

Please see Attachment 1 for the number of unique youth referred to the CBI and ACT.

c. Please see Attachment 1 for the number of unique youth who received each service.

d. Please see Attachment 1 for the average wait time from request to receipt and from referral to receipt in FY 2025 for youth who received CBI and ACT.

e. Please see Attachment 1 for the number of youth who received more than one of these services.

f. CBI and ACT require prior authorizations. Authorizations are issued for 180 days for CBI Level I, CBI Level II, and ACT. For CBI Level III, authorizations are issued for 90 days. If a youth meets medical necessity for additional treatment, CBI and ACT providers submit a continued stay request, which is reviewed and processed by DBH. The other services do not require prior authorizations; however, providers are responsible for delivery services in accordance with model fidelity requirements. DBH does not have data on the duration of services received for the other listed services.

Q63. For each of the services listed in Q61, please provide the number of youth under the custody of CFSA who:

a. Received the service (disaggregated by service and CBI level);
b. Requested but did not receive the service;
c. Number of youth committed to DYRS who;
d. Received the service (disaggregated by service and CBI level); and
e. Requested but did not receive the service.

DBH Response:

a-b. Please see Attachment 1 for the number of CFSA youth who received a service listed in Q.61 in FY25 and FY26 YTD. There were no CFSA youth who requested a service but did not receive at least one service.

c-e. Please see Attachment 1 for the number of DYRS youth who requested a service listed in Q.61 in FY25 and FY26 YTD. There were no DYRS youth who requested a service but did not receive at least one service.

Q64. Please provide the following information for the Children and Adolescent Mobile Psychiatric Service (ChAMPS):

a. Number of staff that administer the program; and their roles, specifying education level and clinical licensure. describe the composition of the two-person teams deployed on calls, including their qualifications and responsibilities;
b. Hours of operation in FY 2025, and 2026, to date;

c. *Number of individuals served by ChAMPS in FY 2025 and in FY 2026, to date, including their race, gender, and ward data;*
d. *Number of calls received and the number of deployments (along with the location of deployments, i.e. school, home, etc) by ChAMPS in FY 2025 and in FY 2026, to date;*
e. *The number of times that MPD was called to assist ChAMPS in FY 2025 and in FY 2026, to date;*
f. *The response time for deployable calls including the longest and shortest response times that occurred in FY 2025 and FY 2026, to date, as well as the average;*
g. *The number of mobile crisis teams;*
h. *Any updates regarding how calls are triaged to ensure that a team is available upon request;*
i. *Updates to the relationships and coordination between the 911 call-takers, Access Helpline, 988 call center, and ChAMPS teams;*
j. *Updates on CRT's performance in responding to evening and weekend calls since the change in ChAMPS' contract, including the number of calls responded to during those hours and the associated response times;*
k. *How the new exclusion of evening and weekend hours has impacted potential users of the service as well as the capacity of the other services that respond to calls during these hours instead of ChAMPS;*
l. *All languages in which ChAMPS services are provided; and*
m. *The findings of any review or evaluation of these services. Please attached any relevant reports.*

DBH Response:

a and b. The ChAMPS program is operated under a contract with Anchor Catholic Charities. The contractor responds to call for crisis support for children and youth Monday – Friday from 8:00 a.m. - 8:00 p.m. Anchor staffs the services during these hours with one part-time clinical director, one full time and one part-time clinical manager, one team lead, two Bachelor level crisis specialists and two masters-level crisis specialists. During the evening and overnight hours (8:00 p.m. – 8:00 a.m.) the DBH Crisis Response Teams (CRT) assigned to duty responds to these calls.
c. In FY 2025, 516 unduplicated children and youth were served by ChAMPS. In FY2026 to date, there have been 174 unduplicated children and youth served by ChAMPS.
d. In FY 25, ChAMPS received 908 calls, of which 298 required a deployment. In FY 26 thus far, ChAMPS received 318 calls, of which 54 required a deployment. The largest source of calls were from schools and the next largest source was parents for both FY 25 and FY 26.
e. This data is not currently available, but DBH will collaborate with Catholic Charities to collect the data moving forward.
f. The average response time for deployable calls in FY25 by Anchor was 35 minutes. The average for FY26 has been 58 minutes.
g. There are 2.5 mobile crisis teams within ChAMPS.
h. All calls are triaged through a clinical manager. The managers determine which cases are deployable and which are not based on the nature of the call. Calls are deployed on an as need basis. If there are no teams available, then the caller is informed, and a secondary plan is made at this time.
i. CRT continues to collaborate with OUC, AHL and 988 to receive both adult and child and youth calls.

j. CRT responds effectively to calls for support for children and youth during evening and weekend hours. Calls received by Anchor during these hours are automatically transferred to the CRT to avoid requiring the public and callers to call different a number from 8:00 p.m. – 8:00 a.m.
k. The transition plan has not had any negative impact on service delivery for the child and youth population or other services that respond to calls during these hours instead of ChAMPS.
l. ChAMPS provides services in all languages through the language access line.

Q65. Please provide the information requested in Q64 for the Community Response Team's response and transport of children and youth aged 18 and under:

y. Number of staff that administer the program; and their roles, specifying education level and clinical licensure. Describe the composition of the two-person teams deployed on calls, including their qualifications and responsibilities.
z. Hours of operation in FY 2025, and 2026, to date.
aa. Number of individuals served by ChAMPS in FY 2025 and in FY 2026, to date, including their race, gender, and ward data.
bb. Number of calls received and the number of deployments (along with the location of deployments, i.e. school, home, etc) by ChAMPS in FY 2025 and in FY 2026, to date.
cc. The number of times that MPD was called to assist ChAMPS in FY 2025 and in FY 2026, to date.
dd. The response time for deployable calls including the longest and shortest response times that occurred in FY 2025 and FY 2026, to date, as well as the average.
ee. The number of mobile crisis teams;
ff. Any updates regarding how calls are triaged to ensure that a team is available upon request.
gg. Updates to the relationships and coordination between the 911 call-takers, Access Helpline, 988 call centers, and ChAMPS teams;
hh. Updates on CRT's performance in responding to evening and weekend calls since the change in ChAMPS' contract, including the number of calls responded to during those hours and the associated response times;
ii. How the new exclusion of evening and weekend hours has impacted potential users of the service as well as the capacity of the other services that respond to calls during these hours instead of ChAMPS;
jj. All languages in which ChAMPS services are provided; and
kk. *The findings of any review or evaluation of these services. Please attached any* relevant reports.

DBH Response:
a. *Number of staff that administer the program; and their roles, specifying education level and clinical licensure. Describe the composition of the two-person teams deployed on calls, including their qualifications and responsibilities:*
There are 71 positions in CRT across three shifts 24 hours a day, seven days a week. There are five COR positions that are co-located with MPD. Administration of the program includes a CRT Director, two program managers, two daytime supervisors, one overnight supervisor, one evening supervisor, and one evening/overnight supervisor. There is also a Quality Improvement supervisor. All of the management positions are occupied by independently licensed behavioral healthcare professionals. Teams of two

direct line staff deploy to calls and can be peer specialists, behavioral health specialists with bachelor's or master's degrees, and staff trained as officer agents. CRT staff are responsible for responding to crisis calls and some can be resolved with telephonic counseling and consultation. Other calls require an in-person, on site response. Staff assess, de-escalate, coordinate care, and connect people to ongoing care.

b. *Hours of operation in FY 2025, and 2026, to date:*

CRT operates 24 hours a day, seven days a week including holidays.

c. *Number of individuals served by ChAMPS in FY 2025 and in FY 2026, to date, including their race, gender, and ward data:*

1) The total number of people age 0-17 seen by CRT in FY25 and FY26 including race, gender, and ward

FY	Total people 0-17
FY25	96
FY26YTD	28

Gender	FY25	FY26YTD
Female	50	16
Male	45	11
Transgender	1	1

Race	FY25	FY26YTD
African American	27	8
Asian	2	0
More than one race	0	1
Other Race	1	0
White or Caucasian	2	0
NULL	64	19

Ward	FY25	FY26YTD
1	1	2
2	7	1
3	6	2
4	11	4
5	7	5
6	6	4
7	8	5
8	5	5
NULL	45	0

d. *Number of calls received and the number of deployments (along with the location of deployments, i.e. school, home, etc) by ChAMPS in FY 2025 and in FY 2026, to date:*

PLACE_OF_SERVICE	FY25	FY26YTD
Community Mental Health Center	4	0
Group Home	1	0
Home	6	2
Pat in Home for Tlhlth Svc	2	1
NULL	63	22
Office	1	1
Other Unlisted Facility	15	2
Pat Not in Home for Tlhlth Svc	4	0

	96	28

e. The number of times that MPD was called to assist ChAMPS in FY 2025 and in FY 2026, to date, For CRT:

FY	Total people 0-17
FY25	6
FY26YTD	4

f. The response time for deployable calls including the longest and shortest response times that occurred in FY 2025 and FY 2026, to date, as well as the average, For CRT:

FY	Longest time	Shortest time
FY25	11:34	0:17
FY26YTD	4:00	0:16

FY	Average
FY25	0:07
FY26YTD	1:21

An example of a call with extended response time is when a family calls with concerns about a youth who is not at home at the time. The time to locate the youth and establish contact is included in the wait time.

g. The number of mobile crisis teams:

There are three to four teams in the evenings and after hours.

h. Any updates regarding how calls are triaged to ensure that a team is available upon request:

Calls are categorized by priority need and seen in priority order if there are more calls in real time then there are teams available to respond. Potentially dangerous calls that exceed reasonable deployment response times are referred to MPD.

i. Updates to the relationships and coordination between the 911 call-takers, Access Helpline, 988 call center, and ChAMPS teams:

DBH is working to strengthen these relationships in FY26.

j. Updates on CRT's performance in responding to evening and weekend calls since the change in ChAMPS' contract, including the number of calls responded to during those hours and the associated response times:

FY	Total Calls
FY24	456
FY25	303
FY26YTD	62

k. How the new exclusion of evening and weekend hours has impacted potential users of the service as well as the capacity of the other services that respond to calls during these hours instead of ChAMPS:

CRT has been able to respond to calls in the Champs exclusionary hours with increased phone and in person response when needed.

l. All languages in which ChAMPS services are provided:

CRT services are offered in Spanish, Amharic, and CRT uses the language line when needed.

m. The findings of any review or evaluation of these services. Please attach any relevant reports:

Crisis Services is planning to hire new staff who will focus on evaluations and quality improvement.

Q66. For individuals served by ChAMPS, how many times did receipt of service result in psychiatric hospitalization in FY 2025 and in FY 2026, to date? Of the individuals who were hospitalized, how many of those hospitalizations were involuntary (FD-12) and what agency, if any, had custody? Of the individuals who were hospitalized, how many had a diagnosis of "serious emotional disturbance"?

a. Please provide the same information for the Community Response Team's response and transport of children and youth aged 18 and under.

DBH Response:

In FY 2025, 52 individuals served by ChAMPS resulted in psychiatric hospitalizations. In FY 26, two youth served by ChAMPS required hospitalization. During FY 25, 24 youth were assessed at the hospital voluntarily, and 87 youth were assessed through an FD-12 process. Data regarding youth in the custody of DYRS or CFSA are not currently tracked. Additionally, clinical diagnosis data, including diagnosis of serious emotional disturbance, are not available at this time. However, all hospitalized youth are connected or re-connected to their core service agency and/or their school based behavioral health clinician upon discharge. These data are not available for the CRT team's response. DBH will work to collect this data moving forward.

Q67. During FY 2024, FY 2025. and FY 2026, to date, how many calls to ChAMPS and any other Youth Mobile Crisis providers were initiated by:

a. MPD;
b. DCPS or a public charter school;
c. Family members;
d. The child or youth affected; and
e. Others

DBH Response:

Please see the table below:

Sources of Calls to ChAMPS and youth mobile crisis providers			
	FY 24	FY 25	FY 26 YTD
MPD	40	29	11
DCPS or public charter school	460	395	139

Family members (includes parents, extended family, foster parents)	380	356	114
Child or youth affected	9	4	0
Others (includes CFSA, CCS, CSA, DBH, DYRS, Hospital, Private Provider)	204	122	54

Q68. Is DBH considering transitioning the ChAMPS program from a contracted or grantee model to an in-house operation?

a. *What factors are being considered in evaluating whether to continue with a contractor/grantee versus internalizing the program?*
b. *How would such a transition impact staffing, service delivery, and program oversight?*

DBH Response:

a. DBH is considering transitioning the program from a contractor/grantee to an in-house operation. The overhead costs associated with administering and delivering the program can be reduced through a government-operated service, leveraging the government infrastructure that already exists to deliver this care for adults.
b. CRT currently provides the backup coverage to ChAMPS answering an average of 567 calls a year in the hours that ChAMPS does not operate. Moving ChAMPS into CRT allows for the cross training of teams, appropriate response 24/7, and cost savings related to overhead costs. DBH anticipates service delivery will continue without disruption, while program oversight will be strengthened through direct DBH management and streamlined monitoring.

Q69. Please explain the work DBH is doing with Child and Family Services Agency to better serve the behavioral health needs of foster children and their families in the District. Please provide the following information for FY 2025 and FY 2026, to date:

a. *The number of children/youth in out-of-home placements DBH served;*
b. *The number of children/youth in in-home care DBH served;*
c. *The percentage of children/youth who were screened within 30 days of entering or re-entering care;*
d. *The number of days it took for a child who has been identified as needing behavioral health services to be connected to those services;*
e. *The services DBH provides to parents and guardians whose children are being served through in-home or out-of-home care;*
f. *The number parents and guardians that received services;*
g. *The services DBH provides to resource providers;*
h. *The number of resource providers who received services from DBH; and*
i. *Documentation that children are receiving timely services and what DBH is doing to improve timeliness of services.*

DBH Response:

In FY25, DBH continued to partner and collaborate with CFSA to better serve the behavioral health needs of children and families in the District. DBH continued to have a staff member co-located at CFSA to support the linkage, enrollment, and follow up of behavioral health services to children, youth, and families needing services.
a and b. The table below show the numbers of CFSA children, youth, and adults in FY25 and FY26 to date, who engaged in DBH services.

FY25		
Placement	DBH services	CFSA Cases
Foster Care	171	379
In-Home	185	481
Total	356	860
FY26		
Placement	DBH services	CFSA Cases
Foster Care	88	338
In-Home	0	5
Total	88	343

c. DBH does not have access to the data that highlights the percentage of screenings conducted. Since FY20, CFSA has conducted mental health screenings for children and youth entering foster care. Through CFSA's mental health redesign, it included three mental health clinician positions to administer mental health screenings and to provide direct therapeutic interventions.

d. Of the CFSA involved youth who were referred directly through the DBH co-located staff, the average time from referral to linkage of behavioral health services is an average of 1 business day.

e, f, g, h. Services are provided to parents, guardians, and resource parents of children and youth involved in the child welfare system, but this data is not aggregated in our database system. Adults have access to services available in the DBH network to address their own needs in addition to psychoeducation and behavior management strategies that will support parenting and family dynamics. Parents, guardians, and resources parents are also instrumental in supporting the behavioral health needs of children and youth impacted by trauma. DBH continues to provide trauma informed and evidence-based programs (EBPs) services which include the following: Parent-Child Interactive Therapy (PCIT), Trauma Focused –Cognitive Based Therapy (TF-CBT), Trauma Systems Therapy (TST), Child-Parent Psychotherapy (CPP), Functional Family Therapy (FFT), Multi-Systemic Therapy (MST), Transition to Independence Process (TIP), Attachment Biobehavioral Catch-Up (ABC), and Intensive Care Coordination (ICC). The EBPs provide youth and families with the skills and knowledge necessary to overcome traumatic events and experiences.

i. Attachment 1 provides data regarding the number of days between date of referral to behavioral health services and enrollment in services. Each referral made directly to the DBH staff co-located at CFSA is tracked from the date of referral to enrollment. On average this is completed within one business day. DBH continues to participate in forums to educate social workers, youth, and families of the multiple entry points to access services which includes contacting providers directly and contacting Access

Helpline. In addition, DBH hosts and participates in roundtable discussions with CFSA and community stakeholders to trouble shoot access and engagement concerns. Also, DBH hosts bi-monthly/quarterly meetings with providers to discuss concerns to include timeliness of services. Lastly, when contacted by social workers and families directly, DBH assists with contacting agencies to connect families with services and leadership to troubleshoot engagement concerns.

Q70. For DBH's early childhood mental health projects, please provide the following information for FY 2025 and FY 2026, to date:

a. *For the Parent Child Infant Early Childhood Enhancement Program, please provide:*
    i. *The provider(s);*
    ii. *Description of the services provided*
    iii. *Type(s) and numbers of clinicians employed;*
    iv. *Capacity and number of children served; and*
    v. *The number and percentage of outcomes for cases (e.g. successful completion, closure for lack of attendance, etc.*
b. *For the Early Childhood Mental Health Consultation Project, Healthy Futures:*
    i. *Provider(s);*
    ii. *List of childcare centers, homes, and schools that are participating;*
    iii. *Services each site has received and any progress/outcome measure available;*
    iv. *The number of teachers, administrators, families, and children being served each year;*
    v. *Amount of funding DBH has allocated to subsidize other costs associated with early childhood mental health consultation (ECMHC), such as certification and training in early ECMHC; and*

DBH Response:

a. The Parent Infant Early Childhood Enhancement Program (P.I.E.C.E.) was initially established in 2009 to provide early intervention and treatment to families with young children birth to seven years old. During FY 2025, DBH expanded the service provision to include adolescents and young adults up to 18. The primary focus of the program remains to intervene early with comprehensive services designed to prevent social emotional/behavioral challenges, reducing stressors within the parent-child relationship and family that might adversely affect the developing child.

i. The P.I.E.C.E. program provides family focused behavior management, individual and family therapy/counseling, art and play therapy, developmental screenings, diagnostic assessments, and home/school visitation for children, youth and their families. Psychiatric evaluations and medication management are provided by the Physicians' Practice Group (PPG) urgent care clinic.

Ii. The staff of the PIECE Program are trained and rostered to provide several early childhood evidence-based practices for children and their families. The following is a list of the programs and a brief description of each of them.

Parent Child Interaction Therapy (PCIT) is a parent coaching program that teaches caregivers skills and techniques to improve their child's disruptive and non-compliant behavior. In PCIT caregivers are

coached in specific skills by the therapist through an earpiece while the therapist observes the caregiver and child playing together in a separate room.

Child Parent Psychotherapy (CPP) is a therapy for parents with infants, toddlers and preschoolers who have experienced trauma(s). CPP is also offered in a hybrid manner including the use of on-line stories art making via white board virtual adaptations and other telehealth applications in addition to in-person sessions.

Attachment & Biobehavioral Catch-up (ABC) is offered to parents and caregivers of babies who are between six and 24 months old. ABC strengthens the parent child relationship while helping the child to learn to regulate behaviors and emotions. The ABC approach helps parents/caregivers identify and respond to their baby's signals. As a result, the parent's relationship with their child is supported to address stress and early challenges.

Iii, iv, v. The PIECE staff includes three clinicians. The credentials of the clinicians are as follows: a Licensed Independent Clinical Social Worker, a licensed clinical psychologist, and one PhD with multiple credentials as a Licensed Professional Counselor, Licensed Marriage and Family Therapist, and is also a board-certified art therapist. The P.I.E.C.E. Program has the capacity to provide services to 90 – 100 children and their families. During FY 25 the P.I.E.C.E. Program provided services to 325 children and their families. During FY 25 the program discharged 62 families, of which 36 (12%) were successful and 26 (8%) were unsuccessful due to a lack of attendance, relocation, and drop out for personal reasons. To date in FY 26, 1st quarter, the program provided services to 168 children and families.

b. For the Early Childhood Mental Health Consultation Project, Healthy Futures:

i. The Healthy Futures Program provides consultation services to child development centers (CDCs) and home childcare providers as well as directly to children and families. These services are provided by a mental health professional. The goals of the program are: (1) building professional skills and capacity of caregivers to promote social emotional development and prevent escalation of challenging behaviors (2) reducing the number of early childhood expulsions and (3) increasing appropriate referrals for additional assessments and services to support child and family functioning. The Healthy Futures Infant and Early Childhood Mental Health Consultants (IECMHC) are comprised of independently licensed mental health clinicians (LICSW, LPC, LMFT), license eligible clinicians (LGSW, LGPC, etc.) and clinicians certified in IECMHC.

Ii. During FY 25 the Healthy Futures program provided services in 91 child development centers and 13 home providers for a total of 104 facilities. Please see attachment for a list of centers.

Iii. The early childhood mental health specialists served 5,172 children across 104 facilities. Healthy Futures specialists provided 164 staff and parent workshops, 2,934 teacher consultations, 489 parent consultations, and 2,866 director consultations. Centers referred 320 children to Healthy Futures for child-specific support and 195 of those children's families signed consent to allow individual observations and interventions. The Devereux Early Childhood Assessment (DECA) was completed for children who received child-specific consultation services. Of the 195 children

whose family signed consent 189 received an initial DECA and 150 received a post DECA. Of those children with follow-up DECAs, all showed improvement in at least one area of concern (attachment, initiative, and self-regulation).

Healthy Futures has continued its collaboration with the Office of the State Superintendent Office's (OSSE) Quality Improvement Network (QIN) and Pre-K Enhancement Program (PKEEP). Through this collaboration with OSSE the Healthy Futures consultants provide self-care and trauma informed practice workshops to the staff of the participating child development centers and homes.

iv. During FY25, Healthy Futures staff supported 104 administrators, 707 teachers, 5,172 children had access to IECMHC, and 195 families and children received child-specific consultation. Data for FY26 is still being collected.

v. DBH allocated the Healthy Futures Program $81,000 to provide the following trainings to the Infant and Early Childhood Mental Health Consultants and Treatment Clinicians:

- **Institute of African American Mindfulness (IAAMS):** IAAMs will lead mindfulness circles with Healthy Futures clinicians to promote individual and collective healing and well-being. The series will introduce mindfulness practices to encourage compassionate interactions and relationship-building within Healthy Futures and the larger community. Mindful Professionals at the Department of Behavioral Health circles support community-building and the cultivation of self-care and resiliency as clinicians deepen their personal mindfulness practice. IAAM will teach-through-practice a variety of mindfulness skills that will be utilized within classroom consultation.

- **Reflective Supervision:** Through this live webinar series, Healthy Futures will focus on skills needed for the whole job, and all the roles of a reflective supervisor with a focus on diversity, equity and inclusion, and the supervisor's use of critical self-reflection and social location. There will also be an infusion of the structure and materials from the FAN and RIOS, two well-developed models of structuring reflective practice and supervision.

- Motivational Interviewing: Motivational Interviewing (MI) is often recommended as an evidence-based approach to behavior change. MI is a guiding style of communication, that sits between following (good listening) and directing (giving information and advice). MI is designed to empower people to change by drawing out their own meaning, importance and capacity for change. MI is based on a respectful and curious way of being with people that facilitates the natural process of change and honors client autonomy.

- **First Play:** Attachment-based Infant-Parent Counseling & Storytelling. FirstPlay® Practitioners guide parents through the FirstPlay Parent Manual© to provide caring, respectful and attuned touch to their infants as provided through a "story-massage" called, The Baby Tree Hug©. Practitioners do not provide the touch activities to the infant. Instead, practitioners instruct, direct, model and supervise parents (on a baby-doll) in the techniques of FirstPlay® Infant Storytelling Massage. While the FirstPlay® Practitioner is demonstrating the techniques, the parent(s) simultaneously follows along and practices the FirstPlay® movements and storytelling

with their own baby. The FirstPlay® Practitioner then guides parents on how to incorporate FirstPlay® sessions into their daily schedules.

- **SMART:** Sensory Motor Arousal Regulation Treatment (SMART) is designed to treat the consequences of adverse childhood experiences, which we now understand as Developmental Trauma. We believe children's natural tendency is toward adaptation, healing, and growth, to unlock this potential, and as such our method focuses on somatic regulation, trauma processing, and attachment-building through collaborative relationships.

- **Starbright Training Institute/Gil Institute for Trauma Recovery and Education:** Expressive therapies allow children and adults to broaden their communication by externalizing worries and concerns through symbols and metaphors. The use of expressive approaches in therapy encourages the release of creative, resilient energy in clients, which can be a powerful agent for insight and change. When families in pain begin to play together, perceptions of each other are changed, communication is accomplished in less direct ways, and individuals experience a decrease in resistance. Through laughter and play, endorphins are released and feelings of wellbeing emerge.

Q71. For FY 2024, FY 2025, and FY 2026, to date, please provide the amount budgeted and spent on Healthy Futures, including a cost breakdown. Include a breakdown of the amount of local, federal, philanthropic, and special revenue funding across all sites. Please include:

a. Evaluation data of Healthy Futures; and
b. Updates on hiring for Healthy Futures.

DBH Response:

See attachment for the FY 2024, FY 2025, and FY 2026 budget for Healthy Futures.

a. FY25 evaluation data and program highlights are below:

- The Healthy Futures program provided services in 91 child development centers and 13 home providers for a total of 104 facilities.
- Healthy Futures served 5,172 children across 104 facilities.
- Healthy Futures provided 164 parent and staff workshops.
- Healthy Futures provided 2,934 teacher consultations, 489 parent consultations, and 2,866 director consultations
- 195 children whose family signed consent 189 received an initial DECA and 150 received a post DECA. Of those children with follow-up DECAs, all showed improvement in at least one area of concern (attachment, initiative, and self-regulation).

b. Updates on hiring for Healthy Futures.

Current funding for FY 25 supported 17 early childhood clinical specialists, two early childhood treatment specialists, three supervisors, and a Program Manager. There are two vacant early childhood clinical specialist positions.

Q72. Please share early childhood expulsion rates in FY 2025, and FY 2026, to date, across the District and by ward and race.

DBH Response:

Healthy Futures continues to provide consultation and education to early childhood directors on the positive impact of working with children that exhibit challenging behaviors rather than expelling them from their programs. Through Healthy Futures, child development center (CDC) staff developed policies, skills and resources that help minimize expulsion as an option for children with challenging behaviors.

In FY 25, there were two expulsions of the 5,172 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 26 to date. Both children expelled in FY25 were 3-year-old African American males, one from Ward 1 and one from Ward 2. This is well below the national level in which prekindergartners are expelled at a rate that is more than three times that of their older peers in grades kindergarten through 12 (6.67 per 1,000 preschoolers, as compared to 2.09 per 1,000 K-12 students) (Walter S. Gilliam, PhD Yale University Child Study Center, 2005).

Q73 Please provide an update on the DC MAP program, including the transition to a new provider in the previous fiscal year. Please include for FY 2024, FY 2025, and FY 2026, to date:

a. *Number of referrals made to the DC MAP program;*
b. *The most common diagnoses for referrals;*
c. *Number of patients served;*
d. *Cause of any discrepancy between the number of referrals and the actual services delivered;*
e. *Average number of days between when a referral is issued and the patient receives services, including the longest wait time experienced in FY 2024, FY 2025, and FY 2026, to date;*
f. *Number of practicing clinicians in DC MAP's current provider, including their credentials and number of vacancies; and*
g. *Summary of findings of any review or evaluation of these services. Please attach any relevant reports, including feedback related to the quality and delivery of services from patients and referring providers.*

DBH Response:

Referral counts reflect documented consultations extracted from the electronic health record (EHR) software through aggregated, master-level data pull encompassing all months in FY 2024, FY 2025, and FY 2026 to date. The EHR software serves as the system of record for documenting completed consultations, while referral activity initiated through a separate provider-driven process is considered in conjunction with the EHR data for analytical purposes. The resulting counts align with the data presented in the monthly DC MAP reports and are intended to support consistency across reporting periods.

Fiscal Year	Number of Referrals
FY 2024	819
FY 2025	759
FY 2026	201

Dates 10/01/2025-01/07/2026

b. Across the reporting periods, the most frequently documented diagnosis in FY 2024 was Depressive Disorders. In FY 2025, Anxiety Disorders were the most frequently documented diagnosis. For FY 2026 to date, Depressive Disorders represent the most frequently documented diagnosis; however, FY 2026 figures should be interpreted as estimates due to a transition in the EHR system during the reporting period.

Diagnosis	**FY 24**	**FY 25**	**FY 26***
ADHD	23.52%	22.37%	21.21%
Disruptive, impulse-control, and conduct disorders	9.61%	16.85%	7.07%
Trauma and stressor-related disorders	10.96%	18.19%	8.08%
Academic/School Problems	2.22%	2.29%	1.01%
Anxiety Disorders	27.34%	27.49%	19.19%
Autism/Developmental Delays	7.64%	4.85%	6.06%
Adjustment Disorder	9.24%	4.18%	4.04%
Suicidality or self harm	4.93%	7.68%	9.09%
Feeding and eating disorders	0.99%	1.21%	1.01%
Depressive Disorders	35.59%	25.74%	28.28%
Bipolar and related disorders	1.97%	1.08%	1.01%
Substance-related disorders (other substance-related)	0.49%	0.27%	0.00%
Obsessive-compulsive and related disorders	0.74%	0.40%	1.01%
Schizophrenia spectrum and other psychotic disorders	0.74%	0.27%	1.01%
Substance-related disorders (poly substance use)	0.00%	0.27%	0.00%
Substance-related disorders (opioids)	0.12%	0.13%	0.00%
Substance-related disorders (alcohol)	0.00%	0.13%	1.01%
Family member mental health problem	0.12%	0.67%	2.02%

c. For FY 2024, FY 2025, and FY 2026 to date, the number of patients served is represented by the number of documented consultations. Under this reporting approach, each consultation is counted as a patient served, including instances in which an individual patient received services more than once during the fiscal year.

Fiscal Year	Number of Patients Served
FY 2024	819
FY 2025	759
FY 2026	201

Dates 10/01/2025-01/07/2026

d. Discrepancies between referrals and services delivered often arise for several reasons. Clients may decline services after a referral is made, fail to attend scheduled appointments, or remain unresponsive to follow-up attempts. In some cases, organizations may be unresponsive or place clients on extended waitlists. Lapses in insurance coverage can also interrupt eligibility for services. Additionally, language barriers may hinder effective communication, limiting an organization's ability to successfully connect with the client.

e. The length of time varies depending on the needs of the child. Overall, DC MAP strives to ensure that referrals lead to a connection with services within 30 days; however, there are some exceptions.

When a PCP requests only to speak with a psychiatrist for medication clarification, the consultation is completed within 24 hours. HMG short-term mental health services typically begin within 72 hours, as this is an in-house service. We have found that the longest wait time is approximately 90 days.

Connections to care or consultations that remain pending for more than 30 days are typically impacted by the following barriers:
Language barriers
Requests for a clinician with specialized training in complex disorders (e.g., eating disorders, pica, etc.)
Requests for a clinician of a specific gender or race
Difficulty engaging families (e.g., disconnected phone numbers, limited follow-up on provided referrals)

f. The table reflects enrolled providers and credentials for FY 2024, FY 2025, and FY 2026 to date. It is unclear what is meant by "vacancies" in this context, as vacancy data is not maintained within the datasets used for DC MAP reporting.

Enrolled Providers	**FY24**	**FY25**	**FY26***
Psychiatrist	1	0	0
Pediatrician	9	31	11
Nurse Practitioner (NP)	11	5	2
Behavioral Health Provider (e.g. psychologist, therapist, counselor)	2	1	2
Care Coordinator/Patient Navigator	2	1	0
Family Medicine	3	0	1
10/01/2025-01/07/2026			

g. Service continuity improved following the transition to the new provider in the previous fiscal

year, resulting in more standardized documentation practices, enhanced referral tracking, clearer communication channels, and more consistent follow-up procedures. Across all fiscal years, there has been strong alignment between referrals and patients served, demonstrating reliable follow-through and effective coordination despite barriers such as insurance lapses and client disengagement.

Diagnostic trends continue to reflect community needs, with depressive and anxiety disorders remaining the most frequently identified concerns. Providers are reporting increased complexity in presenting issues, underscoring the importance of timely consultation and coordinated care. Feedback also identified opportunities for improvement, including expanding multilingual outreach, strengthening reminder systems for families, and increasing collaboration with organizations experiencing chronic waitlist delays. In addition, we have observed a steady increase in families with private insurance being referred to DC MAP. This emerging trend has required the team to explore connections with mental health providers who practice outside of the wards to which we typically refer families.

Q74. Please describe efforts in FY 2025 and FY 2026, to date, to establish the full continuum of psychiatric care for children, including acute care, crisis stabilization, intensive outpatient care, and Intensive Community-Based Interventions in the District, including the following services specifically for children less than 18 years:

a. *Crisis stabilization unit or pediatric CPEP, with an extended observation unit;*
b. *Bridging Clinic for youth who are being discharged from inpatient psychiatric units;*
c. *Therapeutic group home/community residence;*
d. *Intensive outpatient programs;*
e. *Partial hospitalization or day hospital;*
f. *A local Psychiatric Residential Treatment Facility (PRTF), particularly whether there has been any communication with the Mayor regarding the plan required by the ROAD Act; and a*
g. *Substance Use Disorder treatment inpatient or outpatient facility.*

DBH Response:

DBH and the Department of Health Care Finance, DC's state Medicaid agency, began partnering in 2020 to plan for the full integration of behavioral health services in the Managed Care Organizations (MCO) service delivery. The Behavioral Health Integration is a District-wide effort to provide a full continuum of whole-person care to youth. In FY24, because of budget pressures, the planning for full integration was paused.

As part of the system redesign efforts and transition to managed care, a comprehensive rate study was conducted by DHCF's vendor, PCG. The rate study reviewed fifty-three services and their corresponding rates to include services completely new to the District. Services that had rates assigned were aligned with the fiscal impact of staff and training requirements and fidelity which resulted in some rate increases. New rates were established to include Intensive Care Coordination (ICC) which is a comprehensive, holistic, youth and family-driven process for child and youth ages 5-21 who are experiencing behavioral health challenges and Motivational Enhancement Therapy-Cognitive Behavioral Therapy (MET-CBT) which is a short term intervention designed for children/youth with

substance use disorders to increase their motivation to change a substance use behavior and the underlying thoughts or feelings that may trigger maladaptive substance use behaviors.

In FY25, further efforts were made to establish ICC as a Medicaid billable service. Regulations were established that provided guidance on access, implementation, and fidelity. In addition, an ICC Flex Funds Bulletin was developed to provide guidance to the provider network on the services that are covered and the process for submitting a request. There are currently two certified providers with the total capacity of 259 youth. Also, in FY25, three clinicians were certified in MET-CBT which included a school-based behavioral health provider, SUD provider, and Transition-Aged Youth provider.

a. A crisis stabilization unit with an extended observation unit is not currently available within the District. Children are treated in hospitals and are assigned to a designated unit based on their clinical presentation. Youth who are in crisis are placed on a unit to resolve the crisis being experienced. Continued stays are provided in the hospital to youth based on clinical presentation if they meet the medical necessity criteria for continued hospitalization.

b. The District does not have facilities that designate themselves as bridging clinics. Transition and discharge planning are covered services within the District's Medicaid plan. DBH has an established discharge policy which provides the required procedures for providers for effective and safe discharges for children and youth. The child/youth's Core Service Agency or (CSA) and/or Community-Based Intervention (CBI) provider is required to participate in the development of an appropriate discharge plan with the individual's family and the hospital staff. The DBH's PRTF Branch Staff Members provide support to youths (and their family) throughout their treatment in a Psychiatric Residential Treatment Facility (PRTF) as well as during and after discharge. Prior to discharge the DBH staff will ensure that the youth is linked to a Core Service Agency and supports the assessment of need for additional behavioral health services as recommended by the treating PRTF's clinical team.

c. DBH does not provide therapeutic group homes/community residence for youth. DBH partners with agencies to include the Department of Youth Rehabilitative Services (DYRS) and the Child and Family Services Agency (CFSA) that provide therapeutic group homes/community residence for youth under their supervision. DBH works with certified providers to ensure service delivery is consistent across community settings for youth and families.

d. DBH continues to certify providers who serve as core service agencies that offer a full continuum of services to include therapy, medication management, and community support. As a part of the rate study, new services were added to include Intensive Care Coordination, Dialectical Behavioral Therapy, and Attachment-Biobehavioral Catch-up. In addition, in FY25, one of DBH's partners, Medstar Georgetown University Hospital provided outreach to promote their adolescent Intensive Outpatient Program which accepts DC Medicaid. In addition, the Psychiatric Institute of Washington (PIW) recently opened an IOP for 13–17-year-olds and are currently accepting referrals.

e. PIW plans to open a youth Partial Hospitalization Program in January 2026.

f. The District does not have a local Psychiatric Residential Treatment Facility (PRTF); however, DBH has been collaborating with DYRS and CFSA to explore additional options for youth needing more

intensive behavioral health supports. DBH will continue to reach out to PRTFs in neighboring states to explore the possibility of securing increased access to resources for District youth.

g. Hillcrest and the Latin American Youth Center (LAYC) provide outpatient substance use disorder (SUD) services for youth. Additionally, the Department of Behavioral Health (DBH) collaborates with Dr. Kaliamurthy at Children's Hospital to offer specialized support for youth diagnosed with substance abuse disorders. DBH also awarded a grant to Federal City, through the Opioid Abatement Settlement funds, to support a 3.5 level SUD residential treatment facility for youth. The SUD provider is open and is now accepting referrals.

Q75. How many youth were reviewed through the PRTF Medical Necessity Determination process in FY 2025 and FY 2026, to date? What was the rate of approval?

DBH Response:

During FY 2025, 30 youth were reviewed through the PRTF Medical Necessity Determination Process. All 30 youth met medical necessity and were issued a level of care for treatment in a Psychiatric Residential Treatment Facility (PRTF). During the first quarter of FY 2026, three youth were reviewed and all three youth met medical necessity and were issued a level of care for treatment in a PRTF.

Q76. According to DBH policy 200.7, the PRTF Review Committee is supposed to produce an annual report on PRTF referrals and post it to their website. Please provide the annual reports starting from the year the policy was established to now. If these reports have not been produced, please explain.

DBH Response:

The Department of Behavioral Health issued the PRTF Medical Necessity Review Process policy on August 19, 2014, to establish the procedures for medical necessity review for admission to and continued stays for children and youth in a PRTF whose needs cannot be met in the community. Consistent with this purpose, the policy established a PRTF Review Committee to ensure that multiple clinical perspective and community-based treatment alternatives are considered before a PRTF referral is made. The policy defined the PRTF Review Committee membership and duties that included production of an annual report. The annual report was to include

- Summary of all referrals by referral source
- Final decision of the Committee, and
- List of PRTFs used and the addresses

This information is maintained by DBH. However, because of resource limitations, a written annual report has not been produced. The PRTF Review Committee makes information available and shares it at regularly scheduled interagency meetings with CFSA, DYRS, DCPS, OSSE and DHCF.

Q77. Please describe all substance abuse services offered to children and youth and the process for obtaining these services. Please include:

a. *The total number of children and youth who received substance abuse services in FY 2024, FY 2025 and FY 2026, to date. Please breakdown by age, home ward, ward where services took place, how many were in-person/virtual/hybrid, and the types of services.*
b. *The total number of agencies or organizations that provided substance abuse services to children and youth. Please provide (via Excel spreadsheet) a list of the agencies and organizations that provide substance abuse services to children and youth. Include their grant/contract amount, location, Ward, how many children and youth they served in FY 2025 and FY 2026 to date, the format of their services (virtual/in-person/hybrid), what services they provided, and contact information (staff contact, email address, phone number, and website);*
c. *Plans in FY 2026 to expand the types of substance abuse services offered to children and youth; and*
d. *The number children and youth who received services through the Adolescent Community Reinforcement Approach (A-CRA) in FY 2025 and FY 2026, to date.*

DBH Response:

The substance use disorder services offered to children and youth within the District of Columbia include prevention services, early intervention, treatment, and recovery support services. Prevention services are delivered primarily through four DBH-funded DC Prevention Centers (DCPCs) that cover all eight wards, the school-based behavioral health program, and DBH prevention campaigns and activities. Treatment and recovery support services are available through two DBH-certified Adolescent Substance use Treatment Expansion Program (ASTEP) providers, and school-based services. The two ASTEP providers are Latin American Youth Center located in Northwest, and Hillcrest Children and Family Center with locations in both Northwest and Southeast.

The DC Prevention Centers include workshops and trainings on SAMHSA's Strategic Prevention Framework – an approach for developing strategies aimed at addressing and preventing substance use among District youth, engaging and conducting outreach to residents through community events such as health fairs, and fostering the leadership skills of youth via the respective Youth Prevention Leadership Corps. The Prevention Centers have created partnerships with local middle and high schools within their wards and work directly with the school-based behavioral health program to include a focus of substance use prevention. This includes conducting presentations in classrooms and school assemblies on the harms and dangers of substance use, the adoption of curricula aimed at preventing drug use "Too Good for Drugs," and establishing school specific Youth Prevention Leadership Corps.

The ASTEP providers deliver both mental health and substance use services to youth within the community and schools. The ASTEP providers receive self-referrals as well as referrals from school staff, child serving agencies including the DC Department of Youth Rehabilitation Services (DYRS), the Child and Family Services Agency (CFSA). When referrals are made, the ASTEP providers reach out to the referred youth, conduct an assessment, and enroll youth into services that best address their substance use needs.

a. Table A below shows the type of prevention services and the number of children and youth reached during FY 24, FY 25 and FY 26 to date.

Table A. Substance Use Prevention Services Offered to Children and Youth in FY2024			
Number of Youth	Service Wards	Delivery Method	Types of Services

4,011	Wards 1& 2 = 470 Wards 3&4 = 686 Wards 5& 6 = 1,712 Wards 7&8 = 1,143	virtual & in person	Information dissemination, social marketing engagement, and YPLC activities
Substance Use Prevention Services Offered to Children and Youth in FY2025			
Number of Youth	Service Wards	Delivery Method	Types of Services
7806	Wards 1&2 = 937 Wards 3&4 = 2110 Wards 5&6 = 3159 Wards 7&8 = 1600	virtual& in person	Information dissemination, social marketing engagement, and YPLC activities
Substance Use Prevention Services Offered to Children and Youth in FY2026 (to date)			
Number of Youth	Service Wards	Delivery Method	Types of Services
1,090	Wards 1&2 = 104 Wards 3&4 = 133 Wards 5&6 = 375 Wards 7&8 = 478	virtual & in person	Information dissemination, social marketing engagement, and YPLC activities

Table B below shows the number of children and youth offered treatment and support services through all youth SUD providers.

Table B. FY 24 Substance Use Treatment and Recovery Support Services Offered to Children and Youth			
Number of Clients	Service Wards	Delivery Method	Types of Services
389	Wards 1-8	virtual & in person	Individual and Group Counseling, Recovery support
FY 25 Substance Use Treatment and Recovery Support Services Offered to Children and Youth			
Number of Clients	Service Wards	Delivery Method	Types of Services
489	Wards 1-8	virtual & in person	Individual and Group Counseling, Recovery support, MET/CBT
FY 26 to date Substance Use Treatment and Recovery Support Services Offered to Children and Youth			

Number of Clients	Service Wards	Delivery Method	Types of Services
185	Wards 1-8	virtual & in person	Individual and Group Counseling, Recovery support; MET/CBT

b. To provide substance use disorder (SUD) prevention, youth treatment, and recovery support services, DBH works four DBH funded Prevention Centers (DCPCs) which are strategically located throughout the District of Columbia and provide services to all eight wards and two ASTEP providers. Please see the attachment for contact information for each partner.

c. In FY 2026, DBH will continue expanding the types of SUD services and access points for children and youth and their families. One example is the opening of the 3.5 Youth Residential facility. DBH initiated the implementation of a Level 3.5 Youth Substance Use Disorder (SUD) Residential Treatment Services with Federal City Recovery Services (FCRS). As of November 2025, the facility is operational and equipped to support youth 24 hours, 7 days a week and provides up to 16 beds for youth aged twenty-one (21) and under who are experiencing significant challenges in their daily functioning due to SUD.

To expand the reach of universal, selective, and indicated prevention interventions in community settings, DBH has been intentional with regard to not only engaging and partnering with groups and organizations housed strategically throughout the District's eight wards, but also by inviting these groups to apply for funding opportunities released by the agency.

d. Due to staff turnover at the ASTEP provider organizations, there were no staff certified to provide A-CRA in FY2025. A-CRA is only one of the services provided by the ASTEP providers. Other services include individual counseling, group counseling, and the adoption of additional evidence-based interventions such as the Motivational Enhancement Therapy/Cognitive Behavioral Therapy (MET/CBT). DBH will explore the possibility of training providers in A-CRA during FY 2026.

Q78. Please provide the following information for the DC Prevention Centers in FY 2025 and FY 2026, to date:

a. *Locations of centers (if any changed);*
b. *Number of youth served at each Center, broken down by age, grade, race/ethnicity, ward, and gender;*
c. *Number of youth participating in the DC Prevention Center Leadership Councils (please provide the names of the schools they attend); and*
d. *Activities and programs provided by each DC Prevention Centers, including but not limited to Narcan training, community events, and school related initiatives.*

DBH Response:

a-d. Please see Attachment 1 of 1 for DC Prevention Centers FY 25 and FY 26 to date.

Q79. How many teachers or other personnel in FY 2025 and FY 2026, to date, completed the online behavioral health training program for child development facilities and public schools that was launched in FY 2015?

DBH Response:

DBH provided the online behavioral health training through the portal: https://supportdcyouth.kognito.com and all DC administrators and teachers were required to complete the mandated training modules on the same two-year cycle. All District public and public charter school teachers and principals were to complete three courses once every two years to be compliant with the legislative mandate. Additionally, it was highly recommended for educators to take the *Step In Speak Out* course for challenges and concerns related to LGBTQ students. This was an additional module that was available within the portal. Early childhood educators, child development center staff, and child development center administrators, were to complete *At-Risk for Early Childhood Educators.* This simulation was for those administrators, staff, and educators who work with young children and builds understanding, knowledge, and skills in mental health and behavior management. The Division of Early Learning within the Office of the State Superintendent of Education (OSSE) had the completion of the *At-Risk for Early Childhood Educators* module as part of the yearly health and safety requirements, and all educators were to complete their health and safety requirements by September 30, each year.

In FY 2025, 7,485 DC Public School (DCPS) teachers and other personnel completed the online training. For DC Public Charter Schools (DCPCS), 7,681 teachers and other personnel completed the training in FY 2025.

And in FY 2025, 216 Administrators and staff completed the training. The chart below provides information on the number of DC Public School, DC Public Charter School, and DC Child Development Center teachers and other personnel who completed the online training in FY 2025. The contractor no longer offers this training and replacement modules are not yet available in FY 2026. DBH will create a replacement training to ensure compliance with the DC legislative mandate.

	FY25		
	DCPS	**DCPCS**	**CDC**
At Risk Early Childhood	816	323	184
At Risk for Elementary School Educators	1021	N/A	N/A
At Risk for Middle School Educators	N/A	N/A	N/A
At Risk for High School Educators	N/A	336	N/A
Referral Process - District of Columbia	2018	2395	12
Step In, Speak Up!	500	904	1
Resilient Together: Coping with Loss (Elementary)	1086	997	8
Resilient Together: Coping with Loss (Secondary)	624	1025	2
Emotional & Mental Wellness for Elementary/Middle	1003	1260	4
Emotional & Mental Wellness for High School	417	441	5
Total	7,485	7,681	216

Q80. What is the current status of the community-based Level 3.5 SUD treatment facility for youth that was funded through Opioid Abatement Settlement dollars? If the facility is already open, please provide data for FY 2025, and FY 2026, to date, on its utilization, including the number of youth served, referral sources, and average length of stay.

DBH Response:

During FY25, DBH initiated the implementation of Level 3.5 Youth Substance Use Disorder (SUD) Residential Treatment Services with Federal City Recovery Services (FCRS). Through Opioid Abatement funding, Federal City Recovery Services made significant progress in advancing youth residential SUD treatment, particularly in hiring clinical staff, obtaining certifications, staff training, data and facility infrastructure, and community collaboration. There were significant challenges to service delivery during Q4 of FY25, including numerous operational delays and reimbursement challenges.

During this period, FCRS continued work finalizing regulatory approvals, strengthening its referral and partner network, and working to ensure full operational readiness. DBH was instrumental in supporting FCRS navigate the various challenges they encountered during this period. As of November 2025, the facility is operational and equipped to support youth 24 hours, 7 days a week and provides up to 16 beds for youth aged twenty-one (21) and under who are experiencing significant challenges in their daily functioning due to SUD. DBH and FCRS remain committed to the expansion of youth residential treatment services, enhancing service quality, and improving access to life-saving treatment for youth experiencing opioid use disorder. FCRS received two referrals from Hillcrest Children and Family Center but the youth were not admitted due to juvenile detention.

Q81. Please provide an update on the collaborative efforts between DBH and Dr. Sivabalaji Kaliamurthy, at Children's National Medical Center, including the number of youth seen in FY 2025 and FY 2026, to date, including their demographics (age, race, gender and ward) and the outcomes achieved.

DBH Response:

DBH continues its partnership with Dr. Sivabalaji Kaliamurthy and his team at Children's National Hospital to enhance services for children and adolescents with substance use disorders and to bolster engagement in treatment. Children's National Medical Center at its original Takoma Theatre location had its daily hours extended and is open five days a week (Monday through Friday). In April 2025, they opened a new clinic at the Children's National THE ARC in Ward 8. This location is open three days a week (Monday, Wednesday and Thursday). Their new doctors who specialize in addiction and pediatrics split their time between both locations.
In addition, Children's hired two full-time Peer Recovery Support Specialists (PRSS) who offer non-clinical services to help youth begin and stay on their recovery from alcohol and drug use issues. As part of the Addiction Clinic team, they aid in completing referrals to treatment services, engage with youths, and develop service plans that ensure successful connections to treatment. Children's is now training

staff to offer contingency management to help youth manage the highest drug of choice, which is marijuana.

The number of youth served is trending up. In the first quarter of FY 26, Children's served 22 youth which is almost the entire number served in FY 25. Twelve (12) of the youth served in FY26 were new clients while the other (10) were previous clients continuing treatment.
The age, race, and ethnicity of the youth and ward is listed below:

	FY 2025	FY 2026 YTD	Total Served
Total Served:	28	22	50
Ward 1	6	9	15
Ward 2	4	7	11
Ward 3	3	1	4
Ward 4	2	1	3
Ward 5	1	0	1
Ward 6	1	0	1
Ward 7	5	3	8
Ward 8	1	1	2
Multiple Wards	5	0	5
African American	14	7	21
Caucasian	5	6	11
Asian	0	1	1
Other	9	7	16
Biracial	0	1	1
Total	28	22	50
Not Hispanic	18	14	32
Hispanic	10	8	18
Total	28	22	50
Male	12	8	20
Female	16	14	30
Total	28	22	50

Q82. Please provide the following information for SUD services in FY 2025 and FY 2026, to date, for youth ages 18-24:

a. Number of consumers who used detox, outpatient, and residential services;

b. Number of service providers providing services to this age group, including their names, respective capacities, and locations;
c. Average wait times to begin services; and
d. *DBH's strategies for expanding both capacity and accessibility of services, and addressing barriers to this age group.*

DBH Response:

The substance use disorder services offered to youth ages 18-24 within the District of Columbia include prevention services, treatment, and recovery support services (RSS). SUD prevention services are delivered primarily through DBH's four DC Prevention Centers (DCPCs) who serve all eight wards and the youth treatment and recovery support services are made available through DBH's two Adolescent Substance use Treatment Expansion Program (ASTEP) providers. However, youth who are 21 years and older are able to access treatment and recovery support services through DBH's Adult Substance Use Rehabilitative Services (ASURS) program.

a. In FY 25, there were a total of 131 consumers aged 18-24 who utilized detox, outpatient and residential treatment services across the substance use continuum. Thus far in FY26, there has been a total of 72 consumers aged 18-24 who have accessed outpatient treatment services and residential treatment services.

	Total SUD Services 18-24	Detox	Outpatient	Residential Treatment
FY25	131	5	105	21
FY26YTD	72	1	65	6

b. See below for the youth service provider information.

ASTEP Providers	Location	Age Group	Capacity
Hillcrest Children & Family Center	915 Rhode Island Avenue, NE Washington, DC 20001 3029 Martin Luther King Jr. Avenue, SE Washington, DC 20032	12-25	80
Latin American Youth Center (LAYC)	1419 Columbia Road, NW Washington, DC 20009	12-21	25

c. The average wait time to initiate services is contingent upon a number of different factors. These factors include the personal preferences of the individual being referred, availability for an intake assessment at their preferred location, and the individual's commitment to treatment. DBH's expectation and communication to providers is that consumers should be connected to a provider within approximately one (1) week and commence treatment soon thereafter.

d. DBH is aggressively working to increase accessibility to outpatient SUD services. DBH is training ASTEP providers and transitional aged youth serving organizations in evidence-based interventions such as Motivational Enhancement Therapy/Cognitive Behavioral Therapy (MET/CBT) and the promising practice Transition to Independence Program (TIP) which have proven to be effective among older youth populations. The combination of these efforts will be critical in addressing barriers which impede youth and transitional aged youth from seeking services.

The District of Columbia Stabilization Center ("DCSC"), operated by Community Bridges, Inc. (CBI) in partnership with DBH, offers immediate, 24 hours/day, 365 days/year, no cost, low-barrier access to Crisis Substance Use Disorder (SUD) services for individuals 18 years of age and older. Transition aged youth 18 years or older can utilize the Center's services. The DCSC provides individuals experiencing an SUD crisis with person-centered and a recovery-oriented alternative to unnecessary encounters at emergency departments or interactions with law enforcement. The DCSC ensures those individuals seeking or referred for services receive integrated and comprehensive care to address their specific needs in a supportive clinical and recovery-oriented environment.

With regard to increasing capacity and addressing barriers to this age group, DBH initiated the implementation of a Level 3.5 Youth Substance Use Disorder (SUD) Residential Treatment Services with Federal City Recovery Services (FCRS). As of November 2025, the facility is operational and equipped to support youth 24 hours, 7 days a week and provides up to 16 beds for youth aged twenty-one (21) and under who are experiencing significant challenges in their daily functioning due to SUD. DBH and FCRS remain committed to the expansion of youth residential treatment services, enhancing service quality, and improving access to life-saving treatment for youth experiencing opioid use disorder.

Q83. Please provide an update on the creation of the District's comprehensive "Children's Plan," which was last updated in May 2012 and DBH indicated would be published by the end of FY 2025, and has yet to be published.

DBH Response:
During FY25, DBH leadership collaborated with child and youth stakeholders to begin developing a revised strategic plan for Child and Youth Services. In May 2025, DBH held a kick-off meeting for the Children's Plan and invited sister agencies, child, youth, and family advocacy organizations, community-based organizations, Core Services Agencies and other stakeholders to participate. Over the next several months, group members met, shared information, and outlined a path forward. The group decided to divide into three subgroups: early childhood, school-aged youth and transition age youth. Each subgroup was tasked with identifying three to five recommendations to be incorporated into the overall plan.

In August 2026, the larger group reconvened, and the team leads shared preliminary recommendations to be included in the Children's Plan. In September, teams were asked to continue working within their subgroups to refine their recommendations. While there remains strong desire and commitment from both DBH leadership and community stakeholders to complete the Children's Plan, competing priorities

required a shift in activities at the end of FY25. Many of the individuals working on the Children's Plan were also engaged in creating the School Behavioral Health Comprehensive Plan.

DBH remains committed to finalizing the Children's Plan and will hold a meeting in February 2026 to review the updated recommendations and outline next steps to move the plan forward. It is anticipated that the plan will be completed in May 2026.

Q84. How many Peer Navigators did DBH certify in FY 2025 and FY 2026, to date? How many of these navigators are ages 18-24? How many youth ages 18-24 have been engaged by DBH-certified Peer Navigators (of any age)? Please provide a count of the different types of services peer navigators have helped youth receive or connect to.

DBH Response:

DBH did not certify any Peer Navigators in FY 2025 or FY 2026; however, the Transition Age Youth Program (TAY) has supported a peer program called Youth Development Leads in the past. These individuals had lived experience and were hired in various capacities to support the work of the TAY team. All Youth Development Leads had experienced behavioral health challenges, were actively managing their wellness, and received behavioral health support. If the Youth Development Leads were not certified peers, they were encouraged to enroll in the DBH peer certification program. Additionally, all TAY service solicitations require vendors to hire a young adult peer to support their TAY services. The original funding source for this program ended, and DBH will continue exploring alternative funding opportunities.

Q85. What funding did DBH expend for FY 2025 and allocate in FY 2026 to grow the youth behavioral health workforce, including training, recruitment, retention, credentialing/continuing education, or the development of the "TAY Choice Provider" model or Peer Navigator program?

DBH Response:

In 2025, federal grant funding, both from the Mental Health Block Grant and the Clinical High-Risk Psychosis (CHR-P) SAMHSA grant was used to support TAY programing and training. To date, DBH has supported training in the following evidence-based and recovery-oriented practices:

- **Transition to Independence Process (TIP) -** The TIP approach is designed to support young adults from age 14 to 29 with emotional and behavioral difficulties as they transition into adult roles.
- **Seeking Safety** – An evidence-based treatment model addressing co-occurring post-traumatic stress disorder (PTSD) and substance use disorders.
- **Motivational Enhancement Therapy/Cognitive Behavioral Therapy-5 (MET/CBT-5)** – A brief intervention for adolescents with cannabis use disorders consisting of two individual MET sessions followed by three group CBT sessions.
- **Enhanced Illness Management and Recovery (E-IMR)** – A recovery-focused approach designed to support individuals with mental illness in managing symptoms and achieving personal recovery goals.

- **Trauma Recovery and Empowerment Model (TREM)** – A fully manualized, 24- to 29-session group intervention for male or female groups that addresses the impact of trauma.
- **Recovery-Oriented Cognitive Therapy (CT-R)** – A person-centered, strengths-based approach that promotes empowerment, recovery, and resilience by emphasizing individuals' values, aspirations, and capabilities rather than solely focusing on symptom reduction.

The investment in training is intended to strengthen provider capacity and improve services quality while supporting clinicians in providing services and support to transition age youth. DBH will continue to strengthen services and supports for this population to ensure a smooth transition into adulthood.

Q86. What mental and behavioral health counseling, referral, or outreach services does DBH provide specifically for youth aging out of foster care or youth ages 18–24 with prior involvement in the foster care system?

a. *With the recent closure of Wayne Place, what alternative services or placements are currently being used to meet the needs of youth with prior CFSA involvement?*
b. *Please provide data for FY24 and FY25, to date, on the number of youth served through these targeted services, including:*
    i. *Number of youth referred and number who received services;*
    ii. *Types of services accessed (e.g., counseling, substance use treatment, housing-related support);*
    iii. *Average duration of service engagement; and*
    iv. *Outcomes tracked, if available (e.g., housing stability, reduced substance use, improved mental health).*

DBH Response:

DBH maintains co-located staff at CFSA and collaborates with the staff within CFSA's Older Youth Empowerment Administration. These endeavors ensure CFSA is aware of behavioral health services and how to make referrals to identified services.

a. Wayne Place remains open and unhoused District youth with behavioral health concerns may participate in the Wayne Place Independent Living Program.
b. In FY 24, 24 CFSA affiliated TAY were served over the course of 18 months at Wayne Place. In FY 25, CFSA made six (6) direct referrals to Wayne Place. Of the six TAY referred, three (3) were actually placed at Wayne Place; however, their tenure was unsuccessful as they refused all services offered and struggled to follow program rules.

		FY 24	FY25
i.	Number of youth referred and number who received services	24	3
ii.	Types of services accessed	• Counseling, • Behavioral Health Treatments • Community Support	Youth did not actively engage in services

		• Workforce Development • Housing-related support	
iii.	Average duration of service engagement	18 months	7 months
iv.	Outcomes tracked, if available	Transitioned to long term stable housing via CFSA's housing vouchers	Prematurely discharged due to program violations.

Q87. Please provide an update regarding the type of assessments in place for screening students. How many students were assessed in FY 2024, FY 2025, and FY 2026, to date?

DBH Response:

DBH recognizes the importance of identifying events or circumstances that may be traumatic for students and often uses screening tools to guide interventions and treatment. School Behavioral Health (SBH) providers utilize a variety of screeners and assessments to evaluate students' strengths, weaknesses, and overall functioning. The choice of screener or assessment tool depends on the student's needs and developmental stage. For example, young children who attend Child Development Centers are often assessed using the Ages and Stages Questionnaire. Healthy Futures consultants who provide early childhood mental health consultation services support the centers in administering the screener and help to link the children and families to appropriate services when necessary. Children also are referred to the consultant for child-specific consultation services or to a behavioral health provider in the community.

Young students are also screened if they attend a school participating in the Primary Project resource. Primary Project is an evidence-based, early intervention and prevention program for young children in pre-Kindergarten/4 through third grade who have been identified with mild adjustment issues in the classroom. Through one-to-one, non-directive play sessions, the program reduces social, emotional and school adjustment difficulties to improve school-related competencies in task orientation, behavior control, assertiveness, and peer social skills. Four to six weeks after school starts, teachers assess the level of functioning and adjustment of each child in their classroom using the Teacher-Child Rating Scale-Short Form (TCRS-SF). Based on the results of the screening, children with mild adjustments concerns are referred to Primary Project, and children with more significant concerns are referred to a behavioral health clinician in the school. During School Year 2025–2026, Primary Project services were offered in four DC public and charter schools: Patterson Elementary, Takoma Education Campus, Cedar Tree Academy, and Perry Street Prep. A total of 853 students were screened using the TCRS-SF, reflecting strong engagement in early intervention efforts. In FY24, 1,139 students were screened across eight participating schools, including MLK Jr. and Patterson Elementary Schools, Takoma Education Campus, Cedar Tree Academy, Eagle Academy campuses at Capitol Riverfront and Congress Heights, Perry Street Prep, and SELA. During FY26, pre-kindergarten/4 students are scheduled to be screened by mid-January in two participating schools: Takoma Education Campus and Cedar Tree Academy.

All providers complete a diagnostic assessment (DA) for all students participating in treatment services. When completing the DA clinicians gather information (i.e., presenting problem, developmental history, family history, history of abuse, social functioning, and trauma history etc.) from the student and parent/guardian. In addition to the DA, providers sometimes complete additional screeners to gather information about a specific topic or concern. For example, providers may use a specific screener to assess anxiety, depression, substance use, or attention difficulties. The screener helps to provide additional information which aids in creating a comprehensive and effective treatment plan. In addition, providers use screeners for students participating in specific treatment programs (e.g., Bounce Back or Cognitive Behavioral Intervention for Trauma in Schools (CBITS) to assess appropriateness for the program.

Q88. Please provide an update on DBH's School Behavioral Health Program including a list of all schools that as of December 1, 2025 have DBH clinicians, CBO clinicians, or both. Please include:

a. *How much clinician time has been spent on Tier 1, Tier 2, and Tier 3 services;*
b. *How many and what percentage of schools have one or more CBO or DBH clinician currently in place;*
c. *How many schools have been matched by do not have an active DBH or CBO clinician;*
d. *How many schools have not been matched with a CBO (Please identify schools without a CBO clinician and provide the reason why one has not been hired);*
e. *How many schools in each cohort have a School Behavioral Health Coordinator, and what type of position/role do they hold at the school;*
f. *A list of all of the schools in each cohort; and*
g. *Any DBH plans to change the type of professionals that can be involved in the provision of Tier 1 and 2 services.*

DBH Response:

For the most current up-to-date provider directory, please see Attachment 1 of 6 which provides a list of all schools as of January 1, 2026, and their current provider assignment.

a. Please see Attachment 2 of 6. Time Spent on Tiers of Services.

b. As of December 1, 2025, there were 253 schools in the current landscape. Of these, 182 schools (72%) were staffed with at least one CBO, DBH, or LEA provider implementing the public health model of school behavioral health services or providing coverage to meet the school's needs. As of January, the number of schools with a provider increased by six, bringing the current total to 188 schools (74%).
c. In alignment with the transmitted Comprehensive Plan for School Behavioral Health, DBH is actively working to bring the School Behavioral Health Program in-house, as a result there are 54 schools that are now partnered with DBH and currently are pending clinician assignment. As of January 2026, two schools partnered with a CBO are currently vacant. And there are no vacancies with LEA-funded schools. For the most current and up-to-date details, please reference Attachment 4 of 6, titled CBO Partner Schools with Vacancies. Please reference Attachment 3 of 6. Schools Pending DBH Clinician Assignment.

d. In alignment with the Comprehensive Plan for School Behavioral Health, the Department of Behavioral Health (DBH) is actively working to transition the School Behavioral Health Program in-house. DBH recently hired two licensed clinicians and one supervisor. Additional positions will be posted in January. There are 54 schools currently pending the assignment of a DBH clinician.

e. Currently, 99% of schools have identified a School Behavioral Health Coordinator (SBHC). While the majority of school staff undertaking this role are school social workers, some are also principals, special education directors, school psychologist, school counselors, Connected Schools manager, Restorative Justice coordinator, Assistant Directors for Climate, Culture & Support, Director of Integrated Services, Chief of Student Support & Engagement, or SSST coordinators. Please see Attachment 5 of 6. List of SBHC by Cohort.

f. Please reference attachment 6 of 6. Schools by Cohort.

g. DBH continues to lead internal discussions and collaborate with the Coordinating Council on School Behavioral Health and other stakeholders regarding the use of unlicensed professionals and paraprofessionals to deliver Tier 1 (universal) services. Currently, five schools have been assigned a prevention specialist to implement Tier 1 prevention services. These services are designed to be accessible to all students, regardless of challenges, disabilities, or behavioral health risk levels. Tier 1 interventions are delivered school-wide, at the grade level, or within classrooms and include activities that promote behavioral health, programs that strengthen social and emotional competencies, and initiatives that foster a positive school climate and support staff well-being.

DBH is expanding the licensure credentials for hired clinicians beyond social work licenses to include LGPC, LPC, and LMFT. This expansion offers several benefits, including broadening the talent pool and reducing staffing shortages by allowing recruitment from a wider range of qualified professionals. More credential options mean more clinicians available to serve schools, improving access to behavioral health services across Tiers 1, 2 (early intervention), and 3 (treatment) services. Different licenses also bring specialized expertise: licensed professional counselors (LPCs) have strong training in counseling techniques and mental health assessments, while licensed marriage and family therapists (LMFTs) offer expertise in family systems and relational dynamic, both are valuable for addressing issues involving students and families. Additionally, offering multiple licensure pathways can attract early-career professionals, such as LGPCs, who are working toward full licensure, creating a sustainable pipeline for long-term staffing.

Q88. Attachment 1 of 6. List of Schools with DBH, CBO, or LEA
Q88. Attachment 2 of 6. Time Spent on Tiers of Services
Q88. Attachment 3 of 6. Schools Pending DBH Clinician Assignment
Q88. Attachment 4 of 6. CBO Partnered Schools with Vacancy
Q88. Attachment 5 of 6. Schools with a SBHC by Cohort
Q88. Attachment 6 of 6. List of Schools by Cohort

Q89. Individual School Breakdown: For each school with a DBH or CBO clinician in place during FY 2024, FY 2025, and FY 2026, to date, please provide the following information in an Excel spreadsheet:

a. The number of students who met with a clinician;
b. The number of students who were referred to care;
c. The student to clinician ratio for the school, and the average caseloads of CBO clinicians;
d. The most common diagnoses or concerns;
e. The percentage of each referral source (walk-in, teacher, parent, etc.);
f. The prevention programs and services (Tier 1 or 2) that were offered;
g. The number of students who participated in prevention programs;
h. Name and contact information for their clinician(s) and School Behavioral Health Coordinator;
i. Percentage of clinician's time that was billed to Medicaid, Alliance, or private insurance;
j. Relevant links for clinician websites, social media pages, or other materials; and
k. A list of current programs that are meeting the existing need for services, and if not, what is being done to meet the total need.

DBH Response:

All Community Based Organization (CBO) and DBH clinicians are required to report daily activity data using the QuickBase platform. Services and supports across all Tiers are captured using the system which allows DBH to capture data more effectively and efficiently.
Please refer to Attachment 1 of 5 an excel spreadsheet detailing services per school for School Year 2024-2025 (FY 2024 & FY 2025) and School Year 2025-2026 (FY 2025 & FY 2026 to date).

a. Please reference Attachment 1 of 5 FY25 and FY26 Detail Services per school
b. Please reference Attachment 1 of 5 FY25 and FY26 Detail Services per school
c. The School Behavioral Health Program is designed to supplement rather than supplant services available in the school. Each school employs its own providers and resources to support students, families, and staff, in addition to the DBH-funded School Behavioral Health Provider. Although the School Behavioral Health Provider may offer support through Tier-1 prevention and Tier-2 early intervention services to the school community, they are not the sole provider or resource. For specific caseload details by school, please reference Attachment 1 of 5 FY25 and FY26 Detail Services per school.
d. Historically, the most common diagnoses have included Adjustment Disorder, Major Depressive Disorder, Attention Deficit Hyperactivity Disorder (ADHD), and Anxiety. This data is not currently available due to the variety of electronic medical records used by external partners.
e. Please reference Attachment 2 of 5. percentage of each referral source.
f. SBH providers have conducted 9,233 sessions of Tier-1 and Tier-2 programming, encompassing both evidence-based and clinician-created initiatives. Out of these, 6,319 sessions (68%) specifically addressed at least one of the District priorities (Substance use, Suicide, and Violence Prevention). Typical programs offered include, but are not limited to: Anger Management, Anxiety, Ask for Help, Bullying prevention, Conflict Resolution Skills, Coping Skills, Diversity and Inclusion, Empathy, Executive Functioning Skills, Feelings Identification, Grief and Loss, Healthy Relationships/Boundaries, Kimochis, LGBTQ+ Awareness, Love is not Abuse, Mindfulness, Parent Café, Positive Communication Skills, Restorative Justice, Second Step, Self-esteem, Self-care and Stress Management, Self-

regulation Skills, Signs of Suicide, Social Skills, Too Good for Violence, Too Good for Drugs, Trauma, and Zones of Regulation.

g. During School Year 2024-2025 (FY 2024 & FY 2025) and School Year 2025-2026 (FY 2025 & FY 2026 to date), 56,680 students participated in at least one Tier-1 prevention or Tier-2 early prevention program. This figure represents DBH's ongoing commitment to improving data collection and reporting practices to ensure accuracy and reliability. Please note that this figure may include duplicate counts, as students often have the opportunity to participate in multiple programs, underscoring the breadth of engagement and access to services.
h. Please reference Attachment 3 of 5. SBHP Providers Contact Information. Please reference Attachment 4 of 5. SBHC list.
i. This data is not available. DBH is collaborating with DHCF to identify ways we can collect this information in the future.
j. Please reference Attachment 5 of 5. Relevant links for clinician websites, social media pages, or other materials.
k. The gthening Work Plan (SSWP) serves as a strategic tool to identify and implement services that support students' behavioral health needs while fostering a positive school culture. DBH is proud to share that in FY 2025, 83% of school behavioral health teams successfully completed a work plan, demonstrating strong engagement and commitment to student well-being. Programs are thoughtfully selected by each school's mental health team to meet the unique needs of their community. Because the DBH School Behavioral Health Program is supplemental, schools often collaborate with additional providers alongside the DBH-funded SBH resource, creating a comprehensive approach to service delivery. DBH Clinical Specialists play a vital role by partnering with School Behavioral Health Coordinators (SBHCs) to provide technical assistance, guide the SSWP process, and identify gaps in services. When gaps are found, Clinical Specialists work proactively to implement programs that address those needs. To further expand service delivery, DBH introduced innovative models that utilize unlicensed professionals and paraprofessionals to implement prevention and universal behavioral health services. Additionally, efforts are underway to reduce barriers to program expansion through targeted training and robust supervision—ensuring quality and sustainability. Together, these initiatives reflect DBH's commitment to strengthening schools, supporting mental health, and creating environments where students thrive.

Q89. Attachment 1 of 5. FY25 and FY26 Detail Services per school
Q89. Attachment 2 of 5. Percentage of each referral source
Q89. Attachment 3 of 5. SBHP Providers Contact Information
Q89. Attachment 4 of 5. SBHC list
Q89. Attachment 5 of 5. Relevant links

Q90. How many of the schools in Cohorts 1, 2, 3, and 4 have started or completed the SBBH School Strengthening Tool and Work Plan for the 2025-26 school year? Please provide the template for the School Strengthening Tool.

DBH Response:

As of January 2026, 68% of schools have successfully submitted their School Strengthening Work Plan (SSWP) for the 2025–2026 school year. The chart below provides a breakdown by cohort. School teams are leveraging individualized, school-centric data to design SSWPs that address the unique needs of their students, families, and staff. This marks the second year of using the online SSWP database, which has streamlined access and strengthened collaboration across school teams. This year, access was further improved with the addition of School Behavioral Health Coordinator (SBHC) accounts. Moving forward, this enhancement will help eliminate delays at the start of the school year, as most SBHCs remain consistent year to year and can now access the QuickBase SSWP app anytime throughout the school year.

Clinical Specialists continue to provide technical assistance and hands-on support, playing a key role in increasing the number of completed SSWPs in FY25. They have responded to feedback by offering additional guidance for those unfamiliar with the process, ensuring every team feels confident and supported.

With expanded account access, DBH aims to reduce time-related barriers, allowing school mental health teams to begin the work plan process during downtimes. While the expectation remains that all schools will complete an SSWP, some schools have shared that they prefer to wait until they receive a DBH-funded resource. These improvements reflect our shared commitment to strengthening schools and supporting the well-being of students and staff.

Please reference attachment 1of 1. SSWP Template.

SY 2025-2026 Completed Workplans by Cohort as of January 2026		**SY 2024-2025 Completed Workplans by Cohort**
Cohort	**Total Number Completed**	
1	29 of 48 schools (60%)	44 of 48 schools (92%)
2	52 of 64 schools (81%)	61 of 65 schools (99%)
3	36 of 46 schools (78%)	41 of 46 schools (89%)
4	52 of 89 schools (58%)	62 of 90 schools (69%)
Extended Expansion	2 of 6 extended expansion (50%)	3 of 5 extended expansion (60%)
Total	171 of 253 schools (68%)	211 of 254 schools (83%)

Q91. Please provide the following information on the SBBH funding model:

a. *Why the findings of the Rate Study were not updated to reflect current cost given the two-year delay of the study;*
b. *Status of program evaluations conducted by Child Trends including the timeline for publication, the reason for delay, and how the findings will be shared;*
c. *Percentage of total CBO and DBH clinician services, broken down by type of service, that have been able to be billed to Medicaid, private insurance, or other sources in FY 2025 and FY 2026, to date;*

d. What is the total amount billed per school by the CBOs during school years 2024–2025 and 2025–2026, to date? Please provide the same information, broken down by school, for DBH clinicians;
e. Plans for re-evaluating the financial model and the data DBH will use to make decisions;
f. How did DBH factored in the rate study when considering their new comprehensive plan?

DBH Response:

a. The Rate Study was published using data and information that was collected from outside vendors during the original time frame of the contract. DBH will review the findings and collaborate with DC Health Finance and other stakeholders to determine if adjustments are necessary.

b. The Child Trends program evaluations are uploaded onto the DBH website.

c. See attachment 1 for the Medicaid billing data for the DBH SBHP broken down by DBH-employed and CBO clinicians. For each group the data included total Medicaid reimbursements, number of students services, and types of service.

d. See attachments 2 and 3 for the total amount billed per school for DBH clinicians. This data could not be pulled for CBO clinicians. DBH will continue to collaborate with DHCF in the future to be able to pull the data.

e. At this time, DBH does not intend to re-evaluate the financial model, as DBH is proceeding with the planned transition of the program to an in-house model. Clinicians will continue to bill for treatment services in accordance with the established billing and reimbursement structures. DBH will use service utilization data and billing data to monitor implementation of the in-house model, ensure fiscal stability, and support data informed decision making. This information will be used to inform any future adjustments needed to support program sustainability and effectiveness.

f. DBH reviewed the rate study and incorporated as much information into the plan as possible. Several recommendations from the report are included in the Comprehensive Plan, including enhancing support for the prevention and early intervention services, improving access for students and families by utilizing non-licensed professionals to implement prevention services, contracting with telehealth providers for older students, and contracting with an evaluator to measure the effectiveness of the program.

While some findings were incorporated into the plan, other recommendations from the report could not be incorporated. For example, clinician costs identified in the rate study could not be directly applied, as DBH was required to allocate a fixed funding amount for each CBO clinician. DBH also explored adding additional supports to the plan, including a stipend for the School Behavioral Health Coordinators. Due to a $3.4 million cut in FY27, DBH could not include the stipends in the plan.

Q92. Please provide an update on the pilot programs that were launched and implemented in FY 2025 and FY 2026, to date. Include all details for each pilot program, including the number of applications received, the number of schools participating, compensation levels, and any obstacles encountered during the implementation of each individual pilot. Include how the pilots will be evaluated to determine whether DBH will continue in school year 2026-27.

DBH Response:

DBH has been exploring the options to ensure access to behavioral health services in all public schools given ongoing workforce challenges. During SY 2025, DBH implemented two pilots. See below for more information.
Pilot 1B: Pilot 1B represents a second effort for DBH to provide grant funds directly to the DC Public Charter Schools. The FY 2024 Request for Application (RFA) included one (1) Option Yr (October 1, 2024, to September 30, 2025) for FY 2025. The maximum award was $80,819.67. Local Education Agencies (LEAs) received $80,819.67 for a full-time clinician or $40,909.84 for a part-time clinician. The funding included the clinician's cost of salary for non-billable services and funding for supervision ($63,153 + $16,666.67). Additionally, funding also provided $1,000 for workforce development. The FY 2025 Pilot 1B schools represented six (6) of the initial LEA applications and represented 8 schools. These schools were:

1. Elsie Whitlow Stokes Community Freedom PCS, Brookland
2. Elsie Whitlow Stokes Community Freedom PCS, East End
3. Rocketship PCS, RISE Academy
4. Rocketship PCS, Infinity Community Prep
5. Breakthrough Montessori Public Charter School
6. Thurgood Marshall Academy PCS
7. DC Wildflower PCS
8. Mundo Verde Bilingual PCS, J.F. Cook Campus

For FY 2026, a new RFA was published in July 2025, and two applications were received representing three schools. The maximum award was $120,000. LEAs received $120,000 for a full-time clinician or $60,000 for a part-time clinician. The Pilot 1B schools in FY 2026 are:

1. Elsie Whitlow Stokes Community Freedom PCS, Brookland
2. Elsie Whitlow Stokes Community Freedom PCS, East End
3. Thurgood Marshall Academy PCS

Pilot 1B schools continue to encounter significant challenges. These schools face difficulties in hiring and retaining licensed clinicians as well as securing appropriate supervisors. In FY 2025, only two schools reported successfully hiring a clinician, while the majority of the LEAs opted to postpone signing the FY 2025 Notice of Grant Award (NOGA). Currently in FY 2026, the two schools (across three campuses) are staffed with a clinician and an identified supervisor. However, even when positions are filled, schools experience challenges in implementing the public health model of school behavioral health services and meeting grant requirements. Due to the limited number of clinicians providing services within Pilot 1B schools, there is insufficient utilization data to inform data-driven decision-making.

Pilot 2: Pilot 2 represents an effort of DBH to provide flexibility in the school behavioral health model to utilize a Hybrid Telework Model for schools with a student population of adult-learners and high school-aged students and where the schools were matched with a CBO partner yet had a CBO clinician vacancy.

CBO supervisors met with the school's principal and school behavioral health team and determined whether there was mutual school and CBO interest in participating in the Pilot 2: Hybrid Telework Model. CBOs and schools were required to complete paperwork that included an Agreement for Pilot 2 Form and a Pilot 2 Work Schedule Agreement. If approved by DBH to participate in Pilot 2: Hybrid Telework Model, the CBO clinician would provide services through a hybrid model (3 days on campus, in-person services/week and 2 days tele-mental health services/week). Clinicians were required to meet the SBHP requirements included in the NOGA's Scope of Services including the following:

- receive clinical supervision,
- submit data and adhere to the reporting requirements,
- participate in the Community of Practice,
- participate in evaluation activities,
- develop the School-centric Assessment and School Strengthening Work Plan with the school behavioral health team.

The schools initially eligible for Pilot 2 in FY 2025 and FY 2026 were:
1. MBI Health Services for school partnership at Luke C. Moore High School
2. Better Morning Inc. for school partnership at Bard High School Early College DC

Luke C. Moore became ineligible to participate when the clinician vacancy rate required a shift in the staffing model. Despite outreach efforts to increase participation, implementation of the Hybrid Telework Model remained very limited due to the low participation and insufficient data. Based on identified school needs, Better Morning, Inc. and Bard High School mutually agreed not to implement the hybrid model in FY 2026. The assigned clinician is currently on-site five days per week, providing school-based behavioral health services.

During FY 2025, Luke C. Moore experienced a prolonged clinician vacancy. The school is now staffed with a part-time clinician. DBH will continue school, student, and parent conversations to assess both pilot programs to determine whether the Pilots should be sustained during the 2026–2027 school year.

Cluster Model: The cluster model reflects DBH's effort to provide greater flexibility and diversify service delivery by incorporating unlicensed professionals to support the provision of school behavioral health services. During FY 2025, DBH implemented a cluster model as part of its innovative strategies. One Community-Based Organization (CBO) adopted this model, pairing two (2) licensed clinicians with one (1) unlicensed prevention specialist to deliver school behavioral health services across four (4) schools. The schools identified for the two clusters were:

Cluster 1:
- Hart Middle School

- Langdon Elementary School
- Murch Elementary School
- Turner Elementary School

Cluster 2:

- Basis DC Public Charter School
- Burrville Elementary School
- Shining Stars Montessori Academy Public Charter School
- Thomas Elementary School

Due to higher needs at certain schools, one clinician ultimately provided full-time services at a single site, leaving another school without a licensed clinician. Additionally, the CBO was unable to hire the designated prevention specialist, resulting in some schools having only supervisor coverage and no assigned direct provider placement. Clinicians did not meet service benchmarks at these schools, with the exception of Shining Stars, where both the caseload benchmark and the Tier 2 early intervention benchmark were achieved.

For FY 2026, the same CBO continued implementing the cluster model, incorporating adjustments based on stakeholder feedback and other data. The schools identified for the two clusters in FY 2026 are:

Cluster 1:

- Benjamin Banneker High School
- Basis DC Public Charter School
- Murch Elementary School
- Smothers Elementary School

Cluster 2:

- Community College Preparatory Academy Public Charter School
- Langdon Elementary School
- LaSalle-Backus Elementary School

Cluster 1 will consist of two (2) licensed clinicians and one (1) prevention specialist. One clinician will provide services across two schools, while the prevention specialist will serve Smothers Elementary and LaSalle-Backus Elementary Schools. Cluster 2 will include one (1) licensed clinician and one (1) prevention specialist delivering school behavioral health services at Community College Preparatory Academy PCS and LaSalle-Backus Elementary School. Langdon Elementary will have a designated prevention specialist, with Tier 3 treatment coverage provided as needed. At this time, there is no available data for the FY 2026 cluster model, as the CBO has only recently confirmed staffing.

DBH will continue to monitor and evaluate the cluster model to assess its effectiveness in meeting service benchmarks and addressing school behavioral health needs.

Telehealth Services Pilot Program: The telehealth pilot reflects DBH's commitment to expanding school behavioral health services to high school students, adult learners, and online school students who currently do not have a DBH-funded resource. The Request for Applications (RFA) was published in December 2025, and submissions are currently under review. Tier 3 treatment services will be delivered virtually through a HIPAA-compliant telehealth platform and scheduled outside of school hours in the

home or community. Eligible residents are covered under DHCF Medicaid and DBH benefit plans. Services will include, but are not limited to, diagnostic assessments and treatment planning; brief, solution-focused, evidence-based therapy for individuals, families, and groups; office hours for drop-in consultations; and therapeutic support as needed. The grant awardee will also be responsible for providing schools with clear guidance on how students and families can access telehealth services and crisis intervention resources. Once implemented, DBH will monitor and evaluate the pilot to determine its effectiveness in increasing access to quality services and in meeting the behavioral health needs of the students who attend the participating schools.

Q93. Please provide a breakdown of all DBH administrative positions that support the SBBH program. Include the following information for each position:

a. *Role and responsibilities.*
b. *Whether the position provides technical assistance, supervision, program oversight, or other support to DBH clinicians and CBO grantees;*
c. *Number of FTEs assigned to each role; and*
d. *Funding source(s) for each position.*

DBH Response:

Please see attachment 1 of 1 for breakdown of all DBH administrative positions that support the SBHP.

Q94. Since school year 2012, please identify all schools where DBH has placed DBH clinicians (excluding CBO clinicians). For each school and school year (from SY 2012 to the present), please provide:

a. *Billing data;*
b. *Average caseload per clinician;*
c. *Number of student drop-ins;*
d. *Please list any schools where DBH has removed DBH-employed clinicians, along with the reasons for their removal.*

DBH Response:

Establishing and maintaining school partnerships is a cornerstone of the DBH SBHP program. The management team, SBHP program manager and clinical supervisors, engage with school leadership and school behavioral health coordinators monthly at a minimum to monitor and problem solve around clinician school integration and service delivery. The goal of this open and consistent line of communication is to ensure the needs of the school are being met and the clinician is being utilized at all three tiers of the public health model. School reassignments or movements occur after a series of conversations with school leadership. The primary reasons for reassignment of clinician are as follows:

1. School Need and Clinician Utilization
    - The school's level of need has changed resulting in low clinician utilization.
2. Misaligned Partnership
    - The clinician's skills may better align with the needs of another school.
    - Challenges with collaboration or integration into the school team may prompt reassignment.

3.Equity and Access

- Addressing gaps where some schools have no clinician support while others have multiple.

4. Clinician professional growth and retention

- To support clinician retention, an exchange of clinicians between schools to support professional growth goals.

Please see attachment for the list of schools, billing data, average caseload, number of walk-ins, and reasons for reassignments.

Q95. Provide an update on the status of DBH's comprehensive plan to improve the School-Based Behavioral Health program, including, but not limited to the following:

a. *What major revisions have been made since the plan was released, and what prompted those changes?*
b. *Which elements of the plan remain under development, and what is the anticipated timeline for finalizing them?*
c. *How has DBH incorporated feedback from school leaders, clinicians, CBOs, families, and advocates into the revised plan?*
d. *Please describe plans to contract with an expert in school based behavioral health to complete a case study evaluation that will identify effective practices in high performing SBHP CBOs.*
e. *The Comprehensive Plan makes no reference to the School Based Behavioral Health Coordinator role – how does the agency foresee implementing this in the Comprehensive Plan?*
f. *Please provide the implementation plan for the SBBH comprehensive plan that DBH indicated would be completed by November 30, 2025.*
g. *Please provide the raw data collected as part of the School-Based Behavioral Health (SBBH) Environmental Scan.*

DBH Response:

a. While DBH continues to engage and collaborate with school behavioral stakeholders and partners to gather input and feedback, DBH has made no major revisions to the content of the school-based comprehensive plan.
b. Due to the urgency of the need, the team has pivoted to implementation by identifying necessary action steps, resources, and timelines required to achieve the plan's goals and objectives. These steps and their progress are outlined in the attached timeline. See attachment for more details.
c. Various stakeholders, including Coordinating Council members, CBO leadership, DBH and CBO clinicians have provided valuable feedback on the plan. In addition, they have offered concrete steps that DBH can take to successfully implement the plan. Specifically, portions of the feedback have been integrated into the communication and engagement strategies implemented by DBH. DBH plans to join existing parent and youth advisory meetings within government and nongovernment agencies beginning in January 2026. DBH will obtain feedback regarding the plan and hold conversations to gain perspectives on the needs and what resources would effectively address them. Additionally, DBH has begun outreach to schools to discuss the plan and any potential impact the plan will have on their schools.
d. DBH identify an expert, and it is anticipated the contract will be implemented in February 2026.
e. DBH explored the feasibility of adding a stipend for the School Behavioral Health Coordinators. Due to a $3.4 million funding reduction in FY27, DBH did not include the stipends in the FY27

plan. DBH will continue to collaborate with educational partners and explore the possibility of incorporating this support in FY28.

f. Please see attachment 1 for the FY26 Implementation Plan.
g. Please see attachments 2-5 that include the environment scan questions and the corresponding raw data.

Q96. Please provide the following information on DBH's work to promote access to a continuum of quality substance abuse prevention, treatment, and recovery support services for FY 2025 and FY 2026, to date:

a. List of providers and number of consumers served by DBH's outpatient methadone maintenance treatment programs and clinics; and
b. Number of prescriptions, per month, reported to the Prescription Drug Monitoring Program.

DBH Response:

In partnership with its grantees and community partners, DBH continues to lead the effort to promote and enhance access to the full continuum of quality substance use prevention, treatment, and recovery support services in the District. We utilize the following pathways/strategies to achieve these goals:

Web based Resources
A key component of our strategy to increase access to community services is through promotion of the DBH-sponsored website. This site provides information on accessing overdose prevention, prevention, treatment, and recovery support services. Prevention information and resources about the DC Prevention Centers can be accessed via https://dbh.dc.gov/prevention; information about accessing treatment through the DBH Assessment and Referral Center and DBH-certified treatment provider network can be found at https://dbh.dc.gov/page/substance-use-disorderservices; youth specific treatment information is available at https://dbh.dc.gov/youthsudservices; and recovery resources are available at https://dbh.dc.gov/recoveryresources.

DBH also partners with DC Health through its MyRecoveryDC, https://myrecoverydc.org, initiative to provide updated, ward-level information and resources, as well as access to individuals with lived experience for support. The map of services on the website was updated in the FY25 4th quarter. DBH also participates in the Network of Care, another web-based resource that provides information about local behavioral health resources. Lastly, through social media and other web-based platforms, DBH pushes daily messages about accessing services and supports, as well as highlighting the important work of community providers and partners.

Social Marketing
In FY25, DBH continued implementing the "Hope" Campaign ("This Time It is Different"), which targets individuals who need to be engaged or re-engaged in treatment by promoting the District's treatment, recovery services and supports. This campaign continues to run and is visible across the city on buses and in the subway stations. As part of this campaign, by texting "Ready" to 888-811, an individual receives a list of treatment providers who are open and available at the time of the text. In addition, all DBH promotional materials list the number for the Access Helpline (24/7 Hotline,

discussed below) staffed by behavioral clinicians who can address emergent issues at the time of the call or refer the individual to community providers for on-going care.

Outreach and Community Engagement
DBH's Public Engagement Director continues to coordinate outreach efforts and community engagement, leveraging both DBH resources as well teams across community organization. The Public Engagement Director coordinates outreach efforts and builds relationships with other governmental partners and community stakeholders to address the needs of the community. The outreach teams continue to provide support, training, distribute educational materials at community and pop-up events, and conduct community outreach in specified neighborhoods with the highest needs, engaging our most vulnerable citizens.

In the Winter of 2026, through the State Opioid Response (SOR) grant, DBH plans to update the Opioid Ambassador's training, which provides community stakeholders an in-depth overview of DBH's services and supports to enable them to spread the word throughout their communities regarding how those in need can best access services and supports.

Access HelpLine
Through the above pathways, we emphasize to community partners and those seeking care that our Access HelpLine at 1(888)7WE-HELP or 1-888-793-4357 is the most expedient and efficient means to connect to a DBH or certified, community behavioral health provider. This 24-hour, seven-day-a-week telephone hotline, staffed by licensed and trained behavioral health professionals, serves as our Crisis and Triage hub: providing crisis management, counseling, information regarding community services, as well as routine care in the community. The Access HelpLine also receives calls from the "988" National Suicide Prevention Life Line emanating from the District to support individuals and friends or loved ones of individuals struggling with suicidal thoughts, contemplating self-harm, in emotional distress and seeking confidential support.

List of providers and number of consumers served by DBH's outpatient methadone maintenance treatment programs and clinics

In Fiscal Year 2025, the three community-based Opioid Treatment Programs (OTPs) listed below served 906 individuals to date. Complete claims data for the first quarter in FY 2026 is unavailable. All substance use treatment providers began using their own electronic health record (EHR) instead of DATAWITS in FY 2024. This continues to cause some delays in billing.
In addition to the three community OTPs, there is an OTP located at the DC Jail and the Veterans Administration.

Outpatient Methadone Provider	Location	Number of Consumers Served in FY 2025
Behavioral Health Group (BHG)	1320 Marion Barry Way, SE Washington, DC 20020	386
Baymark (Formerly Foundation for Contemporary Mental Health -	2112 F Street, NW Suite 137	326

Partners in Drug Abuse Rehabilitation and Counseling [PIDARC])	Washington, DC 20037	
United Planning Organization (UPO)	1900 Massachusetts Ave, SE, Bldg 13 Washington, DC 20003	194

Number of prescriptions, per month, reported to the Prescription Drug Monitoring Program

DC Health manages the Prescription Drug Monitoring Program (PDMP). As a result, the requested data are not available to DBH at this time. The methadone clinics do not report prescriptions to the PDMP.

Q97. For the Safe Syringe Program, please provide the following information for FY 2025 and FY 2026, to date:

a. Number of syringes distributed, per vendor per month, for the Safe Syringe Exchange program.
b.Targeted geographic areas for each vendor; and
c.The number of sharps collected by each vendor.

DBH Response

a. See *FY 25 Oversight Question 97, Attachment 1 of 2 Overdose Prevention and Outreach Engagement Team syringes* for the number of syringes distributed and exchanged, per vendor per month, for FY 2025.

b. DBH's three mobile Overdose Prevention and Outreach Engagement Teams serve the entire District and are assigned specific geographic areas based on their home office and hotspot data. In addition, they are assigned by DBH to distribute naloxone through Text-to-Live, for syringe cleanups, and to respond to community concerns.

See *FY25 Oversight Question 97, Attachment 2 of 2. SSP Map* for a map of where each vendor is assigned. Us Helping Us (UHU) is assigned to Northwest; HIPS is assigned to Northeast (East of the River) and Southwest (East of the River); and Family Medical and Counseling Services (FMCS) is assigned to East of the River. When issues arise in an area that is not in anyone's targeted area, DBH assigns a team to address the issue on a case-by-case basis.

c. See chart below for the number of syringes, also known as sharps, distributed and collected by each vendor for FY 25. For FY 26, only the number of syringes collected is listed because these teams were no longer distributing as a part of the SOR grant.

Provider	**Number of Syringes Distributed FY 2025**	**Number of Syringes Collected FY 2025**	**Number of Syringes Collected FY 2026 (October and November)**

Family Medical	64,567	43,985	4,830
HIPS	312,933	190,114	12,726
Us Helping Us	10,907	5,025	0
TOTAL	**388,407**	**239,124**	**17,556**

Q98. Please provide the following information for LIVE.LONG.DC 3.0 for FY 2024, FY 2025 and FY 2026, to date:

a.The number of DBH staff dedicated to opioid prevention and response, including grades and titles;
b.An updated list and map of locations (including ward) where the public can get Naloxone;
c.The number of Naloxone that was distributed in FY 2024, FY 2025, and FY 2026, to date. If possible, provide a list of the locations and the number of Naloxone that was distributed at each location;
d.The number of Naloxone trainings conducted in FY 2024, FY 2025, and FY 2026, to date; and
e.A spreadsheet listing the faith-based institutions receiving grants on opioid prevention and treatment, including grant amount and description of services.

DBH Response:

a. There are nine DBH staff who conduct prevention and response activities including the mobile van, naloxone distribution, and ward engagement staff supported by the State Opioid Response (SOR) grant. In addition, another 11 DBH staff and a contractor who manage the SOR grant and perform related activities, including fiscal monitoring and data collection, are supported by the grant. See *FY25 Oversight Question 98, Attachment 1 of 3 Opioid Prevention and Response Staff* for the grades and titles.

b. See https://dbh.dc.gov/page/where-can-i-get-naloxone-dc for locations (including ward) where the public can get free naloxone. Free naloxone is available in all eight wards at 43 pick-up sites including pharmacies, community locations and 12 vending machines. In addition, anyone can text LiveLongDC to 888-811 to request delivery or get the list of pick-up sites. Users will get treatment clinic locations as well.

c. DBH and 149 community and government partners have distributed about 450,000 naloxone kits including 95,772 in FY 2024, 110,544 in FY 2025, and 6,972 in FY 2026 (October–November 2025). See *FY25 Oversight Question 98, Attachment 2 of 3 Naloxone Distribution* for a list of the community-based organizations and the number of naloxone kits that were distributed by each (data from October 2023–November 2025).

d. There were 201 instructor-led naloxone trainings in FY 2024, 185 in FY 2025, and 24 to date in FY 2026 (October–November 2025). Free online naloxone training can be accessed at https://dbhtraininginstitute.networkofcare4elearning.org/. In FY 2024, 2,212 individuals took the training, 4,408 in FY 2025, and 428 in FY 2026 (October–November 2025).

e. See FY25 Oversight Question 98, Attachment 3 of 3 Faith-Based Grantees for a list of the faith-based institutions receiving grants focused on opioid prevention and treatment, including grant amount and description of services.

Q99. How many calls the Access Helpline received related to opioid addiction in FY 2024, FY 2025, in FY 2026, to date? Please provide the following information for the Assessment and Referral Center (ARC) in FY 2024, FY 2025 and FY 2026, to date:

ll. Number of clinicians and other staff conducting assessments;
mm. Number of assessments conducted; and
nn. List of places where consumers were referred, including number referred to each center, description of services, and length of type between referral, intake, and first appointment.

DBH Response:

a. Number of clinicians and other staff conducting assessments:

The DBH Assessment and Referral Center (ARC) employs a multidisciplinary team of five clinicians, including licensed social workers, certified addiction counselors and registered nurses. The multidisciplinary team collaborates to evaluate the consumer's needs and determine the appropriate level of care through a combination of medical triage and a standardized assessment tool.

b. Number of assessments conducted:

FY	Total Assessments ARC
FY24	1047
FY25	708
FY26YTD	150

c. List of places where consumers were referred, including number referred to each center, description of services, and length of type between referral, intake, and first appointment:

To_Agency_Name	FY24	FY25	FY26YTD
APRA Intake Agency	1		
BayMark Health Services of West Virginia, Inc.	2		
Clean and Sober Streets	37	3	2
Family & Medical Counseling Service	12		1
Federal City Recovery Services	65	3	
Holy Comforter St. Cyprian	11		
LaClinica Del Pueblo	1		
MBI Health Services, LLC	1		
NULL	760	691	145
Psychiatric Institute of Washington	107	7	1
Regional Addiction Prevention (RAP)	21	4	1
Samaritan Inns	21		
So Others Might Eat (SOME)	5		
Volunteers of America Chesapeake Inc	3		
Grand Total	**1047**	**708**	**150**

FY	Total days between referral and intake
FY24	52
FY25	12
FY26YTD	6

Q100. Please provide the following information for the DBH Peer Specialist Certification Program FY 2024, FY 2025, and FY 2026, to date:

oo. Number of peers trained and certified;
pp. Duration of the program and any significant enhancements or modifications introduced; and
qq. Number of certified peer specialists working in the District, including roles and activities

DBH Response:

DBH offers three Peer Specialist certification in-person training classes each fiscal year. In addition, an already trained peer specialist can be certified through a waiver testing process. In FY 2024, 36 peers were certified, including 30 through the training class and six were certified through waiver testing. In FY 2025, 38 peers were certified including 32 through the training class and six certified through waiver testing. DBH will hold three Certified Peer Specialist training classes in FY 2026. The first training class will begin on January 26h, 2026.

a. Number of peers trained and certified.

There is currently a total of 219 active DBH Certified Peer Specialists.

b. Duration of the program and any significant enhancements or modifications introduced.

The DBH Certified Peer Training program consists of six weeks of classes and 80 hours of practicum assignments. The training curriculum is aligned with the national standards of peer support.

In FY 2024 DBH enhanced the Peer Certification training application process by creating an electronic application process. The application/database was made available to the public for the FY 2025 application period. Benefits of the system include applicants getting electronic responses regarding complete/incomplete applications upon submission, notification of missing documentation, the ability to save an application in progress and comeback to complete. There are internal benefits that allow all training team members to access application status and associated histories to provide more timely support and follow up to the applicant/certified peer and conduct tracking and trending inquiries. This database system manages all applicant/certified peer related data and significantly enhances overall efficiency and quality of process, utilization of personnel and maintenance of applicant/peer records.

In FY 2025, DBH added Forensic Skills development training for peers. The training is designed to enhance the skills of peer to support residents with behavioral health challenges who may be at risk of becoming justice involved, or those who are currently/previously justice involved. Eight DBH team

members were certified to facilitate the training. In FY 2025, two Forensic Skills training classes were offered. To date, a total of 47 peers have completed the training.

DBH meets at least quarterly with peer specialists to share ideas, solicit input that contributes to advancements in the peer certification program, and offer social support. In addition, the meetings offer an opportunity to identify challenges and progress in the system of care and stay abreast of local and national developments and best practices related to developing a strong peer workforce.

c. Number of certified peer specialists working in the District, including roles and activities.
In FY24, 135 certified peer specialists reported that that they were meaningfully employed. DBH certified peer specialists are working throughout the system of care including Saint Elizabeths Hospital, CPEP, certified providers, and the DC Stabilization Center. In addition, consumers work at MLK Library, Fire and EMS Department, DC Family Court, and four peer-operated centers.

DBH hosted its annual Job Fair in June 2025. Eleven certified providers, staffing firms and the peer operated centers participated. On the spot interviews were held with one peer was hired on the spot and five offered employment contingent upon meeting onboarding requirements.

Q101. *Please provide the following information regarding substance abuse services that are offered to adults in FY 2025 and FY 2026, to date:*

a. The total number (via spreadsheet) of adults who received substance abuse services, broken down by age, home ward, ward where services took place, format (in-person/virtual/hybrid), and the types of services provided.

b. Please provide (via spreadsheet) a list of all agencies and organizations that provide substance abuse services to adults, including location, Ward, how many adults served, the format of their services (virtual/in-person/hybrid), what services they provided, and contact information (staff contact, email address, phone number, and website); and

c. Plans in FY 2026 to expand the types of substance abuse services offered to adults.

DBH Response:

DBH certifies a network of community-based providers to deliver a range of substance use disorder (SUD) treatment service based on the following levels of care established by the *American Society of Addiction Medicine (ASAM)*: Level 1 Outpatient, Level 2.1 Intensive Outpatient Program, Level 2.5 Day Treatment, Level 3.1 Clinically Managed Low-Intensity, Level 3.3 Clinically Managed High-Intensity, Level 3.5 Clinically Managed High Intensity Adult or Medium Intensity Youth, Level 3.7 Medically Monitored Intensive Inpatient Withdrawal Management. DBH also provides a range of substance use disorder prevention and recovery services.

According to our FY 24 MHEASURES report, 5,716 residents received substance use treatment of whom 3,839 or 67% also received mental health rehabilitation services. DBH supports integrating care with screening, diagnosis and treatment for both mental and substance use disorders to treat the whole person for the best health outcomes.

a. See Attachment 1 of 2. consumers served

b. See Attachment 2 of 2. network of SUD providers

c. In FY26, DBH plans to expand services for pregnant and parenting women who are seeking treatment for substance use disorder through outpatient treatment. Additionally, recovery support services will be expanded through an RFA (Request for Applications) which will seek to enhance this service through the establishment of non-Medicaid reimbursable complimentary services. The expansion of these services will be supported by the Substance Use Prevention, Treatment and Recovery Services (SUPTRS) Block Grant.

During FY25, to support the substance use needs of clients in nursing homes, our State Opioid Response Grant (SOR) funded a consultant to conduct SUD training and technical assistance in skilled nursing/long-term care facilities with the goal of encouraging these facilities to provide medication for opioid use disorder (MOUD) and other related treatment in their facilities. This work continues this year and will be expanding to senior housing facilities and community residential facilities over the next year.

Over the past year, DBH recommended funding SOR grants to four community providers to establish new recovery residences for individuals with stimulant use disorder/opioid use disorder (STUD/OUD). Through these grants, individuals with OUD/STUD received intensive care management while living in a safe and monitored recovery residence. Intensive care management includes an assessment of an individual's functional life skills (e.g., personal living skills, social skills, vocational skills and service procurement skills) in order to establish a long-term plan for ongoing recovery. Individuals are not immediately asked to leave the setting if they return to using. Rather, staff work with the resident to get them back on their recovery path. Two of the four providers accepted the grants, Community Bridges Inc. (CBI) and So Others Might Eat (SOME), but two of the providers chose not to accept the award because they received Opioid Abatement grants. The two providers provided housing for 28 individuals starting in April 2025 (SOME) and May (CBI). We will release an RFA this year for three additional recovery homes, one of which will focus on youth in transition.

DBH funded eight grantees to provide comprehensive care management services for individuals with OUD and STUD last year, with a focus on those identified as high-risk. Services include outreach and reengagement, service coordination, medication coordination, overdose prevention, and MOUD support. There were 319 individuals served through these grants, which started in May 2025.

DBH plans to establish a Medication for Addiction Treatment and Electronic Referrals Network (MATTERS) in the District. MATTERS is an innovative, nimble, statewide, rapid access linkage service for patients with opioid use disorder, connecting them to outpatient treatment organizations within as little as 24 hours.

Q102. Please provide the following information on the Stabilization Center since it opened in October 2023:

a. The total number of individuals served, disaggregated by race, age, gender, ward of residence, and housing status;

b. *Percentage of individuals served who have come to the Center more than 1, 5, and 10 times;*
c. *Types of services provided; and*
d. *Numbers of referrals made to other agency programs and organizations, broken down by program/service.*

DBH Response

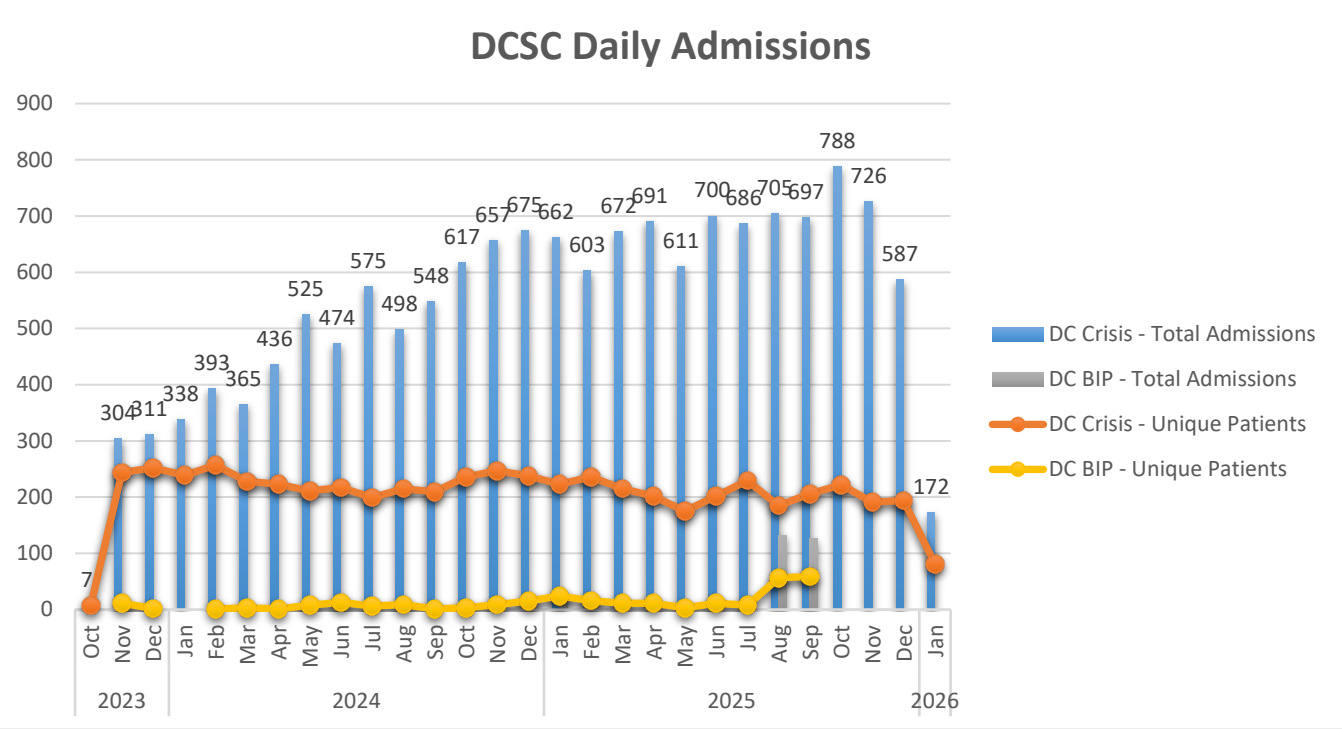
Since the launch of the DC Stabilization Center (DCSC) on October 31, 2023, through January 8, 2026, the Center recorded a total of 15,023 total admissions, representing 3,562 distinct individuals served. The Center averaged 19 admissions per day since launch, with an average length of stay (ALOS) of 14 hours per admission. Fire and Emergency Medical Services (FEMS) transported 5,280 individuals to the Center for evaluation (although not all of these transports resulted in admissions). The remainder of the admissions were walk-ins or referrals from community providers.

a. *The following table breaks out the total number of admissions through January 8, 2026, by race, gender, age, housing status, ward of residence:*

Race	***% of Admissions***
Black / African American	87 %
White	7 %
Other / Not Obtained	6 %
Gender	***% of Admissions***
Male	85%
Female	15%
Other	0%
Age	***% of Admissions***
18 - 29	938 – 6 %
30 - 59	9611 – 64 %
60 - above	4471- 30 %
Unknown / Not Recorded	3 - ~ 1 %
Housing Status	***% of Unique Consumers Served***
Unhoused	1480 - 42 %
Housed	1288 - 36 %
Unknown	794 - 22 %
Total	3562 - 100 %
Ward of Residence (based on self-report)	***% of Admissions***
5	20 %

6	16 %
8	15 %
7	12 %
4	8 %
1	6 %
2	5 %
3	1 %
Unknown / Not Reported	17 %

The graph below outlines the number of admissions by month since the Center opened in October 2023. In the graph, *"Crisis beds"* represents short stay / observation / stabilization beds; while *"BIP beds"* represents longer stay beds (up to 72 hours) utilized for extended assessment and treatment of more complex cases.



b. Percentage of individuals served at the DCSC more than 1, 5, and 10 times:
Of the total number of distinct individuals served over this period (3,562), 653 (18%) were admitted more than once, 103 (3%) were admitted 6 or more times, and 186 (5%) were admitted 11 or more times.

c. Services provided:
The Stabilization Center provides 24/7/365 Medical Crisis / Stabilization / Behavioral services and supports. The services include: safety screening; medical triage / evaluation; behavioral health care assessment; medical stabilization and detoxification; peer counseling / harm reduction support;

medication treatment (as appropriate); withdrawal management (as appropriate); addressing social determinants of health; and referral / linkage to community-based services and resources.

d. Referrals made to other agencies, programs and services upon discharge:
Of the total number of individuals admitted to the Stabilization Center over this period, 1,653 individuals accepted a referral and warm hand off to a community provider: 382 for behavioral health evaluation and treatment and 1271 for shelter / community services.

Q103. Please provide a detailed narrative on the second Stabilization Center project, including:

i. Environmental remediation;
ii. Construction contractor selection;
iii. Construction commencement;
iv. Expected completion date;
v. Planned capacity, including what factors informed the decision;
vi. Operations contractor selection;
vii. Anticipated opening date for accepting individuals; and
viii. *A copy of the Good Neighbor Agreement associated with the second stabilization center, or indicate whether one is being developed*

DBH Response:

Environmental remediation and construction timeline:
The current design / build contractor (Atmos Solutions & Moya Design Partners) was jointly selected by the Department of General Services (DGS) and the Department of Behavioral Health (DBH) in September 2024 following a competitive bid and rigorous selection review process. Construction began in Summer 2025 with an expected completion date of August 2026. Currently, the site has been in active construction on the interior of the building since last summer. Exterior construction recently began. The lot is currently secured with construction fencing. DBH is working closely with DGS and the design / build team on implementing a LEED silver certified facility. DBH plans to publish a Request for Proposals (RFP) in Spring 2026, to select a clinical services provider to operate the Park Rd Stabilization Center once it opens late fall.

Capacity of the Center:
The Park Rd. Stabilization Center will have the capacity to serve 14 individuals in short-stay, crisis management / observation recliners; as well as 2 individuals in extended stay / treatment beds for those requiring a longer period of time for diagnosis, stabilization and treatment. The planned capacity is based on our years long experience operating the first, 35 K St. Center. The average length of stay (ALOS) at the 35K Center has been approximately 14-hours to date. We expect the ALOS of the new Center to be the same. We are confident that the planned capacity and design of the Park Rd. Center will successfully address the needs of the community.

Lessons learned from 35 K St Center:

DBH's experience operating the 35 K Street for over two years, with no adverse safety or clinical incidents, has been instrumental in helping us optimize the operational flow, and clinical effectiveness of

the Park Rd. Center. Planned enhancements include a larger, welcoming patient intake/triage area upon admission, bringing more light into the main dormitory, ensuring that there is sufficient space so drop offs by Fire and EMS (FEMS) are quick and efficient. In addition, the new Center will have increased storage space for consumers' personal belongings, additional private consultation offices for individual counseling, and workstations placed on both floors of the proposed facility to maximize oversight and interactions with patients.

Clinical Criteria and triage of consumers:
DBH and the FEMS Medical Director have developed a detailed, clinically-driven criteria set to assess potential referrals to the Center to ensure only clinically appropriate consumers are admitted to the facility. This clinical assessment tool includes, but is not limited to, reviewing the following functions: cognitive and mental status, blood pressure, oxygen level, pulse, respiratory rate, presence of chest pain, signs of medical trauma, suicidal ideation or intent, and risk of combative behavior. Both FEMS medical staff and Center staff must sign off on the assessment / admission criteria in order for a consumer to be admitted to the facility. All referrals and walk-ins (whether transported by FEMS or not) are assessed using this same clinical assessment tool and process. Consumers who do not meet these admission criteria are referred to an alternative, appropriate level of care. Most individuals admitted to the Center present with alcohol or poly-drug intoxication, rather than opioid intoxication. Patients with all types of intoxication and BH needs can be treated successfully at the Center.

Community stakeholder engagement
DBH has facilitated a number of community and stakeholder engagement meetings in Ward 1 over the past 18 months to answer questions from neighbors and to update them regarding the facility's admission criteria, clinical protocols, safety protocols, construction schedule, etc. Council Member Nadeau, ANC commissioners, business owners and neighbors have attended. In addition to the regular community meetings, DBH is currently in the process of developing a "Good Neighbor Agreement," with input from the community, to clarify the respective roles / responsibilities of various parties involved, communication pathways, problem resolution, etc. DBH is currently working with the Ward 1 ANC and Council Member's office to integrate input from various stakeholders into the proposed document.

A recording of DBH's last community meeting in December 2025 has been posted to the DBH Stabilization Center web site: https://dbh.dc.gov/service/dc-stabilization-center in order to keep residents informed. DBH has also created an email address to receive questions from community members regarding the Center dbh.parkroaddcsc@dc.gov.

Q104. Please provide the following information for Saint Elizabeths[3] Hospital in FY 2024, FY 2025, and FY 2026, to date:

a. Types of services and interventions offered;
b. Number of adult admissions;
c. Number of adult walk-ins;
d. Number of FTEs (broken down by type and certification/license);
e. Number of open work orders; and

f. Major facility upgrades and renovations (including plans for FY 2025).

DBH Response

a. *Types of services and interventions offered:*
Psychiatric inpatient hospital offering behavioral health-related services including psychiatric, psychology, and social work. The hospital also offers general medical services, dental services, pharmacy services, dietetic services, laboratory services, physical therapy, occupational therapy, radiology, respiratory, and rehabilitative care services.

b. *Number of adult admissions:*

Year	Admission #s
2024	428
2025	430
2026 (as of 1/8/26)	6

c. *Number of adult walk-ins.*
Saint Elizabeths does not accept walk-ins

d. *Number of FTEs (broken down by type and certification/license):*
See Attachment 1 of 2. FTEs

e. *Number of open work orders:*
FY 2024 - 146 total, 0 open
FY 2025 - 509 total, 170 open
FY 2026 - 24 total, 8 open

f. *Major facility upgrades and renovations (including plans for FY 2025):*
See Attachment 2 of 2. Capital Projects including major facility upgrades and renovations

Q105. In FY 2024, FY 2025 and FY 2026, to date, how many children were discharged from inpatient psychiatric hospitalization or psychiatric residential treatment facilities and received in-home and community-based mental health services?

a. *Please include CBI, intensive care coordination, and intensive case management services—within 30 days, 60 days, or 90 or more days of their discharge.*

DBH Response:

In FY24, 179 youth were discharged from inpatient hospitalization. Of the youth who were discharged, 125 received a mental health service within 30 days which includes medication management, therapy, community support, substance use services and/or group therapy. Twenty-two youth received a mental health service within 60 days. Six youth received a mental health service within 90 days and 26 youth received a mental health service within more than 90 days. In FY25, 158 youth were discharged from inpatient hospitalization. Of these youth, 120 youth received a mental health service within 30 days. Fourteen youth received a mental health service within 60 days. Seven youth received a mental health service within 90 days. Seventeen youth received a mental health service within more than 90 days. In

FY26 YTD, eight youth were discharged from inpatient hospitalization and all of the youth received mental health services within 30 days.

In FY24, out of the 179 youth discharged from inpatient hospitalization, eight youth received CBI within 30 days, six youth received CBI within 60 days, five youth received CBI within 90 days, and 16 youth received CBI within more than 90 days. In FY25, out of the 158 youth discharged from inpatient hospitalization, 12 youth received CBI within 30 days, two youth received CBI within 60 days, three youth received CBI within 90 days, and seven youth received CBI within 90 days or more. No data is currently available for FY26 YTD for youth who were discharged from inpatient hospitalization and received CBI. There is a 90-day lag on claims being submitted for billing and data being available. DBH will continue to monitor data to assess delays in access to CBI after discharge from inpatient hospitalization.

In FY24, out of 179 youth discharged from inpatient hospitalization, one youth received intensive care coordination (ICC) within 60 days and 12 youth received ICC within more than 90 days. In FY25, out of the 158 youth discharged from the hospital, 7 youth received ICC within 30 days, three youth received ICC within 60 days, one youth received ICC within 90 days, and one youth received ICC within more than 90 days. In FY26 YTD, one youth received ICC within 30 days of discharge from inpatient hospitalization.

In FY24, eight youth were discharged from a Psychiatric Residential Treatment Facility (PRTF). Out of the eight youth discharged, four received a mental health service within 30 days. Three youth received a service within 60 days. In addition, one youth received a mental health service more than 90 days after discharge. In FY25, six youth were discharged from PRTF. Four youth received a mental health service within 30 days. One youth received a mental health service within 90 days and one youth received a mental health service within more than 90 days of discharge from PRTF. No data is currently available for FY26 YTD for youth who were discharged from PRTF and received a mental health service. There is a 90-day lag on claims being submitted for billing and data being available. DBH will continue to monitor data to assess delays in access to mental health services following discharge from PRTF.

In FY24, out of eight youth discharged from PRTF, one youth received CBI within 30 days and seven youth received CBI more than 90 days after discharge. In FY25, out of the six youth discharged from PRTF, six youth received CBI within more than 90 days after discharge from PRTF. No data is currently available for FY26 YTD for youth who were discharged from PRTF and received CBI. There is a 90-day lag on claims being submitted for billing and data being available. DBH will continue to monitor data to assess delays in access to CBI following discharge from PRTF.

In FY24, out of eight youth discharged from PRTF, eight youth received ICC more than 90 days after discharge from PRTF. In FY25, out of six youth discharged from PRTF, six youth received ICC more than 90 days after discharge from PRTF. No data is currently available for FY26 YTD for youth who were discharged from PRTF and received ICC. There is a 90-day lag on claims being submitted for billing and data being available. DBH will continue to monitor data to assess delays in access to ICC following discharge from PRTF.

Q106. What is the rate of readmissions to inpatient psychiatric hospitals for FY 2024, FY 2025, and FY 2026, to date? Please provide a breakdown by adults and youth.

DBH Response:

Please see Attachment 1 of 1 for the rate of readmissions to inpatient psychiatric hospitals for FY 2024, FY 2025, and FY 2026, to date.

Q 107 For those adults about whom DBH receives notification of discharge, please list the following information for FY 2025 and FY 2026, to date (for each hospital or inpatient facility):

a. *How many individuals were discharged within (a) one to 10 days, (b) 11 to 30 days, (c) 31 to 60 days (d) more than 60 days?*
b. *How many individuals were readmitted two or more times during the past three years to either any hospital?*
c. *How many individuals were connected to a CSA within (a) 5 days of discharge from the institution, (b) 10 days of discharge, (c) more than 10 days of discharge, (c) more than 20 days of discharge, (d) more than 40 days of discharge, (e) more than 60 days?*
d. *How many individuals who were assessed or evaluated by a CSA within (a) 5 days of discharge from the institution, (b) 10 days of discharge, (c) more than 20 days of discharge, (d) more than 40 days of discharge, (e) more than 60 days; and*
e. *How many individuals who received mental health treatment from a CSA within (a) 5 days of discharge from the institution, (b) 10 days of discharge, (c) more than 20 days of discharge, (d) more than 40 days of discharge, (e) more than 60 days.*

DBH Response

a. *How many individuals were discharged within (a) one to 10 days, (b) 11 to 30 days, (c) 31 to 60 days (d) more than 60 days;*

FY	Hospital Name	Clients discharged within (days)				
		1-10	11-30	31-60	60+	Total Clients
2025	PIW Adult	968	250	44	136	1245
	UMC	167	7		32	203
	WHC Inpatient	479	137	29	68	678
	Cedar Hill Regional Med	1			2	3
	FY2025 Total	**1509**	**368**	**73**	**235**	**1923**
2026	PIW Adult	163	42	3	32	223
	UMC				1	1
	WHC Inpatient	60	10	2	15	85
	Cedar Hill Regional Med	21	2		1	24
	FY2026 Total	**240**	**54**	**5**	**48**	**320**
Total Clients		**1686**	**406**	**77**	**271**	**2155**

b. *How many individuals were readmitted two or more times during the past three years to either any hospital;*

Hospital Name	Total clients readmitted two or more times in				
	2022	2023	2024	2025	2026
PIW Adult	91	94	249	206	21
UMC	81	87	45	11	

WHC Inpatient	38	47	50	65	5
Cedar Hill Regional Med					1
Total Clients	**210**	**228**	**345**	**282**	**27**

c. *How many individuals were connected to a CSA within (a) 5 days of discharge from the institution, (b) 10 days of discharge, (c) more than 10 days of discharge, (c) more than 20 days of discharge, (d) more than 40 days of discharge, (e) more than 60 days;*

FY	Hospital Name	Time to enrollment after Discharge (Days)						Total Clients
		0-5	6-10	11-20	21-40	41-60	60+	
2025	PIW Adult	11	3	15	21	13	65	128
	UMC	8	1	1	3	5	15	33
	WHC Inpatient	14	3	5	8	8	33	71
FY2025 Total		**33**	**7**	**21**	**31**	**26**	**104**	**214**
2026	PIW Adult	2					1	3
	WHC Inpatient	1						1
	Cedar Hill Regional Med	1						
FY2026 YTD Total		**4**					**1**	**4**
Total Clients		**37**	**7**	**21**	**31**	**26**	**105**	**219**

d. *How many individuals who were assessed or evaluated by a CSA within (a) 5 days of discharge from the institution, (b) 10 days of discharge, (c) more than 20 days of discharge, (d) more than 40 days of discharge, (e) more than 60 days; and*

FY	Hospital Name	Time to first D&A Service (Days) post discharge						Total Clients
		0-5	6-10	11-20	21-40	41-60	60+	
2025	PIW Adult	26	16	16	47	22	92	219
	UMC	5	8	10	6	5	30	64
	WHC Inpatient	22	10	12	15	13	49	121
2025 Total		**53**	**33**	**38**	**68**	**40**	**160**	**370**
2026 YTD	PIW Adult	2	2	2	1	1		8
	WHC Inpatient	1	1					2
	Cedar Hill Regional Med	1						
2026 Total		**4**	**3**	**2**	**1**	**1**		**10**
Total Clients		**57**	**36**	**40**	**69**	**41**	**160**	**379**

e. How many individuals who received mental health treatment from a CSA within (a) 5 days of discharge from the institution, (b) 10 days of discharge, (c) more than 20 days of discharge, (d) more than 40 days of discharge, (e) more than 60 days.

FY	Hospital Name	Time to treatment post discharge (in days)						Total Clients
		0-5	6-10	11-20	21-40	41-60	60+	
2025	PIW Adult	195	90	69	74	33	98	472
	UMC	36	15	18	4	8	27	105
	WHC Inpatient	118	43	36	36	12	44	265
	Cedar Hill Regional Med		1					1
	2025 Total	**313**	**143**	**119**	**111**	**50**	**153**	**725**
2026	PIW Adult	28	8	5	7	1		47
	WHC Inpatient	10	2	3	1			**16**
	Cedar Hill Regional Med	4	1	1				**6**
	2026 Total	**41**	**11**	**8**	**7**	**1**		**66**
Total Clients		**336**	**152**	**125**	**118**	**51**	**153**	**753**

Q108. Describe DBH's current routine oversight process at PIW.

a. *How is DBH ensuring that the Psychiatric Institute of Washington (PIW) is adhering to its incident reporting requirements under D.C. law and DBH policy?*
b. *How many incident reports did DBH receive from PIW in FY 2024, FY 2025 and FY 2026 to date?*
c. *How many investigation reports did DBH receive from PIW in FY 2025 and FY 2026 to date? How many investigations did DBH conduct based on complaints of abuse and neglect at PIW in FY 2025 and FY 2026, to date?*

DBH Response

DBH maintains a contractual relationship with Psychiatric Institute of Washington (PIW) for the provision of acute inpatient psychiatric services. Under this contract, PIW is required to deliver services in compliance with all applicable standards of care established by DC Health, the Centers for Medicare and Medicaid Services (CMS), and The Joint Commission (TJC).

In accordance with DBH policy and contractual requirements, DBH conducts ongoing oversight of care provided to DBH-authorized involuntary patients at PIW. A DBH licensed clinical social worker conducts bi-monthly on-site visits and twice-weekly concurrent chart care reviews of authorized involuntary admissions. Concurrent care reviews assess the patient's current clinical status, engagement in treatment, and adherence to unit treatment. The on-site chart review consists of reviewing randomized approved and authorized involuntary patient charts for timeliness and completeness of required clinical documentation, including psychiatric evaluations, nursing assessments, psychosocial assessments, treatment plans, care coordination notes, and discharge planning documentation. Any identified deficiencies are communicated to PIW clinical leadership and if the deficiency poses a potential risk, immediate remediation is expected, required and verified. DBH maintains monthly summary reports accordingly.

DBH conducts on-site inspections of psychiatric units serving DBH-authorized involuntary patients. These inspections assess the environment of care, including staffing ratios, unit census, safety features, cleanliness, visibility from nursing stations, posted programming, and the overall therapeutic milieu. Medication rooms are reviewed for cleanliness and operational functionality, and unit leadership is consulted to address any identified concerns. Findings from these inspections are documented in monthly summary reports.

Through these oversight activities, DBH fulfills its contractual monitoring responsibilities while regulatory enforcement authority remains with DC Health.

a. *How is DBH ensuring that the Psychiatric Institute of Washington (PIW) is adhering to its incident reporting requirements under D.C. law and DBH policy?*

DBH ensures PIW's adherence to incident reporting requirements under D.C. law and DBH policy through ongoing contract oversight and routine monitoring activities. On a bi-annual basis, the DBH Contract Administrator meets with PIW's Risk Management Officer and Director of Clinical Services to review incident reporting policies, statutory requirements and reporting timelines. Compliance is further verified through bi-monthly site visits and concurrent chart reviews, during which DBH staff assess clinical documentation and identify potential reportable incidents to ensure appropriate documentation and reporting. Any identified gaps or concerns are communicated to PIW leadership for corrective action, with technical assistance provided as needed, and matters requiring regulatory enforcement are referred to DC Health consistent with its statutory authority.

b. How many incident reports did DBH receive from PIW in FY 2024, FY 2025 and FY 2026 to date?

Fiscal Year	Number of Incidents Reports Received
FY 24	139
FY 25	569
FY 26	90

c. How many investigation reports did DBH receive from PIW in FY 2025 and FY 2026 to date? How many investigations did DBH conduct based on complaints of abuse and neglect at PIW in FY 2025 and FY 2026, to date?

DBH requires PIW to submit incident reports to include Major Unusual Incidents (MUI) and Unusual Incidents (UI) through the designated platform, E-Risk. An MUI includes an adverse event that may compromise the health, safety or welfare of persons or property owned or maintained by DBH or its certified providers, contractors or grantees. An UI is any significant occurrence or extraordinary event deviating from regular routine or established procedure but does not rise to an MUI.

DBH is responsible for conducting investigations for individuals for whom DBH has approved for involuntary inpatient stay at contracted facilities. Once an incident report is received from PIW it is forwarded to the DBH Contract Administrator and the Department of Health for awareness. If warranted, DBH Investigative Unit will request a follow up report from PIW to include a summary of

corrective actions implemented by management and the identification of systemic changes toward quality improvements.

DBH attributes the increase of incident reports during FY25 to the increased compliance of PIW submitting incidents reports as required. DBH and DOH leadership met with PIW Administration to discuss expectations of compliance with submitting incident reports to enhance transparency and ensure safety for all PIW patients and staff. Additionally, the DBH contract administrative periodically provides an overview of incident reporting expectations/requirements.

DBH did not receive any investigation reports from PIW in FY2025 and FY2026 to date. During this time period, DBH did not receive any incident reports that alleged abuse and neglect.

Q109. Please provide the following information for the Behavioral Court Diversion program in FY 2025 and FY 2026, to date:

a. *The number of youth who participated, including the type of status offense they were alleged to have committed, the referral source (i.e., judge, probation officer, prosecutor, etc.) and the outcomes for youth in the program;*
b. *The number of youth who received Community Based Intervention (CBI) services through the Juvenile Behavioral Diversion Program;*
c. *The number of youth who received CBI services through the Family Court Social Services Division;*
d. *The average and median wait time for a first appointment with a psychiatrist after referral from the Juvenile Behavioral Diversion Program and the Family Court Social Services Division; and*
e. *The recidivism rate of the youth participants and an explanation of how recidivism rates are measured.*

DBH Response

The Juvenile Behavioral Diversion Program (JBDP) is a voluntary, mental health-based solution or specialty court that provides intensive case management and mental health services to youth in the juvenile justice system with significant mental health concerns. The JBDP has operated within the DC Superior Court Juvenile Division since January 2011. This program connects and engages juveniles and their caregivers/families in appropriate community-based mental health services and supports and provides for a period of engagement during which time the court monitors both the implementation of mental health services and the youth and families' participation in those services. Court-involved juvenile status offenders are given the option of voluntarily participating in mental health services rather than being prosecuted. If successful, participants can have their cases dismissed or shortened lengths of probation sentences.

The goals of the program are to: (1) increase the number of youth able to remain in the community with improved functioning in the home, school and community with appropriate mental health services and supports, (2) reduce the likelihood of the youth's further contact with the criminal justice system as a youth and later as an adult, and (3) to reduce crime in the community and protect public safety. This

program is intended for children and youth who are often served within multiple systems who are at risk of re-offending without linkage to mental health services and other important supports. Participants are required to attend regular court status hearings to monitor progress and to participate in mental health services and other specified court conditions. Youth generally participate in the program from three months to one year, depending on the pace of their overall progress towards individualized goals, as determined by the "team," i.e., all individuals assisting in the youth's service plan (e.g., the youth/family/service providers/probation officer/defense counsel/Education Attorney/AAG and JBDP Judge).

a.) The Juvenile Behavioral Diversion Program (JBDP) serves juvenile offenders who are younger than 18 years of age at the time of the instant offense. All court-involved youth receive mental health screening at the time of initial intake, following arrest. Youth are administered the Connor's Comprehensive Behavior Rating Scale (CBRS) which measures social, emotional, behavioral and academic problems in children and adolescents ages 8 to 18 years. Additionally, youth are administered the Sex Trafficking Assessment Review (STAR) to determine a child or adolescent's risk of sexual exploitation in the community. These screenings are used to initially identify youths who may be appropriate for either the JBDP or Here Opportunities Prepare You for Excellence (HOPE) Court for youth at-risk or involved in the commercial and sexual exploitation of children (CSEC).

Determining eligibility for the JBDP is a two-step process. The Office of the Attorney General (OAG) reserves the right to permit or deny a youth to participate in the program on a case-by-case basis as an initial step in determining a youth's overall eligibility for the program. The OAG makes its determination of "legal eligibility" based on a variety of factors including prior and current contacts with the court, nature and circumstances surrounding the offense, mental health needs, and other relevant social factors. The second step in determining eligibility is a referral to the "Suitability Committee" of the JBDP. There, the Committee determines if the youth meet basic clinical criteria, i.e. (1) the presence of primary mental health diagnosis and/or substance use disorder and (2) that the youth is able to participate in community-based services at the time of entry into the program. The Committee then takes into consideration multiple, additional factors that may impact a youth's ability to fully participate in the program, utilizing a biopsychosocial model of assessment, to determine final, clinical "suitability."

The Suitability Committee transitioned to meeting virtually via Microsoft Teams in April 2020 due to the pandemic. The transition was smooth and has not hindered the Committee's work in any way or caused disruption to the workflow. Meetings continue to be held in a virtual forum with no plan to shift to in-person for the foreseeable future.

A juvenile offender can be referred to the JBDP by the initial hearing judge, the juvenile calendar judge, the Assistant Attorney General (AAG), the youth's defense attorney or a Court Social Services Probation Officer. Once a juvenile is deemed legally eligible, a referral is made to the Suitability Committee whereupon clinical eligibility is determined. The Suitability Committee, co- chaired by a DBH and a Court Social Services Division (CSSD) representative, is otherwise comprised of members from CSSD, the Child Guidance Clinic (CGC), and the DBH "preferred providers," i.e., those Community Services Agencies (CSAs) that are affiliated with the JBDP. These CSAs provide services to most of the youth in the program and collectively offer the range of services most highly utilized by

program participants, including trauma-focused services. Following the clinical review, the Committee establishes recommendations for individualized services for each youth that are both comprehensive and holistic. These recommendations are forwarded to all court officials involved in the youth's case, regardless of their outcome of eligibility for the program. The Committee's recommendations can be implemented outside of the JBDP, should youth decline to enter the program or voluntarily op-out later. All youth enrolled in JBDP receive mental health services through the DBH provider network (or outside DBH's network, as needed) and are supervised by specialized probation officers (trained in the mental health System of Care of DC) of Court Social Services Division (CSSD).

The number of youths who participated in the JBDP program in CY25 is 53. The number of youth participating in JBDP thus far in CY26 is 36. There are currently 7 cases pending entry, i.e. cases found legally eligible and clinically suitable but are in various stages of legal preparedness for entry to the program. Though referrals can be prompted by multiple court or community sources, i.e., judges, probation officers, defense attorneys, etc., it is the OAG that ultimately becomes the main referral source, as all referrals must first be found legally eligible by the OAG. Once legal eligibility is established, a referral is sent by OAG to the Child Guidance Clinic of CSSD, where the clinical referral packet is compiled for review for the Suitability Committee.

Below is a chart that details enrollment and case resolutions (Graduated/Terminated, Certified Back, Charge Dismissed) for youth since the program's inception in CY2011. These data are tracked by year of enrollment in the program, as recidivism data is also collected by enrollment year. Data for CY25 is pending.

JBDP Enrollment Stats
CY2011-2024

Enrollment Year	Graduated	Terminated	Charge Dismissed	Active	Pending	Transfer to HOPE	Total Enrolled
2011	**30**	**24**	**--**	**0**	**0**	**--**	**54**
2012	**37**	**25**	**--**	**0**	**0**	**--**	**62**
2013	**26**	**13**	**3**	**0**	**0**	**--**	**42**
2014	**35**	**16**	**3**	**0**	**0**	**--**	**54**
2015	**30**	**9**	**4**	**0**	**0**	**--**	**43**
2016	**45**	**13**	**2**	**0**	**0**	**1**	**61**
2017	**40**	**32**	**15**	**0**	**0**	**8**	**95**
2018	**26**	**19**	**11**	**0**	**0**	**0**	**56**
2019	**23**	**15**	**7**	**0**	**0**	**1**	**46**

2020	**15**	**8**	**7**	**0**	**0**	**0**	**30**
2021	**20**	**11**	**0**	**2**		**0**	**33**
2022	**15**	**13**	**4**	**2**	**0**		**34**
2023	**5**	**6**	**0**	**25**			**36**
2024	**3**	**10**		**40**	**14**		**53**
Totals	369	225	58	**45**	14		**654**

The chart below details the types of offenses committed by youth in CY24.

Type of Offenses	**Number of Offenses** **Of all youth enrolled in CY 24**
Unlawful Entry and Assault (Threats- Mis. & Felony, Simple Assault, Assault on Police, Disorderly Conduct), Panhandling, Obstruction of Justice	42
Theft (Shoplifting, Receiving Stolen Property, Theft I & II), conspiracy	32
Robbery – UUV-Unlawful Entry Motor Vehicle, Burglary-No , Permit	52
Destruction of Property/Fare Evasion/Disorderly Conduct, Possession of Implements of Crime	15
Runaway	2
Truancy	0
Sex Abuse	0
Possession of Weapon/Ammunition	14
Robbery while armed/Assault with Weapon/Assault with intent to rob/Carjacking/Unlawful Discharge of Weapon/Second Degree Murder, First Degree Murder/Assault with intent to kill	13
Possession of Controlled Substance	0
Credit Card Fraud	2
Total Offenses	**172***

*Youth are often charged with multiple offenses. This list includes pre- and post-adjudicated charges

b.) Of the 53 youths that were involved in JBDP in CY25, 17 youth received or are currently receiving Community-Based Intervention (CBI) services, i.e., CBI I (Multisystemic Therapy (MST), CBI II and III for a total percentage of 32%. This data point indicates that a high percentage of youth participants of the JBDP meet criteria for the most intensive, community-based services that DBH offers, further indicating that JBDP youth participants are among the highest at-risk youth (and families) served by DBH through this one program. Although CBI was not provided to all youth involved in JBDP, participants received services from an array that are offered through the Mental Health and Rehabilitation System (MHRS) through DBH, e.g., community support, individual and family-based therapies, evidence-based practices (Trauma-Focused Cognitive Behavioral Therapy (TFCBT), Trauma Systems Therapy (TST), Functional Family Therapy (FFT), High Fidelity Wraparound, Transition to Independence Process (TIP) and Transition Age Youth (TAY) services), and substance use services. Each youth enters the program with a preliminary, individualized plan for services and treatment created by the Suitability Committee following a comprehensive review of the case. The plan is then implemented once the youth enter the program and is adjusted to the needs of the youth and family as they progress through the program. Recommendations for services while in JBDP are based on clinical determinants, services already in place, and willingness to engage in intensive services and service criteria.

c.) DBH does not have access to the universe of youth involved with Family Court Social Services Division. Therefore, we are unable to provide the number of youths receiving CBI services through Court Social Services Division.

d.) The average and median wait time for a first appointment with a psychiatrist is within a two-week period from the time of referral for medication management, according to the protocols established with preferred providers of the program. However, advocacy is made on a case-by-case basis by the DBH Program Coordinator to assist program participants in securing earlier appointments with the youth Core Service Agency (CSA) or through DBH's Howard Road programs, in the event of an urgent need.

e.) Court Social Services' Child Guidance Clinic (CGC) is responsible for collecting and analyzing the majority of the JBDP data. Recidivism is defined as "a plea or found involved" in a crime up to one year after completion of the program. Recidivism rates are calculated one-year post-graduation. Since youth enter and exit the JBDP on a rolling basis, data cannot be analyzed until the entire cohort for the year has reached one-year post-graduation. Therefore, the rate of recidivism for the CY25 cohort is not yet available as not all participants have reached the one-year post-graduation mark.

Below are the recidivism data for the JBDP since the program's inception in calendar year 2011

Calendar Year	**Total Number of Youth Enrolled**	**Total Youth w/ Reconvictions within 12 months of exiting JBDP**	**Recidivism Rates**
2023*	44	5	11%
2022	34	8	24%
2021*	33	15	45%

2020	25	7	28%
2019	47	10	21%
2018	56	17	30%
2017	95	19	20%
2016	61	9	14.5%
2015	33	6	18%
2014	54	12	22%
2013	42	6	14%
2012	62	19	30%

*Excludes info for youth who exited the program < 12 months; 2019 to 2021 calculated per youth vs. per reconviction

Q110: Please provide an update on the DBH services to consumers under the custody of the Department of Corrections, including services provided in the READY Center. Please specify the number of individuals served, types of services provided, and any measurable outcomes or improvements in mental health and substance use treatment for this population in FY 2024, FY 2025 and FY 2026, to date.

(a): How does DBH provide age and developmentally specific services for transitional age youth (18-26) entering/exiting the jail?

(b): What data does DBH currently collect to monitor and evaluate continuity of mental health care for individuals transitioning between jail, community supervision, and community-based settings?

DBH Response:

DBH continues to collaborate with the Department of Corrections (DOC) in supporting individuals with behavioral health needs during and after DOC custody. The Forensic Services Division (FSD) continues to provide pre-release and post-release linkage to behavioral health services for consumers returning to the community from DOC. FSD staff track performance data for all READY Center linkage services and share data reports with relevant partners, including DOC.

During FY24, FSD staff engaged approximately 1,000 individuals, reconnecting 405 individuals with behavioral health services at their Community Service Agencies (CSA) and initiating new linkage to services for 64 individuals. FSD staff engaged approximately 1,200 individuals in FY25. Of those individuals whom we engaged, 509 individuals were reconnected to CSAs for behavioral health services, and 138 individuals were newly connected to CSAs for initial intakes, reflecting a notable increase in both reconnections and the initiation of new linkage compared to FY24. Most of these DOC residents were linked to services within 30 days of their scheduled release date to the community. FSD's focus on pre-release linkage continues to support timely access to behavioral health care for individuals immediately upon release from the DC Jail. To date in FY26, FSD staff have engaged 384 individuals thus far, including 171 individuals reconnected to a CSA and 44 newly linked to behavioral health services.

Additionally, DBH assists with the coordination of behavioral health care for individuals while in DOC custody. FSD staff cross-reference electronic medical records to identify whether new DOC admittees have received behavioral health services locally. If so, FSD staff provide available information about individuals' diagnoses and treatment to care providers at DOC and Unity, its contracted healthcare provider in the DC jail, to allow for prompt interventions and to promote continuity of care and delivery of behavioral health services for individuals while incarcerated.

(a) DOC's behavioral health provider, Unity Health Care, provides direct care services to individuals who reside at the DC Jail. DBH provides available information to Unity care providers about individuals' history of treatment shortly after they enter the jail. FSD staff engage individuals, including those considered transitional age youth, at DOC within 30 days of their scheduled release date. FSD's focus on pre-release linkage continues to support timely access to behavioral health care for individuals immediately upon release from the DC Jail. Upon release, transitional age youth are connected to a DBH certified provider for services. The provider then provides an age-appropriate treatment program that addresses their unique behavioral health needs.
(b) FSD routinely collects and shares aggregate data reflecting the number of consumers who are newly connected and reconnected to their CSA for behavioral health services when transitioning from the jail to a community-based setting. Federal privacy laws limit DBH's ability to "monitor and evaluate" individual's case-specific mental health care without the individual providing specific written authorization.

Q111. Please provide the following information for the Community Response Team in FY 2024, FY 2025 and FY 2026, to date:

a. DBH policies or procedures that describe standards for the District's mobile crisis system:
b. Number of calls from 911 diverted to DBH;
c. Types and percentages of services billed to insurance or Medicaid;
d. Number of Community Response Team FTEs (indicate whether staff are full or part-time);
e. Number of vacancies on the Community Response Team;
f. Community Response Team budget and spending;
g. Number of calls received and responded to;
h. The locations where the team was dispatched, by ward;
i. Breakdown of how many calls related to children and youth or adults; and
j. Top 5 types of crises addressed.

DBH Response:

a. DBH policies or procedures that describe standards for the District's mobile crisis system:

Please see the attached zip drive folder for DBH policies/procedures describing the District's behavioral health mobile crisis system.

b. Number of calls from 911 diverted to DBH;

DBH 911	
Year	**Answered Calls**

FY24	668
FY25	870
FY 26 YTD	158

c. Types and percentages of services billed to insurance or Medicaid:

CRT Service Billed by Procedure Code and Fiscal Year			
Fiscal Year	Service	% Medicaid Billed	% Other Billed
24	H0023	99%	1%
	S9484	98%	2%
	S9485	100%	0%
25	H0023	93%	7%
	H0211	93%	7%
	S9484	98%	2%
	S9485	100%	0%
26	H0023	Claims Data not yet available due to 90 claims lag	
	S9484		
	S9485		

d. Number of Community Response Team FTEs (indicate whether staff are full or part-time)

The Community Response Team has 69 total FTEs budgeted. There are no part-time positions.

e. Number of vacancies on the Community Response Team:

There are currently 25 vacancies in the Community Response Team. Twelve (12) positions are currently posted, 11 of which are supervisory positions. One (1) person has been temporarily promoted to program manager. One (1) administrative position will be detailed to the Community Response Team in the next two weeks.

f. Community Response Team budget and spending:

Total Budget: $10,571,366.67
Personnel services: $7,698,765.79.
Non-personnel services: $2,872,600.88

g. Number of calls received and responded to:

Number of calls received and responded to	
Year	Referrals

FY24	6,085
FY25	4,203
FY26	760

Most calls received by CRT are resolved on the phone and do not require an in-person crisis intervention.

h. The locations where the team was dispatched, by ward:

	Ward 1	Ward 2	Ward 3	Ward 4	Ward 5	Ward 6	Ward 7	Ward 8	Ward Null
FY24	350	540	307	354	681	427	665	688	2070
FY25	231	414	202	230	480	393	482	468	1302
FY26	42	56	546	626	101	78	94	92	218
Total	623	1010	546	626	1262	898	1241	1248	3590

Ward is reported from the dispatch note and is not a required field in FY25. Ward was made a required field in FY26.

i. Breakdown of how many calls related to children and youth or adults:

Calls by age group		
	0-17	18+
FY24	698	4475
FY25	437	3332
FY26	94	652

j. Top 5 types of crises addressed:

Top 5 types of crises					
	Aggression	Suicidal Ideation	Oppositionality	Family Problems	Property Destruction
FY24	106	78	64	42	35
FY25	57	53	28	22	16
FY26	17	24	7	4	4

The top five types of crises addressed by the Community Response Team are aggression, suicidal ideation, oppositionality, family problems, and property destruction. For FY26, suicidal ideation is currently outpacing aggression as the lead type of crisis addressed.

Q112. Please provide the following on the DBH 9-8-8 Suicide & Crisis Lifeline:

a. *Number of FTEs for 9-8-8, number of vacancies (please indicate which staff are contractors), and where they are located:*
b. *Number of calls received through 9-8-8, by month with the total listed for the entire year;*
c. *How 9-8-8 is operating with/within the Access Helpline;*
d. *The average response time for calls, and the longest and shortest wait times that occurred to date;*
e. *Data showing that the implementation of 9-8-8 has replaced calls for mental health-related issues to 911;*
f. *How many calls from OUC 911 call takers that were not answered by 9-8-8 call takers and transferred back to OUC;*
g. *Any changes to the protocol for service, follow-up, or referral;*
h. *Description and number of each call type;*
i. *Please summarize the findings of any review or evaluation of these services and attach any relevant reports;*
j. *Please share any updates to how DBH collaborates with the Office of Unified Communications or other public safety cluster agencies to implement this program; and*
k. *Please describe the marketing/outreach strategy for 9-8-8 services (billboards, digital, commercials, etc.) and how much funding is used for this purpose.*

DBH Response:

a. *Number of FTEs for 9-8-8, number of vacancies (please indicate which staff are contractors), and where they are located:*

\

988 FTEs			
Year	**FTEs**	**Contractors**	**Vacancies**
FY 24	4	0	12
FY25	6	0	10
FY 26 YTD	9	0	7

All FTEs are in the Call Center at DBH headquarters, 64 New York Avenue NE, 3rd floor.

b. *Number of calls received through 9-8-8, by month with the total listed for the entire year:*

	FY24	FY 25	FY 26
October	505	768	857
November	600	691	692
December	505	897	697
January	561	722	
February	827	521	

March	950	603	
April	972	639	
May	1087	618	
June	933	647	
July	968	746	
August	1017	761	
September	1025	720	
Total	**9950**	8423	2246

c. *How 9-8-8 is operating with/within the Access Helpline:*

The AHL has nine full time designated 988 call takers for chat and text—three on the day shift; three on the evening shift, and three on the night shift. Currently, there are two part-time Gallaudet interns dedicated to 988 chat and text. Upon implementation of video phone capability, the interns will also service the 988-call line to address our deaf and hard of hearing population. Three additional AHL staff are assigned to serve as back-up for the 988 call takers, to address any gaps in coverage and/or an increase in call volume or expected increase in call volume. To ensure 24/7 coverage of the 988 call lines, all AHL staff are cross trained in 988 functions.

d. *The average response time for calls, and the longest and shortest wait times that occurred to date:*

e. *Data showing that the implementation of 9-8-8 has replaced calls for mental health-related issues to 911:*

988 Response Time			
	Avg. Response Time	**Shortest Wait time**	**Longest Wait time**
FY 24	13 seconds	15 seconds	1 minute 58 seconds
FY 25	15 seconds	14 seconds	17 seconds
FY 26	16 seconds	15 seconds	16 seconds

9-8-8 diversion from 9-1-1			
	911 Diverted Calls Answered	**Abandoned Calls**	**Total Calls Diverted**
FY 24	668	141	809
FY 25	870	165	1035
FY 26	158	23	181

f. *How many calls from OUC 911 call takers that were not answered by 9-8-8 call takers and transferred back to OUC:*

Unanswered 9-8-8 Diversion Calls	
FY 24	141
FY 25	165
FY 26	23

OUC 911 calls are routed to five AHL staff members co-located at OUC. Additional AHL staff serve as back-up to address OUC 911 calls. OUC diversion calls are not routed directly to 988 call takers, however 988 calls requiring 911 emergency intervention and follow-up are supported by the AHL/OUC co-located staff.

g. Any changes to the protocol for service, follow-up, or referral:

In FY 24, chat and text launched in the District of Columbia. There have been no changes to the protocol for service, follow-up, or referrals. However, training in chat and text has been added as a component to new staff training within the AHL. Communication, guidance and protocols have been updated to ensure inclusion of 988 chat and text as a function of AHL's existing workflow.

h. Description and number of each call type:

FY24

Line	**Total Calls**
988	9950
Admin	3557
Crisis	13645
DBH911	440
Spanish	6
Special Initiatives	3
Suicide	2
Test Queue	2
Warm Line	4538
WMATA	3
Youth	2
Grand Total	**32148**

FY 25

Line	**Total Calls**
988	12894
Admin	2785
Crisis	26920
DBH911	870

Spanish	0
Special Initiatives	0
Suicide	0
Test Queue	0
Warm Line	2785
WMATA	5
Youth	0
Grand Total	46259

FY26

Call Data	**Total Calls**
Total Number of Calls - 911	181
Total Number of Calls - 988	3079
Total Number of Calls - Crisis (Suicide)	8105
Total Number of Calls - Warm Line	1723
Total Number of Administrative Calls	2
Total Number of Hospital Line	1688
Total Number of Special initiative Line	0
Total Number of WMATA Line	1
Total Number of Youth line	0
Total Number of Calls	**14779**

Descriptions:
DBH911: A direct line to the Department of Behavioral Health used by OUC for individuals needing quick access to mental health resources or crisis intervention and EMS or MPD is not warranted.
988: Calls received from The National Suicide Prevention Lifeline, now accessible via 988, offers free and confidential support to individuals in crisis or emotional distress.
Crisis: This category includes urgent calls where individuals are experiencing a mental health crisis requiring immediate assistance.
Warm Line: A non-crisis support line that offers emotional support and listening services for individuals seeking a friendly conversation or guidance.
Administrative/Hospital Line: Administrative calls typically involve enrollment, transfer, and discharge concerns. Grievances, questions, operational inquiries, and other non-crisis-related matters. Service Inquiries from law enforcement and hospital emergency rooms when a consumer is experiencing a mental health crisis and service information is not immediately available. In early FY25, the AHL changed to a new phone platform (Amazon Connect). All calls previously identified as

Administrative transitioned to the Hospital Line in March 2025. The administrative line is in the process of being redefined to support consumer and provider inquiries for enrollments and transfers.
Spanish: Dedicated support for Spanish-speaking callers, ensuring accessibility for those who prefer or require communication in Spanish.
Special Initiatives: Calls that pertain to specific projects, programs or outreach efforts.
Suicide: Focused on individuals expressing suicidal thoughts or behaviors, providing critical support and intervention. Previously 1-800-SUICIDE. Although there is still an active line, calls historically received on this line are now received through 988.
WMATA: Calls related to issues or information regarding the Washington Metropolitan Area Transit Authority, which may include mental health concerns encountered in transit settings.
Youth: Specialized support for younger individuals, addressing the unique challenges and crises faced by children and adolescents.

i. Please summarize the findings of any review or evaluation of these services and attach any relevant report:

For FY 24, FY 25 and FY 26, AHL has continued to use reports from our call queues which provide the total and breakdown of calls received, answered, missed and/or abandoned. Our CRM further speaks to call type, escalation and follow-up and is used to cross match calls and documentation.
Queue: A queue refers to a line or list of callers waiting to be connected to a service representative or automated system. In customer service contexts, calls are placed in a queue when all available agents are busy, and callers wait for the next available representative.
Answered Calls: Answered calls are those calls that have been successfully received and responded to by a service representative or automated system. This metric indicates the number of incoming calls that were not abandoned and were engaged by an agent or system.
Abandoned Calls: Abandoned calls are those calls that were disconnected by the caller before they were answered. This can occur when a caller hangs up while waiting in the queue, often due to long waiting times or loss of interest. Abandoned calls are an important metric for measuring the efficiency of our call platform as it allows the AHL to determine if call abandonment is due to system error. Additionally, abandonment not due to system errors informs us of whether our staffing pattern requires rearrangement to address increased call volume or whether related to staff performance concerns.
CRM: The CRM is our Customer Relationship Management software used by staff to document call interactions. The is an important tool to ensure clear communication between team members when matters require escalation, service coordination and follow-up. It further provides a better understanding of the call-types and service requests, which informs protocols, workflows and training opportunities.

j. Please share any updates to how DBH collaborates with the Office of Unified Communications or other public safety cluster agencies to implement this program:

For FY24, FY 25 and FY 26, DBH continues to actively collaborate with the Office of Unified Communications (OUC) in addition to other public safety agencies in support of the 988 program. The AHL has maintained five FTEs at OUC and has continued to provide training to OUC personnel on mental health crisis response protocols. This collaboration has continued to promote seamless communication during emergencies. The AHL Clinical Supervisor is on site at OUC twice per week and engages in regular meetings with the OUC team to further support diversion protocols, facilitate coordination of resources, and provide clinical support to AHL call takers managing diverted calls. DBH

and OUC are developing shared protocols to enhance data collection and analysis and support 988 follow-up, helping to refine service delivery. This collaborative approach aims to create a comprehensive support system for individuals in crisis, improving outcomes across the community.

k. Please describe the marketing/outreach strategy for 9-8-8 services (billboards, digital, commercials, etc.) and how much funding is used for this purpose.

During FY 24, and FY25, 988 was marketed on the DBH social media platforms. Alternative 988 marketing campaigns are being explored for FY 26.

Q113. Please provide a detailed narrative on any changes to the Access Helpline that have taken place in FY 2025 and FY 2026, to date, including:

a. Changes to key functions of the Access Helpline;
b. Changes to staffing levels; and
c. Training or preparation for Access Helpline staff.

DBH Response:

a. Changes to key functions of the Access Helpline:

During FY 25 and FY 26 YTD, the AHL extended and enhanced new staff training to ensure efficiency in all mediums (calls, chats, texts) and effectively manage crisis response calls. The consumer choice form process, originally implemented in October 2023 in preparation for the managed care carve-in, remains within the AHL.

In FY 25 the AHL changed call platforms from STORM to Amazon Connect with minor changes to our call line descriptions (Administrative Line changed to Hospital Line). To ensure efficiency in call taker documentation, additions were made to our CRM to ensure that pertinent information could be captured in mandatory fields.

During FY 2024, approval of ACT, Rehab Day, Supportive Employment and Supplemental Units transitioned from the AHL. AHL Clinical Care Coordinators maintained responsibility for reviewing medical necessity for Psychiatric Crisis Stabilization Services (Crisis Beds). In October of FY 2026, Crisis Bed review and authorization transitioned to Comagine, with the AHL maintaining responsibility for reviewing requests for uninsured residents. It is expected that these requests will also transition to Comagine in the coming weeks. From May – September of FY 2025, the AHL temporarily resumed review and approval of Community Support supplemental units. This task was fully transitioned to Comagine in October of FY 2026.

During FY 26, DBH will revise the 988-follow-up workflow to ensure that the 988-911 workflow is more streamlined and communication in coordination of care and services is more efficient.

b. Changes to staffing levels:

In FY 24 and FY 25 staffing levels increased with the addition of five staff on the 988 team. For FY 26, the AHL is anticipating filling the remaining 7 vacancies.

c. Training or preparation for Access Helpline staff:

In FY 24, FY 25 the AHL continued to focus on training in support of effective crisis management, implementing suicide risk assessments, motivational interviewing and active listening and de-escalation. Several AHL clinical staff have received training and been certified as DBH Officer Agents. For FY26, the AHL will be conducting refreshers trainings on the identified topics to also include HIPAA, effective triage and resource planning.

Q114. Please provide detailed information for FY 2024, FY 2025, and FY 2026, to date, about the DBH Access Helpline. Please include:

a. Total number of FTE assigned to the Access Helpline (broken down by type or level)
b. Number of FTEs by shift;
c. Location of each FTE (e.g., remote, centralized call center, other);
d. Number of vacancies and roles currently unfilled (broken down by type or level);
e. Breakdown of staff roles (e.g., clinicians, call takers, supervisors, contractors);
f. Average number of calls handled per FTE per month;
g. Average response time and call duration;
h. Call volume by month and total for each fiscal year;
i. Hours of operation and any changes to availability over time; and
j. Any recent or planned efforts to expand staffing, training, or infrastructure to meet demand.

DBH Response:

d. Total number of FTE assigned to the Access Helpline (broken down by type or level)

Please see FTE total and breakdown listed in the chart below:

AHL FTEs						
	Clinical Supervisor	Clinical Care Coordinator	Care Coordinator	Access Counselor	Peer Counselor	Total
FY 24	2	5	5	11	1	24
FY 25	2	5	7	11	1	26
FY 26	2	5	7	14	1	29

e. Number of FTEs by shift:

AHL FTEs Per Shift							
	Shift	Clinical Supervisor	Clinical Care Coordinator	Care Coordinator	Access Counselor	Peer Counselor	Total
FY 24	Day	1	3	2	6	0	12
	Eve	1	1	2	4	0	8
	Night	0	1	1	1	1	4
							24
	Day	1	3	3	6	0	13

FY 25	Eve.	1	1	2	4	0	8
	Night	0	1	2	1	1	5
							26
FY 26	Day	1	3	3	6	0	13
	Eve.	1	1	2	6	0	10
	Night	0	1	2	2	1	6
							29

f. Location of each FTE (e.g., remote, centralized call center, other)

AHL Staff Location			
	AHL Main Call Center	OUC	AHL/211 Call Center
FY 24	19	5	0
FY 25	16	5	5
FY 26	20	5	4

*g. Number of vacancies and roles currently unfilled (broken down by type or level)**:***

AHL Current Vacancies (includes 988 vacancies)					
Year	Clinical Care Coordinator	Care Coordinator	Counselor	Clinical Supervisor	Total
FY 24	7	4	4	1	16
FY 25	7	2	4	1	14
FY 26 YTD	7	2	1	1	11

h. Breakdown of staff roles (e.g., clinicians, call takers, supervisors, contractors):

Clinical Care Coordinator/Clinicians – Licensed Social Workers, Nurses and Counselors with thorough knowledge of behavioral health diagnoses for children and adults, triage and crisis intervention. Serves as the clinical team lead providing professional intervention, assessment, coordination and referrals for clinically complex cases to assure safe and successful resolution of contacts. Provides clinical consultation to Care Coordinators and Counselors when needed for complex calls. Responsible for review and LOC determination for specified DBH services.
Care Coordinators – Care Coordinators are licensed prepared staff professionally trained or with a background in behavioral health. Care Coordinators serve as call takers providing crisis and supportive intervention, prevention services, triage and assessment information and referrals to callers through 988 and the AHL call lines.
Access Counselors – Access Counselors serve as call takers supporting both the 988 and AHL call lines providing crisis intervention and prevention, information and referral and supportive counseling.
Peer Counselors – Peer Counselors support the AHL's warmline providing emotional support, coping strategies and connection to resources for callers to the line.
Clinical Supervisors – Provides operational management for the call center overseeing the call center's schedule and ensuring coverage during increased call volume. The Clinical Supervisors provide clinical oversight and consultation providing real time support and guidance in complex matters/escalated matters to ensure sound clinical approach to services and caller safety. Supervisors support call center

staff and ensure staff development through conducting and/or identifying ongoing professional development and training in addition to policy and protocol development and implementation.

i. Average number of calls handled per FTE per month:

FY 2024 average monthly calls per FTE is not available for the dates of October 2023 – January 2024 due to previous AHL call platform holding data for a period of no more than 365 days.

Avg. Calls by Month per FTE												
	Oct	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sept**
FY 24					**149**	**168**	**154**	**161**	**141**	**165**	**166**	**160**
FY 25	**155**	**145**	**149**	**154**	**139**	**162**	**177**	**162**	**175**	**207**	**188**	**172**
FY 26	**187**	**144**	**175**									

	FTEs	**Average Call per FTE**
FY 2024	**24**	**1339**
FY 2025	**26**	**1779**
FY 2026	**29**	**509**

*j. Average response time and call duration**:***

	Avg. response time	**Avg. Call Duration**
FY 24	27 seconds	8.18
FY 25	26 seconds	6.51
FY 26	45 seconds	4.92

k. Call volume by month and total for each fiscal year:

FY24

Line	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Total**
988	873	1009	1009	1155	977	1032	1032	1073	8160
Admin	404	441	447	492	385	513	456	419	3557
Crisis	1606	1828	1716	1670	1552	1782	1740	1751	13645
DBH911	58	66	58	69	41	61	42	45	440
Spanish	1	1	0	0	0	3	0	1	6
Special Initiatives	0	1	0	0	1	1	0	0	3
Suicide		1	1						2

Warm Line	644	694	470	472	422	562	719	555	4493
WMATA	0	1	0	1	0	0	1	0	3
Youth	1	0	0	0	0	0	0	1	2
Grand Total	**3587**	**4042**	**3701**	**3860**	**3379**	**3954**	**3990**	**3845**	**30309**

FY25

Line	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Total**
988	883	836	1023	826	605	795	867	824	843	937	940	948	10377
Admin	544	513	538	549	524	114	1	0	1	0	1	0	2785
Crisis	1917	1781	1752	1887	1890	2294	2449	2268	2571	3134	2672	2305	26920
DBH911	41	69	37	61	47	87	98	85	89	118	69	69	870
Hospital Line	-	-	-	-	-	291	502	449	471	492	600	594	3399
Special Initiatives						9	2	0	0	0	0	1	12
Warm Line	632	562	511	548	535	616	693	490	471	696	602	528	6884
WMATA		1		1			1						3
Youth	0	0	0	0	0	0	0	0	0	0	0	25 (*FSP)	25
Grand Total	**4017**	**3761**	**3863**	**3991**	**3607**	**4209**	**4613**	**4213**	**4542**	**5378**	**4884**	**4470**	**51225**

FY26

Line	**Oct**	**Nov**	**Dec**	**Total**
988	1107	899	977	2983
Admin	0	0	2	2
Crisis	3034	2246	2825	8105
DBH911	75	52	54	181
Hospital Line	605	515	568	1688
Special Initiatives	0	0	0	0
Warm Line	644	694	470	1808
WMATA		1		1
Youth	0	0	0	0
Grand Total	**3587**	**4042**	**3701**	**14768**

FY26

Call Data	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sept**
911	41	69	37	61	47	87	98	85	89	118	69	69
98	883	836	1023	826	605	795	867	824	843	937	940	948
Crisis (Suicide)	1917	1781	1752	1887	1890	2294	2449	2268	2571	3134	2672	2305
Warm Line	632	562	511	548	535	616	693	490	471	696	602	528
Admin. Calls	544	513	538	549	524	114	1	0	1	0	1	0
Hospital Line	-	-	-	-	-	291	502	449	471	492	600	594
Special initiatives Line	-	-	-	-	-	9	2	0	0	0	0	1
wmata Line	-	-	-	-	-	3	1	0	0	1	0	0
Youth line	0	0	0	0	0	0	0	0	0	0	0	25 (*FSP)
Total Number of Calls	**4,017**	**3761**	**3863**	**3991**	**3607**	**4209**	**4613**	**4213**	**4542**	**5378**	**4884**	**4470**

FY26

Call Data	**October**	**November**	**December**
Total Number of Calls - 911	75	52	54
Total Number of Calls - 988	1107	899	977
Total Number of Calls - Crisis (Suicide)	3034	2246	2825
Total Number of Calls - Warm Line	615	460	648
Total Number of Administrative Calls	0	0	2
Total Number of Hospital Line	605	515	568
Total Number of Special initiative Line	0	0	0
Total Number of WMATA Line	0	1	0
Total Number of Youth line	0	0	0

Total Number of Calls	**5436**	**4173**	**5074**

*l. Hours of operation and any changes to availability over time**:***

During FY 24, FY 25 and FY YTD, the AHL has continued to operate as a 24/7 behavioral health crisis call center. There have been no changes to availability or hours of operation.

m. Any recent or planned efforts to expand staffing, training, or infrastructure to meet demand:

During FY 24 there were 3 additional workspaces/cubicles added to the AHL's main call center in support of increased staffing. As of FY 26 YTD, the AHL has exhausted all space within the main call center. As vacancies continue to be filled, the AHL will need to address options for call center expansion and location.
In FY26 the AHL will continue to provide cross training in chat and text functionality to ensure all staff are versed in every aspect of 988. Currently all staff are trained to address 988 calls and serve as back-up call takers to the 988 team. Additionally, there will be planned training for the AHL/OUC co-located staff to become certified crisis specialists, further enhancing their skillset in crisis intervention, prevention and recovery. Continued evaluation of infrastructure to enhance system interoperability between OUC and DBH, and well as examination of system integration between the CRM, the OUC CAD system, and other systems like iCAMS the call center uses to reduce documentation errors, facilitate timely response, and improve outcomes are underway.

Q115. Please provide the following information on the Access Helpline for FY 2025, and FY 2026, to date:

a. The number of days, on average, between when a family or child calls the Access Helpline and when they are referred to a CSA:
b. The number days, on average, between when a family or child is enrolled and their intake appointment with a CSA;
c. The number of days, on average, between when a family or child is enrolled and when they receive a diagnostic needs assessment;
d. The number of days, on average, between when a family or child is enrolled and when they receive their first service as part of a treatment plan;
e. Please provide a breakdown of (e) by service type, including medication management, CBI, community support, counseling, and psychiatrist appointment;
f. All languages in which Access Helpline services are provided; and
g. The number of children who were moved around to more than one CSA.

DBH Response:

a. The number of days, on average, between when a family or child calls the Access Helpline and when they are referred to a CSA:

For FY 25 and FY 26 YTD, residents are referred to a CSA the same day they call the AHL.

b. *The number of days, on average, between when a family or child is enrolled and their intake appointment with a CSA:*

Average Wait Time (Days) between enrollment and intake		
	Adults	**Children**
FY25	11	20
FY26	5	10

c. *The number of days, on average, between when a family or child is enrolled and when they receive a diagnostic needs assessment:*

	Average Wait Time (Days) D & A services	
	Adults	**Children**
FY25	51	28
FY26	10	11
	Average Wait Time (Days) Medicaid MCO services	
	Adults	**Children**
FY25	44	36
FY26	10	3

d. *The number of days, on average, between when a family or child is enrolled and when they receive their first service as part of a treatment plan:*

	Average Wait Time (Days) between enrollment and 1st service	
	Adults	**Children**
FY25	43	48
FY26	33	34

e. *Please provide a breakdown of (e) by service type, including medication management, CBI, community support, counseling, and psychiatrist appointment:*

FY 25	**Service group**	**Service sub-group**	**Service details**	**Number served**	
	Clinic Services	Prescriber Visits	Prescriber Visit	26,647	
		Therapy	CPP-FV	1	
		Therapy	Family Therapy	365	

		Therapy	Group Therapy	283
		Therapy	Individual Therapy	13,432
		Therapy	MET-CBT	4
		Therapy	Trauma Focused CBT	49
		Therapy	Trauma Systems Therapy	0
3.	Supportive Community Services	Community Support	Community Support	37,354
4.	Intensive Community-based Treatment	CBI	CBI Level I (MST)	22
		CBI	CBI Level II/III	174
		CBI	CBI Level IV (FFT)	9

FY 26	**Service group**	**Service sub-group**	**Service details**	**Number served**
	Clinic Services			
		Prescriber Visits	Prescriber Visit	11,721
		Therapy	Family Therapy	61
		Therapy	Group Therapy	41
		Therapy	Individual Therapy	4,425
		Therapy	MET-CBT	0
		Therapy	Trauma Focused CBT	5

3	Supportive Community Services	Community Support	Community Support	22,392
4	Intensive Community-based Treatment	CBI	CBI Level I (MST)	0
		CBI	CBI Level II/III	49
		CBI	CBI Level IV (FFT)	0

f. All languages in which Access Helpline services are provided:

For FY 25 and FY 26 YTD, the AHL provided services in Spanish, Portuguese and French. The Language Line is used to deliver services in languages not provided by staff.

g. The number of children who were moved around to more than one CSA:

Total Children with more than one CSA enrollment	
FY25	115
FY26	3

Movement from one CSA to another is based upon parental or guardian choice. DBH does not move a child from one CSA to another without parental or guardian request.