Council of the District of Columbia
Committee on the Judiciary and Public Safety

Hearing Record

1350 Pennsylvania Avenue, N.W., Suite 108, Washington, DC 20004

To: Nyasha Smith, Secretary to the Council

From: Brooke Pinto, Chairperson
Committee on the Judiciary and Public Safety

Date: July 12, 2023

Subject: B25-291, the Safer Stronger Amendment Act of 2023; and
B25-247, the Female Genital Mutilation Prohibition Act of 2023

On June 27, 2023, the Committee on the Judiciary and Public Safety held a public hearing on "B25-291, the Safer Stronger Amendment Act of 2023; and B25-247, the Female Genital Mutilation Prohibition Act of 2023". Notice of this public hearing was published in the District of Columbia Register on May 26,2023 and the record remained open until July 11, 2023. A video recording of the hearing can be viewed online at oct.dc.gov

The following witnesses submitted testimony for the record:

- Robert Hay Jr. (FGM)
- Sara Imershein (FGM)
- Caitlin LeMay, The U.S. End FGM/C Network (FGM)
- Angela Peabody (FGM)
- Kelly Vaughan, GGWW (FGM)
- Mariya Taher, sahiyo (FGM)
- Michele Hanash, ahafoundation (FGM)
- Elana Suttenberg, USAO-DC (FGM)
- Troy Burner, Justice Policy Institute (FGM)
- D.C. Criminal Code Reform Commission (FGM)
- Pranav Nanda, CareNotCages
- Misty Thomas, Council For Court Excellence
- Access Housing
- Rev. Andre' N. Greene
- Andre Lee
- Antoine Coleman
- Anthony Muhammad
- Ayomide Abatan

- Hoffman & Associates
- Adam Weers, Trammell Crow Company
- Betsy Biden
- Brenda Lee Richardson
- Brian L. Schwalb, OAG
- Capital RiverFront
- Kristy Love, CJCC
- Danielle Robinette, Children's Law Center
- D.C. Criminal Code Reform Commission
- Celeste M. Bryant, WIN
- Colie Levar Long
- Courtney Stewart, National Reentry for Returning Citizens
- Craig Watson
- Daniel Kinard, Free Minds Book Club and Writing Workshop
- Dawit Getachew, fwd.us
- Douglas M. Firstenberg
- Douglas Keillor, Juvenile Justice Advocates International
- Dr. Sheila Brooks, SRB Communications
- Jake Wiener, EPIC
- Elizabeth Ngatchou*
- Rosalie Ngatchou*
- Ingrid Tehamo*
- Emmanuel Agboola*
- Sabrina Mimms*
- Elisabeth Olds, Dynamic Strategies
- M. Elizabeth Bowman
- Emily Cassometus, DC Justice Lab
- Eric J. Jones, AOBA
- Eric Weaver, NAARC
- Family Against Mandatory Minimums (FAMM)
- Fernando Gomez-Prada
- Fassihian Goli
- G King
- Gene Downing
- Gregory Pemberton, DC Police Union
- Steven Grigg, Republic
- Greater Washington Hispanic Chamber of Commerce
- Heather Pinckney, The Public Defender Service
- Hector Torres and Jay Haddock
- Innocence Project
- Irving Brockman, Free Minds Book Club and Writing Workshop
- Jacob Brown
- Jamal Childs, Free Minds Book Club and Writing Workshop
- James Cole

- James Dunn, Free Minds Book Club and Writing Workshop
- Jarrell Allen, Free Minds Book Club and Writing Workshop
- Joshua Bernstein, Bernstein Management Corporation
- John Duggenmos, DCNC
- Josh Lopez, Metro DC Hispanic Contractors Association
- Kathleen Martyn
- Keela Hailes, Free Minds Book Club and Writing Workshop
- Rev. Rob Keithan, All Souls Church Unitarian
- Kevin Thomas, CFMB
- Liz Komar, The Sentencing Project
- Kristen Barden, Adams Morgan Partnership BID
- Kristen Hubbard
- Lanet Scott
- Laura Furr
- Lenwood Johnson
- Leonard E. Bishop, ANC 7F08
- Lindsey Appiah, DMPSJ
- Loughton B. Sargeant
- Luis Villafane, Free Minds Book Club and Writing Workshop
- Lula Hagos
- Margueritte Norton
- Mark Jordon, OIJJFO
- Michele Molotsky, District Bridges
- Monica Hopkins, ACLU-DC
- More Than Our Crimes
- Naida Henao, NVRDC
- Nazgol Ghandnoosh, The Sentencing Project
- Office of the District of Columbia Auditor
- Pathenia Proctor
- Peggy Keller
- Penelope Spain, Open City Advocates
- Peter Otteni, bxp
- Pretrial Justice Institute
- Randall Mcneil
- Rev. Anthony J. Motley
- Rondell Jordan, Open City Advocates
- Sandra Ashford
- Sandra ‘SS” Seegars, CRAV
- Santha Sonenberg
- Sarah Comeau, School Justice Project
- Sakar Sunrita
- Shannon Battle
- Shawn Ruffin
- Shirley Hopkinson

- Shurland Oliver
- Robert Vinson Brannum, DC For a Safer DC
- Sydne Smith
- Tara Libert, Free Minds Book Club and Writing Workshop
- Ifetayo Belle, School Justice Project
- Restaurant Association Metropolitan Washington (RAMW)
- Solomon Keene Jr., HAWDC
- Travis Ballie
- Troy Michalak
- Rev. Vincent J. De Rosa
- Warren Allen, The Sentencing Project

ATTACHMENTS

(A) Witness List
(B) Hearing Notice
(C) Copies of written testimony

COUNCIL OF THE DISTRICT OF COLUMBIA

COMMITTEE ON THE JUDICIARY AND PUBLIC SAFETY

BROOKE PINTO, CHAIR

NOTICE OF PUBLIC HEARING ON

B25-291, the Safer Stronger Amendment Act of 2023 B25-247, and the Female Genital Mutilation Prohibition Act of 2023

Tuesday, June 27, 2023, at 12:00 P.M.

Councilmember Pinto's Youtube Page (www,youtube.com/@cmbrookepinto)
DC Council Website (dccouncil.gov)
Council Channel 13 (Cable Television Providers)
Office of Cable Television Website (entertainment.dc.gov)

PUBLIC WITNESSES (B25-247)

1. Senator Michael Brown, Public Witness
2. Michele Hanash, AHA Foundation
3. Ngoltoingar Bayor, Public Witness
4. Pedro Lima, National Hispanic Council on Aging

PUBLIC WITNESSES (B25-291)

1. William P. Lightfoot, Former DC Council Member At-Large
2. Misty Thomas, Council for Court Excellence
3. William Fairfax Sr. Public Witness
4. Doug Firstenberg, StoneBridge
5. Tony Williams, Federal City Council (virtual)
6. Pastor H. Lionel Edmonds, DC POWER (virtual)
7. Angela Franco, DC Chamber of Commerce (virtual)
8. Robbie Woodland, ANC 8C06 (virtual)
9. Lanet Brown, Public Witness (virtual)
10. Jayann Sepich, DNA Saves (virtual)
11. Marquette Muschette, Public Witness (virtual)
12. Jody Kent Lavy, Campaign for the Fair Sentencing of Youth (virtual)
13. Eddie Ellis, Campaign for the Fair Sentencing of Youth (virtual)
14. Kristen Hubbard, Public Witness (virtual)
15. Sandra Seegars, Concerned Residents Against Violence (CRĀV) (virtual)
16. Laura Furr, Public Witness

17. Gene Downing, Thrive Under 25 Coalition
18. Bryant Woodland, Second Look Project
19. Danielle Robinette, Children's Law Center
20. Sandra Williams, Concerned Residents Against Violence (CRĀV) (virtual)
21. Colie Long, Georgetown University
22. Scott Goldstein, EmpowerED (virtual)
23. Monica Hopkins, ACLU (virtual)
24. Shawn Townsend, Restaurant Association Metropolitan Washington (virtual)
25. Leonard E. Bishop, ANC 7F08 (virtual)
26. Rondell Jordan, Open City Advocates
27. David Domenici, BreakFree Education (virtual)
28. John Guggenmos, DC Nightlife Council (virtual)
29. Aakash Thakkar, Public Witness (virtual)
30. Joel Castón, Public Witness (virtual)
31. Lenwood O. Johnson, Concerned Residents Against Violence (CRĀV)
32. Naïké Savain, DC Justice Lab
33. Emily Cassometus, DC Justice Lab
34. Kathy Henderson, ANC 5D06
35. Naida Henao, Network for Victim Recovery of DC (virtual)
36. J.P. Szymkowicz, ANC 3D07 (virtual)
37. Eric Jones, AOBA (virtual)
38. Ronald Moten, Public Witness
39. Gregg Pemberton, DC Police Union (virtual)
40. William Stinson, Fire Fighter/Paramedic (virtual)
41. Courtney Stewart, The National Reentry Network for Returning Citizens (virtual)
42. Maryn Larsen, The National Reentry Network for Returning Citizens (virtual)
43. Mylan Barnes, Public Witness (virtual)
44. Elisabeth Olds, SAVRAA Independent Expert Consultant (virtual)
45. Natalia Otero, DC Safe (virtual)
46. Randall McNeil, Arnold Ventures
47. Shannon Fyfe, Neighbors for Justice
48. Rev. Ryane Nickens, TraRon Center, Washington Interfaith Network (WIN)
49. Rev. Delonte Gholston, Peace Fellowship Church, WIN (virtual)
50. Mike Silverstein, Public Witness (virtual)
51. Richard Lake, Developer Roundtable (virtual)
52. Tenille Patterson, Pretrial Justice Institute (virtual)
53. Kareem McCraney, Public Witness (virtual)
54. Sarah Staudt, Prison Policy Initiative (virtual)
55. Abed Almaala, Almaala Farms- Union Market (virtual)
56. Kelly Mikel Williams, ANC 8E03 (virtual)
57. Madeline E. Nelson, Public Witness (virtual)
58. Michael Mustafaa Plummer, Public Witness (virtual)
59. Anthony Petty, Public Witness (virtual)
60. Kaitlin Calogera, Public Witness (virtual)
61. Rob Keithan, All Souls Unitarian Church, WIN (virtual)
62. Lois Fingerhut, Adas Israel, WIN
63. James Carpenter, Neighbors for Justice

64. David Bailey, Public Witness
65. Goli Fassihian, Public Witness (virtual)
66. Norvelle Nelson, Public Witness (virtual)
67. Abel Nuñez, Central American Resource Center (virtual)
68. Eva Torres, STARR Restaurants (virtual)
69. Hilary Cairns, Public Witness (virtual)
70. Jacqueline Kinlow, ANC 8D01 (virtual)
71. Samuel Crews, Public Witness (virtual)
72. Irving Brockman, Public Witness (virtual)
73. Buwa Binitie, Danters Partners (virtual)
74. Dr. Shirley A. Hopkinson, Public Witness (virtual)
75. Vonetta Dumas Jennings, Public Witness (virtual)
76. Portia I. Hurtt, Esq. Washington Gas
77. Luis Villafane, Public Witness
78. Pranav Nanda, Public Witness
79. Joshua Lopez, Metro DC Hispanic Contractors Association
80. Delia Houseal, PhD, MPH, ANC 7E06 (virtual)
81. Cullen Gilchrist, Union Kitchen (virtual)
82. Juliet Howell, Public Witness (virtual)
83. Jasmine Heiss, Beyond Jails Initiative, Vera Institute of Justice (virtual)
84. Suzette Nicole Young, Public Witness (virtual)
85. Matthew Smith, JBG Smith (virtual)
86. Sheila Brooks, SRB Communications (virtual)
87. Charday White, Building Bridges Across the River (virtual)
88. Michele Molotsky, District Bridges (virtual)
89. Betsy Biden, Public Witness (virtual)
90. Micaela Deming, DC Coalition Against Domestic Violence (virtual)
91. Sarah Comeau, School Justice Project
92. Tyrell Johnson, Public Witness
93. Lamont Peete, Public Witness
94. Pam Bailey, More Than Our Crimes
95. Eric Goulet, Ward 3 Member, D.C. State Board of Education (virtual)
96. Anthony Muhammad, Public Witness (virtual)
97. Janet Taylor, Public Witness (virtual)
98. Nicholas Joseph Martino, ABOVEGROUND (virtual)
99. Robert Vinson Brannum, DC for a Safer DC (virtual)
100. Kevin Eastman, Public Witness (virtual)
101. Molly Gill, Families Against Mandatory Minimums (FAMM) (virtual)
102. Daniel Kinard, Public Witness (virtual)
103. Rev. Vincent J. De Rosa, Pastor, St. Mary Mother of God Catholic Church (virtual)
104. Maria Patricia Corrales, Public Witness (virtual)
105. Rodney Brown, Public Witness
106. Dr. Nazgol Ghandnoosh, The Sentencing Project
107. Liz Komar, The Sentencing Project
108. Gail S. Perkins, Public Witness
109. Warren Allen, The Sentencing Project
110. Raymond Lee, Wah Luck Adult Day Care Center (virtual)

111. Nathaniel Erb, Innocence Project (virtual)
112. Frank Chauvin, Public Witness (virtual)
113. Travis Ballie, Public Witness (virtual)
114. Queen Afi, Domestic Violence Wears Many Tags (virtual)
115. Richard Horrell, Mozzeria Inc. (virtual)
116. Andre Lee, Senators Satchel Paige Little League (virtual)
117. Penelope Spain, Open City Advocates
118. Halim Flowers, Public Witness
119. Crystal Carpenter, Campaign for the Fair Sentencing of Youth
120. Destiny Fullwood-Singh, Second Look DC
121. Aris Comprés, Owner, Los Hermanos Dominican Restaurant
122. Tayo Belle, School Justice Project
123. Gregory Sherrod, Public Witness
124. Loneldon Windsor, Public Witness
125. Rebecca Turner, Campaign for the Fair Sentencing of Youth
126. Morgan Jameson, Equality Chamber
127. Michael Stewart, Public Witness
128. Saleem Davis, Public Witness
129. Tara Libert, Free Minds Book Club
130. James Dunn, Free Minds Book Club
131. Jamal Childs, Free Minds Book Club
132. Keela Hailes, Free Minds Book Club
133. Dante "Rick" Boyd, Public Witness
134. Shannon Battle, Public Witness
135. Raymond Dodd, Public Witness
136. Craig Watson, Public Witness
137. Joshua Miller, Public Witness
138. Jodie McLean, EDENS
139. Norma Lazo, Public Witness
140. Keisha Hudson, Children's Focus Foundation
141. Isaish Hall, Public Witness
142. McKayla Harris, Public Witness
143. Johnae Brittingham, Public Witness
144. Angel Williams, Public Witness
145. Maria McPhail, Vida Senior Centers
146. Ernesto Grijalva, Public Witness
147. Josefa Campos, Public Witness
148. Troy Burner, Justice Policy Institute
149. Tomeka Watson-Lewis, Public Witness
150. Derrick Lewis, Public Witness
151. Daniel Kramer, Dukes Grocery
152. Marja Plater, Washington Lawyers Committee
153. Rev. Andre Greene, Varick Memorial AME Zion, WIN
154. Rev. Willian H. Lamar IV, Metropolitan AME, WIN
155. Dawit Getachew, FWD.US
156. Daniel Burdge, The Creamery LLC
157. Jarrell Allen, Public Witness

158. Josefina Darui, Public Witness
159. Ned McAllister, Public Witness
160. Santha Sonenberg, Public Witness
161. Jake Wiener, Electronic Privacy Information Center (EPIC)
162. Dr. Madhwi Venkatraman, Migrant Solidarity Mutual Aid Network
163. Sandra Ashford, HBI-DC
164. Pedro Lima, National Hispanic Council on Aging

GOVERNMENT WITNESS

1. Brian Schwalb, Attorney General for the District of Columbia
2. Elana Suttenberg, Special Counsel for Policy and Legislative Affairs, United States Attorney's Office for the District of Columbia
3. Heather N. Pinckney, Director, Public Defender Service for the District of Columbia
4. Lindsey Appiah, Deputy Mayor for Public Safety and Justice
5. Mark Jordan, Executive Director, Office of Independent Juvenile Justice Facilities Oversight
6. Jinwoo Park, Executive Director, Criminal Code Reform Commission

COUNCIL OF THE DISTRICT OF COLUMBIA

COMMITTEE ON THE JUDICIARY AND PUBLIC SAFETY

BROOKE PINTO, CHAIR

REVISED

NOTICE OF PUBLIC HEARING ON

B25-291, the Safer Stronger Amendment Act of 2023; and
B25-247, the Female Genital Mutilation Prohibition Act of 2023

Tuesday, June 27, 2023, at 12:00 PM
Room 500, John A. Wilson Building
1350 Pennsylvania Avenue, NW, Washington, DC 20004

To watch live:
Councilmember Pinto's Youtube Page (www.youtube.com/@cmbrookepinto)
DC Council Website (dccouncil.gov)
Council Channel 13 (Cable Television Providers)
Office of Cable Television Website (entertainment.dc.gov)

On Tuesday, June 27, 2023, Councilmember Brooke Pinto, Chairwoman of the Committee on the Judiciary and Public Safety, will hold a hearing on B25-291, the Safer Stronger Amendment Act of 2023 and B25-247, the Female Genital Mutilation Prohibition Act of 2023. The hearing will begin at 12:00 PM in Room 500 of the John A. Wilson Building, 1350 Pennsylvania Avenue, NW, Washington, DC 20004. Public witnesses will also have the option to testify virtually. The hearing will be broadcast live on DC Council Channel 13 and streamed live at www.dccouncil.us, entertainment.dc.gov, and youtube.com/@cmbrookepinto.

B25-291, the Safer Stronger Amendment Act of 2023, includes a series of amendments aimed at improving public safety in the District. These changes include:

- Increasing penalties for certain crimes, including violent crimes against individuals with physical or mental impairments, transit and for-hire vehicle workers, transit passengers, and people at public parks and recreation centers. The bill also creates a felony offense of strangulation.
- Increasing penalties for possession of illegal firearms.
- Making it easier for adults and youths who have been charged with certain dangerous or violent crimes to be held prior to adjudication. The bill would also allow youths who have been charged to be held prior to adjudication for their own protection.
- Eliminating caps on reimbursements under the Private Security Camera System Incentive Program, which helps residents and business owners buy security cameras that can assist the Metropolitan Police Department in solving crimes.
- Directing pretrial services agencies to provide GPS location data for individuals under supervision to MPD upon request; and making GPS data admissible in criminal proceedings.
- Directing MPD to collect DNA samples from individuals who have been charged with first-degree sexual assault.
- Expanding judicial discretion and adding to the list of considerations when individuals seek a reduced sentence under the Incarceration Reduction Amendment Act.

- Expanding the membership of the Sentencing Commission and giving the Chief of MPD a vote on the Commission.

B25-247, the Female Genital Mutilation Prohibition Act of 2023, would prohibit the practice of female genital mutilation and cutting ("FGM/C") in the District. It would also prohibit a parent, guardian, or conservator from removing a person under their care from the District for the purpose of facilitating FGM/C in another state or country. Female genital mutilation and cutting is a harmful practice involving the full or partial removal, or injury to a woman's external genitals. According to the World Health Organization, FGM/C is a practice with no valid medical purpose. Tragically, the practice still occurs across the United States, including in the District. The CDC has estimated that more than 51,000 women in the Washington metro area have undergone FGM/C in the past or are at risk. This bill would make it a criminal offense to engage in female genital mutilation and cutting; it would also create a private right of action for parties who are harmed by the practice. In addition, the bill would require that the Department of Health develop educational training and materials for community members and mandated reporters on the harms associated with FGM/C and how to recognize the signs that a person might be at risk.

The Committee invites the public to testify or to submit written testimony, which will be made a part of the official record. Anyone wishing to testify should contact Ms. Aukima Benjamin, Committee Manager to the Committee on the Judiciary and Public Safety, at least 24 hours prior to the start of the hearing at (202) 724-8058 or via e-mail at judiciary@dccouncil.gov. Witnesses will have the option to testify in-person or virtually; witnesses should specify which option they are electing at the time they contact the Committee Manager. Witnesses who anticipate needing language interpretation, or requiring sign language interpretation, are requested to inform the Committee of the need as soon as possible but no later than five business days before the hearing, which is Tuesday, June 20, 2022. We will make every effort to fulfill timely requests; however, requests received in less than five business days may not be fulfilled and alternatives may be offered.

If you are unable to testify at the public hearing, written statements are encouraged and will be made a part of the official record; testimony may be submitted to judiciary@dccouncil.gov. The public may also leave voicemail testimony for the Committee by calling (202) 630-7585, which will be transcribed and made part of the hearing record. Members of the public leaving voicemail testimony should speak slowly and clearly, state their full name and the organization they represent, if any, and note the bill, hearing, or agency that they are submitting testimony on. For privacy purposes, members of the public are asked to not provide an e-mail, phone number, or other personal contact information in voicemail testimony.

The record will close at the end of the business day on Tuesday, July 11, 2023.

This hearing notice was revised to reflect the removal of B25-135, the Illegal Dumping Enforcement Amendment Act of 2023, from the hearing agenda.

Public Witness Testimony: B25-291, the Safer Stronger Amendment Act of 2023

Delivered by Pranav Nanda to the Committee on Judiciary & Public Safety on June 27, 2023

Good Afternoon Chairperson Pinto, Councilmembers & Staff,

Thank you so much for the opportunity to testify today about B25-291. I am not going to be referring to this legislation by name because there is nothing about it that will make DC safer or stronger. While I join the growing coalition of neighbors, community members, and community organizations calling on the DC Council to reject the bill in its entirety – the focus of my testimony is going to be Title II, Subtitle B: Criteria for Detaining Children.

To start, let me be abundantly clear, there is no such thing as caging children for their own protection. We are lying to ourselves if we think jail is a safe place for anyone, let alone children. And when I say children, let me be more specific about who this legislation targets – Black Children. Despite only representing roughly half of DC's youth population, 92.46% of children who were securely detained pretrial from 2015-2020 were Black (and the other 6.58% were Hispanic).[1] There is no question that this legislation is going to have a disparate impact on Black Children.

This proposed legislation is not about making DC safer – it is about elected officials blaming children to avoid being held accountable for failing to make the investments and pass the policies necessary to create a safe and thriving community for young people to grow up in. And blaming them in a way that is deeply harmful, traumatic, and will significantly worsen racial inequities.

Our society has failed children multiple times well before they ever find themselves involved in the juvenile legal system. According to the Criminal Justice Coordinating Council, youth involved in the system are much more likely to have reported neglect (49.8%) and abuse (23.0%), than youth not involved in the system (17%, 10.2%).[2] Furthermore, youth involved in the system are much more likely to have experienced homelessness (11.7%) and receive TANF benefits (24.1%), than youth outside of the system (4.8%, 12.3%).[3] Additionally, youth involved in the system are much more likely to have been retained in schools (30.2%) and suspended (44.2%) from school than youth outside of the system (5.8%, 11.8%).[4] What does this data show us? That we are failing these young people.

It is impossible to demonstrate how many ways this administration has and continues to fail our young people, so I will provide just a few lowlights.

- This administration has failed to provide young people with safe & secure housing.[5]
- This administration has failed to provide young people with access to healthy & nutritious food. [6]
- This administration has failed to provide young people with engaging educational experiences,[7] safe school buildings,[8] & recreational opportunities.[9]

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[1] https://www.dcjsat.net/DYRS.html
[2] Erin Patin, A Study of Factors that Affect the Likelihood of Juvenile Justice System Involvment (Criminal Justice Coordinating Council, 2022).
[3] Id.
[4] Id.
[5] Chelsea Cirruzzo, Report: Homelessness up in D.C. region for the first time in years (Axios, 2023) (finding that D.C. counted 512 more people experiencing homelessness than the previous year, an increase of about 12%.)
[6] Kyle Swenson and Susan Doyle, 1 out of 3 people in D.C. region face food insecurity, survey finds (Washington Post, 2022)
[7] Lauren Lumpkin, D.C. math, reading test scores fall to lowest levels in more than 5 years (Washington Post, 2022)
[8] Martin Austermuhle, In D.C., Some Parents And Teachers Struggle With Aging Schools That Are Years Away From Being Modernized (DCIst, 2023).
[9] Courtney Rozen, There's A Lot Of Competition To Snag A Spot In The City's Affordable Summer Camps (DCist, 2019)

- This administration has failed to provide young people with trauma-informed mental & emotional care.[10] [11] [12]
- This administration has failed to provide young people with economic stability & security.[13] [14]

As the great Coretta Scott King once said, "I must remind you that starving a child is violence. Neglecting school children is violence. Punishing a mother and her family is violence. Discrimination against a working man is violence. Ghetto housing is violence. Ignoring medical needs is violence. Contempt for poverty is violence." If we want to talk about violence, we must talk about all forms of violence. These young people experience violence long before they ever are allegedly involved in it.

And let me add one more form of violence – caging children. The research is unequivocally clear – caging children is traumatizing and harmful. Caging children further traumatizes them and prevents normal adolescent development [15] by exposing them to the harsh cruelties of jail.[16] It puts children at a greater risk for both physical [17] and sexual violence [18] and is worse for both their short and long-term physical and mental health.[19] [20] [21] Caging children cut off their access to necessary community resources such as mental health support, educational and employment opportunities, and their connections to positive influences.[22] [23] [24] [25] I implore the members of the DC Council to listen to young people who have been caged and to hear their stories.

Some people, try to say that caging kids is necessary "tough love". That, pardon my language, is BS. Caging Black kids has been referred to by different terms throughout the history of this country, but no matter how much

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[10] 2020 Behavioral Risk Factor Surveillance system (BRFSS) survey, Centers for Disease Control (finding that "50% of DC-based 18-24-year-olds surveyed reported experiencing 2 or more adverse childhood experiences prior to turning 18")

[11] Jeff R. Temple, et al., The Impact of COVID-19 Pandemic on Adolescent Mental Health and Substance Abuse, 71 J. Adol. Health, 277(2022) (finding that "the Covid-19 induced isolation, loneliness, stress, and economic challenges were linked to increased mental health and misuse of licit and illicit substances")

[12] Adolescent Behaviors and Experiences Survey - United States, January-June 2021, Centers for Disease Control, U.S. Dept of Health & Human Services (April 1, 2022)(finding that 37% of high school students reported experiencing poor mental health during the pandemic and 44% reported feeling persistently sad or hopeless during the past year.")

[13] https://twitter.com/TheTRIGGERProj/status/1673267392158355456?s=20

[14] https://twitter.com/PranavNandaDC/status/1671610605340377092?s=20

[15] Richard Mendel, Why Youth Incarceration Fails: An Updated Review of the Evidence (The Sentencing Project, March 2023).

[16] Subini Annamma, Jyoti Nanda, Jamelia Morgan, Youth Incarceration Harms America's Children. It's Time to End It (Time, 2022)

[17] Maltreatment of Youth in U.S. Juvenile Corrections Facilities: An Update on Juvenile Correctional Facility Violence (Annie E Casey Foundation, 2015) (finding pervasive problems with physical abuse and excessive use of force by facility staff; sexual abuse; overreliance on isolation and restraints; youth-on-youth violence; and violence against staff have shown no sign of abating)

[18] Ivy Lyons, DC youth rehab employee federally charged with sexually abusing teen in custody (WTOP, 2023)

[19] Barnert, E. S., Dudovitz, R., Nelson, B. B., Coker, T. R., Biely, C., Li, N., & Chung, P. J. (2017). How does incarcerating young people affect their adult health outcomes?. Pediatrics, 139(2). (Finding Incarceration duration during adolescence and early adulthood is independently associated with worse physical and mental health later in adulthood)

[20] Teplin, L. A., McClelland, G. M., Abram, K. M., & Mileusnic, D. (2005). Early violent death among delinquent youth: a prospective longitudinal study. Pediatrics, 115(6), 1586-1593. (Finding youth who were incarcerated in detention were 4.4 times as likely as a youth in the general population to die between the ages of 15 and 24

[21] Aalsma, M. C., Lau, K. S. L., Perkins, A. J., Schwartz, K., Tu, W., Wiehe, S. E., Monahan, P., & Rosenman, M. B. (2016). Mortality of Youth Offenders Along a Continuum of Justice System Involvement. American Journal of Preventive Medicine, 50(3), 303–310. (Finding that kids who were incarcerated in youth detention centers or adult correctional facilities were 1.7 times and 2.5 times more likely to die prematurely, respectively than youth who were arrested but never confined)

[22] Emily Davies Judge holds D.C. in contempt for failing to provide education to older students with disabilities in jail (Washington Post, 2022)

[23] Improving Educational Outcomes for Youth in the Juvenile Justice System. National Juvenile Justice Network. (Finding that as many as two-thirds of children fail to reenroll in school after returning from confinement.)

[24] Aizer, A. Juvenile Incarceration, Human Capital and Future Crime: Evidence from Randomly-Assigned Judges. NBER Working Paper Series. (Finding that children who are incarcerated are 39 percent less likely to graduate from high school compared with other public school students from the same neighborhood who are not incarcerated)

[25] Holman, B. The Dangers of Detention: The Impact of Incarcerating Youth in Detention and Other Secure Facilities. A Justice Policy Institute Report. (Finding that high school dropouts face higher unemployment, poorer health (and a shorter life), and earn substantially less than youth who do successfully return and complete school.)

effort and money is put into creating a facade of "care" the reality remains the same — caging children is violent. It is traumatizing. It is harmful.

And on top of that it is actually WORSE for public safety. Once again, the research is unequivocally clear. This approach failed in the '90s and it will fail again. Caging children, especially children who are low-risk, increases recidivism in the short term [26] [27] and makes it more likely that they are arrested for violent offenses [28] and incarcerated as an adult [29] [30]. We know that the further into the juvenile injustice system children are dragged into, the worse the public safety outcomes are.[31] Simply put, caging children does the exact opposite of making DC "Safer and Stronger."

Nothing I have said is new. The Mayor has been told all of this repeatedly. Frankly, even by some of her own advisors.[32] Yet despite all of this, we are here today, facing a choice. We could reject data, research, and most importantly lived experiences, return to the failed strategies of the past and send a message to another generation of Black Children that their lives do not matter, by passing this harmful legislation. Or we could reject this harmful legislation and instead come together as a city to build the systems of care necessary to help the community heal, break the cycle of violence, and create the safe and thriving community that our young people deserve. I choose the latter, and I hope you do too.

Thank you so much for your time and I am happy to answer any questions you might have.

Best
Pranav Nanda
Ward-6 Resident

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[26] Seigle, E (2014). Core Principles for Reducing Recidivism and Improving Other Outcomes for Youth in the Juvenile Justice System. The Council of State Governments Justice Center (Finding that youth assessed as a low risk who were incarcerated were rearrested almost twice as much as low-risk youth who were placed on probation or received diversion services in lieu of supervision)

[27] Fabelo, T., Arrigona, N., Thompson, M. D., Clemens, A., & Marchbanks, M. P. (2015). Closer to home: An analysis of the state and local impact of the Texas juvenile justice reforms. Council of State Governments Justice Center. (Finding that adjudicated youth who were allowed to remain in the community on probation were 30% less likely to be arrested for a subsequent offense than comparable youth sent to state corrections facilities)

[28] Baron, J.B., Jacob, B. & Ryan, J.P. (2022). Pretrial Juvenile Detention. NBER Working Paper No. 29861. (Finding that confinement in a juvenile detention center as a youth resulted in a 39% increase in adult arrests for violent offenses and a 40% increase in adult arrests for all felony offenses

[29] Aizer, A., & Doyle Jr, J. J. (2013). Juvenile Incarceration. Human Capital and Future Crime: Evidence from Randomly-Assigned Judges. NBER Working Paper No. 19102 (Finding that incarceration in a locked juvenile detention facility resulted in a 22-26% increase in the likelihood of subsequent incarceration in an adult jail or prison.)

[30] Gilman, A. B., Hill, K. G., & Hawkins, J. D. (2015). When is a youth's debt to society paid? Examining the long-term consequences of juvenile incarceration for adult functioning. Journal of Developmental and Life-Course Criminology, 1(1), 33-47. (Finding that young people incarcerated during adolescence were nearly four times more likely to be incarcerated in adulthood than comparable peers who were not incarcerated (controlling for delinquent conduct, gang membership, peer delinquency, and other relevant risk factors)

[31] Erin Partin, Juvenile Recidivism: A 2018 Cohort Analysis. Criminal Justice Coordinating Council. (Aug 2022) (Finding the deeper a child's involvement with the juvenile legal system was the more likely they were to recidivate during the intervention and in the two years following.)

[32] https://twitter.com/jennygathright/status/1673446875783897088?s=20

2023-2024

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Council for Court Excellence
Improving Justice for the Community

Statement of the Council for Court Excellence
Before the Committee on Judiciary and Public Safety
of the Council of the District of Columbia

Hearing on B25-0291, Safer Stronger Amendment Act of 2023

Good afternoon Chairperson Pinto and members of the Committee. My name is Misty Thomas and I am the Executive Director of the Council for Court Excellence. CCE is a nonpartisan, nonprofit organization with the mission to enhance justice in the District of Columbia. For over 40 years, CCE has worked to improve the administration of justice in the courts and related agencies in D.C. through research and policy analysis, convening diverse stakeholders, and creating educational resources for the public. Please note that in accordance with our policy, no judicial member of CCE participated in the formulation or approval of this testimony. This testimony does not reflect the specific views of, or endorsement by, any judicial member of CCE.

CCE opposes the omnibus legislation as currently presented for three main reasons. First, the timeline being advanced to pass this bill precludes sufficient consideration of its disparate provisions by community stakeholders, experts, and the most impacted residents and clear analyses about why these are or are not the right solutions for D.C. There was a mere six weeks from introduction until this hearing, which is the lone public opportunity for residents and advocates to weigh in on the bill as part of the Council's legislative process. The bill's provisions cross many different topics and implicate many types of expertise – privacy, sentencing, criminal charging, judicial discretion, incarceration, community supervision, policing and technology. This rapid timeline – especially amid budget season – for such important topics precludes Councilmembers' close review and consideration, diverse constituent education and engagement, and sufficient public dialogue regarding the likely efficacy of the proposals and their comportment with constitutional protections.

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Second, although some proposals in the bill may, in concept, be meritorious or uncontroversial, many provisions would have significant impacts on peoples' due process rights and their liberty. This bill proposes changes that would increase the use of incarceration for both adults and children. These are, therefore, some of the most profound and serious changes we can make to our laws. But, to date, many of the provisions in B25-0291 have not been studied at length or recommended by the leading experts on Code revision or sentencing, and some are specifically at odds with what was recently recommended by this Council, as well as independent D.C. commissions focused on research, data, and best practices.[1] We should want to hear independent and evidence-based analysis on each these policies, as well as the views of practitioners who work in these systems, advocates, and residents with their own varied expertise before making such important changes to the D.C. Code. We hope that testimony at this hearing will provide the Committee and Council a better sense of how much agreement there is from the experts in the field and the communities whose safety we are trying to improve. And if there is not clear or near consensus that this bill will make us safer in the short and long term, then we need to take a step back.

Third, it is important that changes like the ones proposed in B25-0291 are well supported as evidence-based practices. Unfortunately, no data or evidence has been provided by the Administration or otherwise to support that each of these reforms is effective or a proven crime reduction strategy, has deterrent value, or will solve the community's current concerns and safety issues. Of course, all of us share in the grief that many D.C. residents are feeling as they continue to see their loved ones harmed by or taken away because of growing gun violence. We respect and understand the real fear that people have of their property being taken or being put in a threatening situation. These are indeed some of the most pressing concerns of our community. And it makes sense that the District wants to be proactive in trying to curb those behaviors.

However, through all of the research that CCE has done over the years, our review of scholarship and best practices in public safety and incarceration, and the perspectives of community stakeholders with whom we work, we are concerned that the provisions in this bill do not have a clear nexus to these urgent public safety issues facing D.C. For example, will the possibility of a

[1] *See, e.g.* District Task Force on Jails & Justice recommendations (2021), Criminal Code Reform Commission's recommendations (2021).

harsher sentence based on the traits of certain victims (which the perpetrator may not know) be effective in deterring those crimes? Does the data tell us that more serious sentences for gun possession crimes decrease the prevalence of gun possession? Does the data show that detaining more children charged with crimes leads to better outcomes for those individual children or the safety of their communities? Regarding the proposed changes for petitions to reduce sentences, is there evidence that expression of remorse correlates to making an individual more likely to return safely to the community? And, do we want to exclude people who have maintained their innocence throughout their incarceration? Regarding the DNA collection provisions, and setting serious civil liberties concerns aside, in practice, how many arrestee DNA samples will require processing and how might that slow the other case work of our already beleaguered crime lab? These are just a few data and evidence based details that would be important for the Council to know before making significant changes to the liberty and due interests of our children and other residents.

We have concerns that the provisions in this bill, especially as they relate to children or people who committed crimes as emerging adults, focuses on punishment only and not addressing root causes. CCE is currently conducting an examination of how and whether D.C. is focusing adequately on children who are in the abuse and neglect system, but also enter the juvenile justice system, sometimes called "crossover youth."[2] We want to help vulnerable D.C. kids avoid either system with identification and support as early as is possible. The Criminal Justice Coordinating Council recently released an updated version of their report on root causes of youth crime that shows marked differences in rates of childhood maltreatment, special education and behavioral health needs, homelessness, and poverty, among other factors.[3] Their detailed and D.C.-specific research points us to prevention, rather than punishment. We believe that prevention and intervention should be key priorities for D.C. youth in this difficult time. Indeed, nowhere in the District's own 2022 Gun Violence Reduction Strategy report was there any recommendation related to sentencing enhancements or increased incarceration. Rather, it

[2] *See,* Council for Court Excellence, *Our Children in Crisis: A Focus on D.C.'s Crossover Youth,* (2021) (describing and discussing the population considered crossover youth).
[3] Erin Partin, *A Study of Factors that Affect the Likelihood of Juvenile Justice System Involvement*, Criminal Justice Coordinating Council (October 2022).

focused on prevention, intervention, and community transformation. Those are evidence-based strategies that deserve the District's full-throttled energy.[4]

In conclusion, given that the timeline does not give adequate space for robust consideration of how these changes would actually impact incidents of crime or constitutional protections, CCE recommends that the Council reject the *Safer Stronger Amendment Act of 2023* as currently proposed, and on its current timeline for adoption. This bill should not move forward until there is persuasive research, analysis, or data to support its key provisions and there has been time for considerable community engagement. While some provisions may ultimately be positive or uncontroversial, many would have a profound impact on D.C.'s Black residents, increase the District's adult incarcerated population (which is more than 90% Black), and lead to more children being incarcerated (even though Office of the Attorney General, which prosecutes youth crime, reports that youth make up only 7% of all current arrests in D.C.). This justifies measured consideration by all stakeholders and that is not possible in the current posture.

This concludes my testimony. Thank you for your time and I look forward to answering any questions you may have.

[4] National Institute for Criminal Justice Reform, *Washington, DC Gun Violence Reduction Strategic Plan,* (2022) (commissioned by the D.C. Criminal Justice Coordinating Council and Office of Gun Violence Prevention).

ACCESS HOUSING
accesshousingdc.org

Access Housing Inc. DC
820 Chesapeake Street SE
Washington, DC 20032

Re: Testimony fir Mayor Bowser's Safer Stronger Amendment Act of 2023

To Whom it May Concern,

Access Housing is in full support of Mayor Bowser's Safer Stronger Amendment Act of 2023. As a community provider in ward 8, located on the corner of Chesapeake Street SE and Southern Avenue SE, we have seen an increase in violence in our area of service. We are in full support of this initiative as a veteran community, in hopes that this will lead to a decrease in the gun violence and shooting in our neighborhoods, as well as improve police – community relations.

Access Housing Inc DC is a non-profit organization that provides housing support for homeless veterans. We have served thousands over the years and currently house sixty-one veterans within our programs. The majority of our veterans have mental or physical impairments that increase their chances of becoming targets for violent crimes. We care about the safety of the population we serve, the team that contributes to our mission, as well as the residents in our neighborhood. Accessing Housing hopes that this initiative will unite communities and strengthen accountability and provide safer living.

Sincerely,

Gregory Crawford

Gregory Crawford, Executive Director

At this time, I must say no to the Mayor’s bill. I feel overall it’s not a bad bill but there are some areas I think needs more attention. Having worked in the Juvenile Justice can’t support B25-291 that will allow judges to jail children who are not a risk to public safety by expanding the pre-trial detention law in order to "protect the child. “This will Not Reduce Reoffending: Research has found that detaining youth, especially youth who are low risk to public safety, increases recidivism. Making it easier to jail children for offenses that do not involve a gun or any physical injury to anyone by expanding the presumption of detention. Research has found that more severe punishment does not reduce offending or arrests among youth. Adopting the proposed changes will lead to increased harm to our children while making us less safe. DC's detention rate is higher than any other state and four times the national average. Youth detention undermines public safety. These proposals, if passed, would mark a return to the failed policies of the past. The Strategic Gun Violence Reduction Plan, that has not been signed off on by the Mayor or the DC Council. This has strong, researched recommendations that has center community-based solutions. Let’s look at other programs that have not been funding.

The Mayor's proposal also ignores the history of systemic racism in the District and the genuine growth and change that IRAA petitioners-now older adults-have made. IRAA recipients have overcome significant challenges and contribute to improving public safety as changemakers in our communities. They are small business owners, dedicated employees, devoted fathers, violence interrupters, and vibrant community members who make DC a better place. Please let’s SAY YES TO THE SCIENCE! Science supports keeping IRAA exactly as it is. The Mayor’s proposal disregards what scientists, doctors, and the United State Supreme Court have acknowledged about the development of youth.! Please let’s rethink some of these things and look at other avenues that will truly help detour the crimes of our youth.

Respectfully Submitted,

Rev. Andre’ N. Greene

Varick Memorial AME Zion

ANDRE LEE

PRESIDENT SENATORS SATCHEL PAIGE LITTLE LEAGUE

TESTIMONY IN FAVOR OF MAYOR BOWSERS SAFER STRONGER AMENDMENT ACT OF 2023

GOOD AFTERNOON CONCILMEMBER PINTO AND COMMITTEE MEMBERS, MY NAME IS ANDRE LEE AND I'M THE CURRENT PRESIDENT OF SENATORS SATCHEL PAIGE LITTLE LEAGUE. I'M TESTIFYING TODAY IN FAVOR OF MAYOR BOWSERS SAFER STRONGER AMENDMENT ACT OF 2023.

I'LL MAKE THIS TESTIMONY SHORT AND TO THE POINT, THIS CITY HAS IN THE PAST COUPLE OF YEARS SEEN AN INCREASE IN CRIME AND HOMICIDES AND THE LAWS ON THE BOOKS NOT CHANGE IN A VERY LONG TIME. WE HAVE TO START SOMEWHERE IN TRYING TO LOWER THE CRIME AND HOMICIDES IN THIS CITY AND CHANGING SOME OF THESE LAWS MAY HELP, THE CRIMES IN THIS CITY IS GETTING WORSE AND AS A MENTOR & COACH TO OUR YOUTH I SEE THE AGE OF THESE CRIMES BEING LOWER AND HAVING CONVERSATIONS WITH SOME OF THE PARENTS ON OUR TEAMS AND IN THE COMMUNITY THEY ALL HAVE EXPRESSED CONCERNS AND SAY THAT THE CITY LAW MAKERS HAVE TO COME UP WITH STRONGER PENALTIES TO TRY AND DETER SOME OF THIS CRIMINAL ACTIVITY, ALONG WITH MORE PROGRAMS THROUGH DPR AND JOBS!! ALL OF THIS GO HAND AND HAND.

THANK YOU FOR ALLOWING ME TO TESTIFY IN SUPPORT OF THE SAFER STRONGER AMENDMENT ACT OF 2023

Global Woman® P.E.A.C.E. Foundation|14001-C St. Germain Drive #453|Centreville, VA. 20121|703.832.2642|www.gwpfnd.org

I am honored to be invited to contribute to this very important cause by making a statement. I applaud you for the action and efforts you have taken in this matter. My name is Angela Peabody, Executive Director of Global Woman P.E.A.C.E. Foundation.

Global Woman P.E.A.C.E. Foundation was founded in 2010 on the principles of ending violence and injustices against women and girls. The mission of the organization is to empower women and girls through education to eradicate gender based violence, especially female genital mutilation.

Furthermore, we are committed to the campagin to end FGM, and believe in ending the practice through education. Therefore we support this Bill, "The Female Genital Mutilation Prohibition Act of 2021" in the interest and future of girls.

Approaches to ending FGM are:

- The passage of laws to have the practice criminalized
- Education & Information through community outreach
- Media coverage is crucial
- Engage & train frontline health professionals
- Involve parents & community leaders (Presentations at PTA meetings)
- Involve school districts
- Engage and train law enforcement (Police officers need to know how to identify suspicions)
- Teach lessons about it in schools (Virginia currently has an education law to include FGM in the school curriculum)

Prior to the passage of the law in Virginia, an East African in Virginia was chasing his daughter down the street with a knife, attempting to perform FGM on her. A woman from and her daughter shielded the girl from the father and called the police. When the Fairfax Police arrived, they did not know anything about FGM. Because the woman had attended a presentation on FGM a few years earlier that I had hosted, she was knowledgeable about FGM and understood what the girl said as she was running. However, there was not a law in Virginia at the time, the father was arrested for attempted malicious wounding, and was later released.

Education is a slower process toward ending violence and injustices; however we believe that it is the surer road to eradication.

Thank you for your time and kind consideration. We hope you will pass this Bill to have the practice of FGM criminalized in the District of Columbia.

Respectfully,
Angela Peabody
Executive Director

ANTHONY MUHAMMAD

July 27, 2023. Hearing Before Council Member Brooke Pinto on B25-291 Safer Stronger Amendment Act of 2023, Amendments Proposed by Mayor Muriel Bowser

I am a Co-convener of CRAV, the President of 7District MPD, CAC, a Ward 8 resident, and an opponent of victims. I believe when preventative measures do not stop a person from committing a crime, they need to be prosecuted regardless of the age of the person, and THE TEACHERS, and the Parents need some accountability for delinquent juveniles. The parents and teach should be on record, with CFSA, for seeking help for the juvenile. I am in full support of all amendments, but why make blacks the focus as the real criminals?

W.E.B. DuBois wrote:
Even today the masses of the Negro see all too clearly the anomalies of their position and the moral crookedness of yours. You may marshall strong indictments against them, but the counter-cries, lacking though they may be in formal logic, have burning, truths within them which you may not wholly ignore, O southern gentleman! If you deplore their presents here, the ask, who brought us? When you cry, deliver us from the vision of intermarriage, they Answer, that legal marriage is infinitely better than systematic concubinage, and prostitution (that we experience doing slavery). And if in just fury you accuse their vagabonds of violating women, they also in fury quite is just may reply: the rape which your gentlemen have done against helpless black women in defiance of your own laws is written on the foreheads of 4 million mulattos, and written in ineffaceable blood. And finally, When you fasten crime, upon this race as its peculiar trait, they answer that slavery was the arch-crime and lynching, and lawlessness, is twin abortions; that color and race are not crimes, and yet it is they (color and race), which in this land receive most unceasing condemnation, North East South and West".

I am not excusing Street crime. But Justice is a two Edge sword wielded by truth.

Crime is a consequence of an unjust society and a corrupt political, economic and social system. The rate of recidivism, or tendency to return to criminal habits indicates that there is no real reform. In fact, the inmates propensity toward criminal behavior only worsens after going to prison.

I agree on this part that Ms. Sandra Seegras wrote, "My amendment proffer, is that the law on gun possession should include a penalty enhancement that if the person arrested for possession of a gun does not reveal where they got the gun they should be sentenced up to one and 1/2 times the maximum fine, otherwise authorized for the offense, and should be imprisoned for a term of up to one, and 1/2 times the maximum term of imprisonment authorized for the offense".

If a juvenile clearly kills someone with a gun, 14 years old, and up they should be charged as an adult. Write legislation that holes a juvenile as an adult, if they premeditatedly kill a human being in Washington DC.

Anthony Muhammad
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202-359-3517

Council of the District of Columbia
Committee on the Judiciary and Public Safety
Brooke Pinto, Chair
Testimony of Antoine Coleman
Public Hearing
The Safer Stronger Amendment Act of 2023
Tuesday, June 27, 2023
Room 500
Wilson Building 1350 Pennsylvania Ave NW Washington DC

My name is Antoine Coleman, and I am an IRAA recipient. Born and raised in Southeast, D.C., my story is very similar to the many young, black men who had to endure Washington's streets when it was at its absolute worst. Violence itself had become normalized. And I'd had no idea how truly devastating my own decisions actually were and how negative of an impact my actions had on the whole of my own community.

At the age of 21, I was sentenced to 66 years to life. I'd had no convictions before then, juvenile or adult. Subsequently, I was sent to Beaumont, Texas, the worst federal penitentiary in the country at the time. It was there I learned the word "homie." I eventually stopped through the many prisons across the country housing D.C. inmates, and after almost 22 years, that word "homie" would come to mean so much more for me. The same young men who once warred with one another, who I likely never would have met on the streets because of the vicious territorial setting we were raised in, these were now some of the same young men who exchanged books… Who once encouraged violence now counseled one another. Even in the unimaginable circumstances many of us were faced with, we somehow found the strength and courage to not only pull ourselves up such a dark looking road, but pushed one another to be better men regardless of that.

How this all relates to IRAA is that we were once the young men some had labeled "Super Predators." Caged, and expected to act like the savages many of us were on the streets, we instead grew into ourselves, as did our understanding, respect and appreciation for our fellow man. We no longer saw each other as the enemy, but instead, as men fighting to overcome traumatic pasts and move forward in a much more positive light. We worked together and not against one another. That shift in mentality towards the fellow man had translated into much better action in dealing with what were sometimes complicated and precarious issues. When the Second Look Amendment Act opened its window, many of us were already standing in line waiting to push one another through. And even after our liberation, in which we could've taken off in every which direction, that same sense of comradery is still quite clear as we continue to fight to pull all those who were once said would never have love and respect for one another. What this Committee sees with our support of one another, our families also see. Our children also see. The community also sees. The youth who still look up to some of us also sees. With that said, I don't believe there is anyone more suitable to have an immediate and positive impact on our youth than the ones who have overcome the trauma that afflicts them today. I sincerely ask this Committee to please consider not what we have said, but what we have done and many of us continue to do in our city's fight for a better community for all. Thank you for your time.

My name is Ayomide Abatan and I live in Michigan Park. I'm writing to support Mayor Bower's efforts to make DC even safer for residents. For me, public safety is something that's very personal.

On top of my job teaching local elementary school students how to code, I delivered with DoorDash for a few months. I really enjoyed dashing, which helped me to bring in extra income when it seemed like it would be tough to make ends meet. Picking up meals and biking them around Washington, DC is something that I really enjoyed.

Unfortunately, my bike was stolen last month, and I haven't been able to dash since. That means it has suddenly become more difficult for someone like me who is supporting myself in part thanks to these earning opportunities. I know my story is one that many people can sadly relate to — not just in my neighborhood, but across Washington, DC.

I've been living in the District for 20 years, and care deeply about making sure it's safe for everyone. Public safety is something that we can agree is important to all of us, and I urge the Council to work with Mayor Bowser to identify solutions that will improve public safety in DC.

Sincerely,
Ayomide Abatan

June 23rd, 2023

By Electronic Mail
judiciary@dccouncil.gov
BPinto@dccouncil.gov

Honorable Councilmember Brooke Pinto
Committee Chair
Judiciary & Public Safety Committee
District of Columbia City Council
1350 Pennsylvania Avenue, DC 20004

RE: B25-291, the Safer Stronger Amendment Act of 2023

Dear Councilmember Pinto, Members of the Committee, and additional Members of the Council:

I am writing in support of the Safer Stronger Amendment Act of 2023, as a resident, father, and colleague of those that are directly affected by local crimes. As a resident of DC for over 20 years, currently residing in Ward 4 and working in Ward 6, I have witnessed firsthand the effect and aftermath of crimes committed in the District. The personal safety of my family, friends, and colleagues is of primary concern, and one that I worry about daily.

Working in Ward 6 and being a part of the development and growth of the Wharf has been the greatest accomplishment and honor of my career. The Wharf generates $75MM of annual tax revenue for the District, which is put at risk when our visitors and tenants are suffering violent personal and property. Crime and the foundational aspect of personal safety is affected. An increase in crime and a decrease in safety directly impacts the success and longevity of our local (and prospective) businesses and residents.

Several plans for the post-covid rebirth of Downtown have been created over the last several plans. The DC Comeback Plan and the Downtown Action Plan will have meaningful success only in an environment where residents, workers and visitors to the District feel safe. It is imperative that the courts in DC be empowered to hold violent and repeat criminals pre-trial. The proliferation of guns, gun related crimes and carjackings in the city is unacceptable for a world-class city.

In this month alone (June 2023), the District of Columbia surpassed 100 homicides sooner than any year in the last two decades (2003). This terrifying statistic is one that should not be overlooked or attempted to be watered down. Crime, the fear of crime, and the view from my neighbors, co-workers and tenants, that no one is listening and/or cares to listen, is our current reality and concern. The District of Columbia is our Nation's Capital and with that comes the opportunity and responsibility to lead by example by implementing acts that put the safety of the public at its forefront.

The Judiciary & Public Safety Committee and the Council should, without hesitation, pass the Safer Stronger Amendment Act of 2023 to make it clear to residents and businesses that their safety, their concerns, and their experiences matter, and that those that might perpetrate crimes will be dealt with appropriately.

Sincerely,

Shawn Seaman
President, Hoffman & Associates

cc: Chair and Members of the City Council
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nvrdc
Network for Victim Recovery of DC

Committee on the Judiciary & Public Safety
Hearing on Bill 25-0291, "Safer Stronger Amendment Act of 2023."
Statement of Naida Henao, *Network for Victim Recovery of DC's Head of Engagement*
June 27, 2023

Thank you Chairperson Pinto, Committee members, and staff for your commitment to protecting the rights of victims in the District. My name is Naida Henao, and I am testifying on behalf of Network for Victim Recovery of DC (NVRDC) in my capacity as its Head of Engagement. Since 2012, NVRDC has implemented its broad mission and commitment to supporting over 9,000 crime victims and survivors through free, holistic, and trauma-informed legal, advocacy, crisis intervention, and therapeutic services in the District.

With rising crime rates in DC we understand our community's concern and desire to see a change. While there are aspects of B25-291 that NVRDC supports, overall we feel that the bill's approach to public safety fails to address the root causes of crime, which are more often tied to poverty, inequities in opportunity, and lack of societal support rather than "low" sentences or "weak" penalties. NVRDC is concerned that many of the provisions in this bill may result in overcriminalization of conduct, disparate impacts on communities of color, and have limited support for survivors/victims of crime in the District. While many DC residents have suffered harm and fear for their safety, increases in criminal sentencing alone cannot create accountability when they fail to center the healing and trauma of the individuals involved.

After more than three years of sustained trauma from the global pandemic and multiple local public health emergencies, DC is experiencing a 23%[1] increase in violent crime when compared to this same time last year and a 28% increase in all crimes.[2] Despite these figures,

[1] As of June 26, 2023 per DC's Metropolitan Police Department's statistics; https://mpdc.dc.gov/page/district-crime-data-glance.
[2] The increase is borne by some neighborhoods more heavily. "A greater percentage of people living in Wards 7 and 8 feel unsafe—more than 4 in 10—in areas east of the Anacostia River, where residents face the greatest inequities

when Chairwoman Pinto held a three-day public roundtable on gun violence,[3] many DC residents identified wanting more investments in trauma healing, less investments in carceral responses to crime, and to feel safe. The 2021 DC Police Reform Commission's listening sessions also reported that many DC residents do not desire interaction with police or the criminal legal system and want alternatives to system-based options.[4] In fact, victims prefer that the criminal justice system focus more on rehabilitation than punitive responses to harm.[5] These findings are in line with the first-ever national survey of victims' views on the criminal legal system, finding that by a margin of 3 to 1, victims would prefer to hold people who cause harm accountable through options beyond prison like restorative justice (RJ).[6] Similarly, 77% of survivors of the most serious violent crimes said that prosecutors should focus on solving neighborhood problems and stopping repeat crimes through rehabilitation, even if it means fewer convictions.[7]

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to economic opportunity and the highest concentrations of violent crime (2/3 of all DC homicides in 2023 occurred in these communities), compared to other parts of the city."

[3] March 3, 4, and 6, 2023. Specific quotes can be found in the following articles: https://dcist.com/story/23/03/07/dc-gun-violence-roundtables-solutions/; https://wjla.com/news/local/dc-gun-violence-prevention-council-councilmember-brooke-pinto-roundtables-public-safety-series-crime-youth-shootings-carjackings-discussion-virtual-in-person-forum-washington-dmv-district-initiative-government; https://www.wusa9.com/article/news/crime/district-council-crime-roundtable-searches-for-solutions-to-gun-violence/65-e4412fb9-e6a8-4e5c-9ab7-1a69f82ffe10.

[4] DC Police Reform Commission, Decentering Police to Improve Public Safety, April 2021, https://dccouncil.gov/police-reform-commission-full-report/ (p. 5, 35, 55, 62, 77).

[5] Alliance for Safety and Justice. (2019). Crime Survivors Speak The First-Ever National Survey of Victims' Views on Safety and Justice. https://allianceforsafetyandjustice.org/wp-content/uploads/documents/Crime%20Survivors%20Speak%20Report.pdf.

[6] Restorative justice is a response to wrongdoing that prioritizes repairing harm and recognizes that maintaining positive relationships with others is a core human need. It seeks to address the root causes of crime, even to the point of transforming unjust systems and structures: https://restorativejustice.org/what-is-restorative-justice/three-core-elements-of-restorative-justice/.

[7] Alliance for Safety and Justice. (2019). Crime Survivors Speak The First-Ever National Survey of Victims' Views on Safety and Justice. https://allianceforsafetyandjustice.org/wp-content/uploads/documents/Crime%20Survivors%20Speak%20Report.pdf.

NVRDC wants to be clear that we are not claiming that all victims want the same approach. In fact, this Committee is likely familiar with our prior testimony where we've discussed the cost of treating crime victims as a monolith. While some of our clients do want accountability in the form of incarceration, a growing number of clients and residents within our community want other options after they've been victimized, as is reflected by the surveys I cited earlier. Their reasons vary greatly and span from not feeling safe with the police or criminal legal system; wanting to prioritize their medical, housing, or psychological needs; or because their definition of "justice" differs from what the courts can offer. The Safer Stronger Act fails to address these calls for change and continues to attempt to approach community violence through a one-size-fits-all approach instead of striving for policies that make a wider variety of residents feel safe in the District.

Some provisions that stand out are: the proposed increased detention of youth, which has disproportionately impacted Black and Brown students,[8] instead of addressing the resources for intervention and support for youth at their schools; and imposing mandatory minimum sentences, which deprive judges the ability to have discretion based on the facts of the case and deprive the ability for crime victims to have meaningful say about the sentence imposed, contrary to their rights under local law.[9]

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[8] Georgetown Law's Center on Poverty and Inequality's Report "Girlhood Interrupted: The Erasure of Black Girls' Childhood" (2020), https://genderjusticeandopportunity.georgetown.edu/wp-content/uploads/2020/06/girlhood-interrupted.pdf; American Psychological Association, "For Black Students, unfairly harsh discipline can lead to lower grades" (2021), https://genderjusticeandopportunity.georgetown.edu/wp-content/uploads/2020/06/girlhood-interrupted.pdf.

[9] For example, under DC Code § 23–1904, the Crime victims' rights at sentencing, victims not only have the right to be present at the defendant's sentencing, but also have the right to submit a statement, prior to the imposition of a sentence, for consideration by the Court.

There are also provisions like making strangulation a felony, or requiring DNA sample collection from persons charged with a variety of sexual abuse offenses, that have a good intent; however, they fail to address the underlying issue. With strangulation specifically, making this offense a felony alone will unlikely have any effect on the safety of our clients. While the clarification of the "significant bodily injury" definition is helpful,[10] making this offense a felony will not change the low frequency of prosecutions, the need for increased trainings by necessary professionals to identify strangulation risk factors and injuries, or increase the accessibility and amount of resources that survivors need to safely escape the person who caused them harm.[11] Once again, we need to invest in our current systems of prevention and support to make a difference. A change to the code alone may not be sufficient to cause a change in our client's level of safety.

NVRDC would respectfully recommend that this bill shift to make more room for alternative approaches and create more space for the voices of other agents in our community, such as victim service providers who are providing the critical resources and support depended on by many District residents. Specific changes that could be made to modify the bill would be:

- Modify the Incarceration Reduction Amendment Act to require judges to make an inquiry with prosecutors to ensure that they made a good faith effort to notify the victim of the proceeding, conferred with the victim about their position (as should be done under the DC Crime Victims' Bill of Rights),[12] and referred them to community resources, including crime victims' rights attorneys, where applicable.

[10] More specifically, NVRDC supports the broader range of injuries being included in the new definition (as well as injuries that occur frequently with strangulation) and the inclusion of the term "suffocation."
[11] Similarly, increased collection of DNA samples of sexual abuse offenses may not lead to an increase in investigations or prosecutions of these crimes.
[12] DC Code § 23–1901

- Require trauma-informed trainings for various District entities who interact with survivors, eg. the courts, prosecutors, defense attorneys, but also schools.
- Considering that nearly 1 in 2 victims say that they did not get the support they wanted because they did not know where to find that support,[13] we recommend a greater investment in community outreach campaigns about how to access existing services within the District.
- With the pandemic worsening many conditions for survivors of power-based violence and other crimes, the requests for services has significantly increased for service providers like NVRDC. The District's largest domestic violence response agency (DC SAFE) reported a 57% increase in requests for services since the start of the pandemic. According to the DC Coalition Against Domestic Violence (DCCADV), 52 requests for services go unmet every day in DC.[14] Victim service organizations cannot be expected to handle significant increases in the requests for services, without a stronger investment in the organizations and their staff that do this important work.
- Respond to the growing demands for alternatives to the criminal legal system by investing more in restorative justice projects and diversion programs for mental health, substance use, etc.

Conclusion

NVRDC thank you Chairperson Pinto, this Committee, and the Council for its continued effort to address public safety. However, we feel strongly that the path towards healing our community

[13] Alliance for Safety and Justice, Crime Survivors Speak: National Survey of Victims' Views on Safety and Justice, https://allianceforsafetyandjustice.org/wp-content/uploads/2022/09/Alliance-for-Safety-and-Justice-Crime-Survivors-Speak-September-2022.pdf.

[14] DC Coalition Against Domestic Violence Annual DV Occurrence Fact Sheet. dccadv.org/resources/fact-sheets-and-statistics/.

lies in investing in more community-based approaches that center on healing and support of those who have been traumatized instead of centering punishment. Thank you for your time. I'm happy to take any questions you may have.

July 11, 2023

Testimony of Lula A. Hagos
Associate Professor of Clinical Law
Director, Criminal Defense and Justice Clinic
George Washington University School of Law

Before the Committee on the Judiciary and Public Safety
Council of the District of Columbia
B25-291, Safer Stronger Amendment Act of 2023

Dear Chairwoman Pinto and Members of the Committee:

My name is Lula Hagos, and I am an Associate Professor of Clinical Law and Director of the Criminal Defense and Justice Clinic at George Washington University School of Law ("GW Law"). Thank you for the opportunity to submit testimony for your consideration of Bill 25-291, the "Safer Stronger Amendment Act of 2023." I write to strongly urge the Council to reject this proposed legislation.

My testimony is informed by eleven years of experience representing both adults and children in the District as a former public defender and clinical professor. Currently, I direct the Criminal Defense and Justice Clinic at GW Law, which represents individuals who cannot afford counsel facing misdemeanor charges in the District. Prior to this role, I was a trial attorney with the Public Defender Service for the District of Columbia and a Prettyman Fellow at Georgetown University Law Center, where I represented adults and youth and supervised law students in D.C. Superior Court. I have served as an advocate at the pretrial and postconviction levels and have worked with many returning citizens over the years. I believe the proposed legislation before the Committee would be counterproductive to our shared goal of public safety, perpetuate overincarceration and racial disparities in the city, and devastate the lives of many D.C. residents and their families. I would like to focus specifically on the draft provisions that seek to amend the Incarceration Reduction Amendment Act ("IRAA") and expand pretrial detention for children and adults.

<u>IRAA</u>

IRAA should not be changed. Drawing from an extensive body of science, empirical research and United States Supreme Court precedent that recognized the brain development of young people and their diminished culpability in the criminal legal system, the Council engaged in a deliberative and thoughtful process when it passed IRAA in 2016 and the Second Look Amendment Act in 2019. Since then, countless men and women - indeed, over 93 % - who have been released under this legislation are thriving, living peacefully with their families and

positively contributing to our community. In essence, IRAA recipients have epitomized the power of redemption, affirming that this legislation has overall been a great success. To blame those who have earned sentence reductions under IRAA for any rise in violent crime in the city would be unfair and inaccurate. Quite the opposite, so many of the men and women who have been released are actively working to make our community safer - as youth mentors, outreach advocates, violence interrupters, among other roles. This proposed legislation ignores the data clearly demonstrating the successes of IRAA recipients.

The proposed amendments also greatly diminish IRAA's central focus on rehabilitation and redemption. Courts already have wide latitude to determine whether to grant someone relief under IRAA. Currently, the law directs judges to grant a reduction only after a thorough determination that an individual is not dangerous and the interests of justice support a reduction, which involves an assessment of several broad factors. After an extensive review, those who are seeking a reduced sentence under IRAA essentially must prove their fitness to return to the community. Permitting judges to deny relief even after an individual meets each and every one of these exhaustive criteria would encourage arbitrary and biased decisions. Furthermore, the increased emphasis on the nature of the offense and remorse in the proposed bill would seriously undercut the rehabilitative purpose of IRAA. The nature of the offense is a static factor that is not reflective of one's growth and promise for being a productive member of our community. Judges already can and do consider the underlying facts in deciding relief through other statutory factors. Because all IRAA cases involve serious crimes, reinserting the "nature of the offense" as a required factor - language previously rejected by the Council - would undoubtedly result in the denial of relief for people who can otherwise demonstrate that they are not dangerous and deserve to be given a second chance. Similarly, judges can already consider one's remorse as the law currently stands; however, requiring them to weigh it as a factor unfairly excludes those who assert their innocence but can otherwise meet the criteria for release. In sum, by limiting those who qualify under IRAA and do not pose a danger to the community, this proposed bill would directly undermine public safety and only deepen the harms caused by mass incarceration.

Pretrial detention

In addition, the proposed legislation's focus on expanding the pretrial detention statutes for children and adults will similarly not advance public safety and be harmful to D.C. residents. Even short periods of pretrial detention can be incredibly destabilizing – people lose their jobs, homes, public benefits, the ability to care for their children - increasing the likelihood that people will return to the criminal legal system upon their eventual release. By contrast, according to recent data from the city's Pretrial Services Agency, which monitors everyone who is released to the community pending trial, 92% of those individuals did not have further contact with the system while awaiting trial and only 1% was rearrested for a violent offense. This proposal is not grounded in data that demonstrates that locking up more people pending trial will make us safer, only failed and short-sighted strategies from our past.

The draft provision that expands the power of judges to detain more children before

adjudication is particularly troublesome and antithetical to rehabilitation, the primary goal of juvenile court. Detaining children who do not pose any risk to the community, but rather "for their protection," will cause real harm to children and their families. Having worked with youth in the city's juvenile system since 2008, I have seen that harm up close. I practiced in juvenile court at a time when the law permitted judges to hold children in the name of self-protection. A remarkable number of my clients were detained on this basis - not because they posed any risk to others, but often because they needed additional support and protection from the adults around them. They may have lacked family support, housing and food security, or were in desperate need of mental health treatment. Rather than provide supportive services in the community, those clients were placed in an environment where they were isolated, traumatized, and often victimized. I cannot recall a single case where a client was better off having been locked up. Rather, they experienced lasting negative impacts on their learning, mental health, home life, future involvement in the system, and more. This bill would unquestionably impact Black children the harshest, who make up nearly all of the children entangled in the District's juvenile system, perpetuating racial disparities that continue to plague our community. The city's resources would be better applied towards community-driven strategies that address crime *prevention*, such as improving housing stability, education, job opportunities, and mental health services, the types of issues that often drive system involvement in the first place.

Thank you for this opportunity to testify before the Committee and please feel free to contact me with any questions.

Sincerely,

Lula Hagos

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June 23, 2023
Honorable Councilmember Brooke Pinto
Committee Chair
Judiciary & Public Safety Committee
Council of the District of Columbia
1350 Pennsylvania Avenue, NW
Washington, DC 20004

Re: B25-291 – Safer Stronger Amendment Act of 2023

Councilmember Pinto and Members of the Council of the District of Columbia:

It will come as no surprise to you that my firm, like so many other major corporations with a significant presence in the District, is acutely concerned about the surge in crime our City has been experiencing in recent years.

As a District resident of 17 years, and as a member of the executive leadership team of the largest commercial real estate development firm in the US, I am respectfully asking for your help with, partnership in, and support of, the Mayor's Safer Stronger Amendment Act of 2023.

Trammell Crow Company has maintained a consistent presence as a major employer in the District for four decades. Through our workforce, and through the construction and permanent jobs generated by the 14M square feet we have developed in DC-proper over the past 40 years, we are directly responsible for a substantial level of economic activity, tax revenue generation, and positive fiscal impact on the City. Our work has spanned all quadrants of the District and produced a number of iconic projects from Market Square, to the Columbia Hospital for Women, to the Shops at Dakota Crossing.

Safety and security are critical components of the success of all our assets, but our retail and office assets are particularly sensitive to these factors. As one example, several retailers in the shopping center we developed at Dakota Crossing have struggled to deal with the substantial enhancements to security measures they have had to implement in recent years, all of which serve to depress revenues, increase expenses, and ultimately stifle their performance as tax generating and job creating engines. As another example, we recently completed the new headquarters building for the DC Department of General Services (DGS) on Minnesota Avenue, a building which we are particularly proud of given the statement it makes about what a trophy-quality public office building should look like, and the economic impact the District can have East of the River when it focuses its resources in smart and strategic ways. As impactful as the DGS project has been, however, it was not without its struggles. The public safety challenges our GC and subcontractor teams faced during the construction process were extremely challenging, and downright scary at times. Said plainly, we experienced a level and frequency of violence during the construction phase of this building (2021 – 2023) that I have never seen in the 18 years I have been involved in real estate development in the District.

TCC remains committed to our presence in DC and to our role as a long-term, engaged, and supportive corporate partner for the City. As recently as 3 years ago, we made the decision to continue this decades-long commitment and remain in the District when our firm was presented with the opportunity to move. We held firm to that decision through the depths of the COVID pandemic, and used the move as an opportunity to expand our footprint and enhance our presence from our former space in Georgetown to a larger suite in an office building we own at BLM Plaza.

Our leadership team prides itself on maintaining strong relationships with District government leaders like yourself across multiple terms and administrations, and we will gladly make ourselves available to you at any point to discuss this topic further, or to serve as a resource and partner to you in any way that we can. We are grateful to each of you for the time and tireless efforts that you devote to serving District residents, and to leading on the Council in such an important role.

Therefore, I am again, respectfully, asking that you join forces with my firm and with the broader business community in strongly supporting the Mayor's Safer Stronger Amendment Act of 2023, and in working together to make the District safe for all residents, workers and businesses.

Thank you for your time and consideration.

Sincerely,

Adam C. Weers
Chief Operating Officer
Trammell Crow Company

My name is Betsy Biben. For 40 years I worked for the Public Defender Service for the District of Columbia (PDS). The first20 years I worked as a line staff forensic social worker. The second 20 years I lead the O-R-D for PDS often described as the "social work division." ORD is the first social work component of a public defenders' office in the country and has been in existence for 52 years.

Five years ago, I started a therapeutic support group for men and women returning home after serving at least 15 years of incarceration. Most of the men? who attend the weekly group had been confined between 28 and 46 years. Last May I retired from PDS but not my volunteer work with the support group "15-30-Life."

I have had the privilege of consulting in over 100 IRAA cases. I specialize in reentry planning and community support.

The people who have been released have EARNED the right to be released home to our community. They promised that if they came home, they would give back to our community AND THEY HAVE!

I believed then – in 2018, when the first people began returning home under IRAA, - and I am **very pleased** to say I believe **now** more than **ever**, that the men who have returned to our community have overwhelmingly created a healthier D.C. Their careers or jobs vary, to name a few,

John Lewis Fellows

Education & Juvenile Justice Reform Fellow

Non-profit Founding Director

Artists

Program Analysist

Summer Camp Director

Mentors

School Safety Guards

Paralegals

Non-profit Board members

Conflict Resolution Trainers

Maintenance workers

Negotiation Trainer

Night Counselor in Youth Housing

Violence Interrupters

Secret Santa Claus

Job Counselor

Fitness Coaches

National Speakers

Grocery chain store Manager

Researchers

Advocates

Peer Counselors **VOTERS**

Community Organizers **AND LOVING PARENTS (& GRANDPARENTS)**

IRAA men are committed to creating peace in our DC community. They feel obligated to **GIVE BACK**. For much of their incarceration they have wanted to change whatever was possible because they knew they could never fix their shameful actions which brought them to prison. They are deeply remorseful. They pray for their victims and surviving family members' well-being. With few exceptions, those released under IRAA are **FLOURISHING**. **They have a lot to teach us.**

NO ONE SHOULD DOUBT THAT THEY ARE STRENGTHNING OUR COMMUNITY.

Good afternoon,

For 40 years I worked for the PDS of D.C., the 1st 20 years as a line staff forensic social worker. The 2nd 20 years I lead the O-R-D for PDS often described as the "social work division." ORD is the 1st social work component of a public defenders' office in the country and has been in existence for 52 years. Five years ago, I started a therapeutic support group for men and women returning home after serving at least 15 years. Most who attend the weekly group had been confined between 28 – 46 years. Last May I retired from PDS but not my volunteer work with the support group "15-30-Life." My name is Betsy Biben.

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VOTERS

AND LOVING PARENTS (& GRANDPARENTS)

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NO ONE SHOULD DOUBT THAT THEY ARE STRENGTHNING OUR COMMUNITY.

Testimony on Mayor's New Legislation by Brenda Lee Richardson, Police Service Area 702 | June 27, 2023

Safer Stronger Amendment Act of 2023

Good Day Chairman Pinto and other distinguished Councilmembers. My name is Brenda Lee Richardson. I am a Ward 8 resident and member of PSA 702 Outreach Committee. PSA 702 is gravely concerned about the alarming increase in crime and gun violence. If the city can work towards a zero-carbon footprint by 2035, then surely, we can strive for a zero tolerance of gun violence by 2025. In the past there seemed to be an unspoken tolerance for gun violence in Ward 8 from the community's perspective, however it is starting to spill over into favored communities and now we experience this sense of great urgency.

The criminal justice system must take some responsibility for this growing threat that continues to descend on Ward 8. Criminals need to be detained for as long as it takes for them to get the message ~ "NOT IN DC!" As the criminal justice system stands now it seems to handcuff MPD.

The proliferation of illegal guns in Ward 8 is astonishing and to find that these weapons are now in the hands of our misguided teenagers is a testament to the gravity of this plague. The miscreants who engage in illicit activity have not only occupied our disfavored neighborhoods but have become masters at hustling the police, the DC Government and the court system. More importantly, it seems that our innocent children continue to be disposable human capital at the hand of gun violence and sexual violence. I was appalled to learn from the DC Sentencing Commission Fast Facts that 59% of sex offenses in the District involved sexual abuse of a minor. The District of Columbia is sending the wrong message when 97% of all felony cases sentenced in 2022 were resolved via a plea agreement. So, does this mean a trial is an inconvenience for the court system because it costs too much money, but sending criminals back into traumatized communities to commit more crime is acceptable? Furthermore, in 2022, according to the DC Sentencing Commission, carrying a pistol without a license and unlawful possession of a firearm prior felony constituted 83% of counts sentenced in the weapon offense category. Assault with a dangerous weapon and robbery represented 70% of counts sentenced in the violent offense category. Law abiding citizens in our nation's capital in Ward 8 deserve the right to live safely, be protected and served with dignity rather than being exposed to gun violence and the terrorism it imposes on an already wounded and disfavored police service area. Thank you for allowing me to support parts of this critical legislation.

Statement of Brian L. Schwalb
Attorney General for the District of Columbia

Before Councilmember Brooke Pinto, Chairwoman
Committee on the Judiciary and Public Safety

Public Hearing on B25-291, the Safer Stronger Amendment Act of 2023
Tuesday, June 27, 2023, at 12:00 PM

Introduction

Chairwoman Pinto, Councilmembers, and residents of the District of Columbia. Thank you for the opportunity to testify about the proposed Safer Stronger Amendment Act of 2023.

For the last 20 months—during my campaign and transition, and since being sworn in as DC Attorney General in January—I have been meeting with and listening to DC residents in every ward and neighborhood of our City. From these conversations, one thing is abundantly clear: people are very worried about crime and, in particular, gun violence. They are justifiably asking their elected leaders what we are doing to protect them, their families, their businesses and their communities. They are not interested in finger pointing or political posturing. They want us to work together to address crime with the same sense of urgency they are feeling.

My views on this bill are informed by those conversations. I share the urgent desire to improve public safety, but in my view, this bill will do little to accomplish that goal. To be sure, there are a handful of helpful provisions that close existing loopholes but, overall, the legislation defaults back to tried-and-failed policies that will not make us safer. When it comes to juvenile justice, this bill will result in locking up more kids pre-trial even though there is no good data to suggest that kids who are released pre-trial are committing violent or serious offenses, and even though there is decades of research indicating that incarcerating children leads to *increased* crime rates. If we are serious about improving public safety, we must focus our resources and attention on programs that address and disrupt the underlying causes of crime. Unfortunately, on that critical front, the proposed legislation is silent.

Before addressing some specifics in the bill, I want to discuss what my office is doing to address crime, and how we think about the pressing issues at hand. At the Office of Attorney General for the District of Columbia (OAG), there is no higher priority than promoting public safety. When people don't feel safe walking to school, shopping for groceries, pumping gas or riding on the Metro, we can't get to the other hard and necessary work of creating a more prosperous, thriving, inclusive Washington, DC where the abundant resources, opportunities, and potential of our great City are shared equitably and by everyone. Given the bifurcated nature of our criminal justice system under the Home Rule Act and our lack of Statehood, OAG has authority to prosecute only a small segment of crime in the District—juvenile crime and some adult misdemeanors. But OAG is the only prosecution office in the District headed by an elected official accountable directly to District voters. For that reason, we have a unique perspective on criminal justice issues, as well as a unique responsibility to think critically about improving public safety for everyone who lives in, works in and visits the District. From that unique vantage point, OAG has been able to identify gaps in the District's public safety ecosystem and develop innovative, evidence-based solutions to address those gaps, including violence interruption, truancy prevention, restorative justice, and other similar programs.

Another way OAG tries to address gaps is by proposing new legislation when we have determined that existing laws require amendment or supplementation. As you know, we have worked regularly with the Council to improve laws that protect DC residents, consumers, seniors, tenants, workers, and the environment. We appreciate that the proposed legislation is being offered to address residents' very real fears about crime. At the same time, we know DC residents want and expect

their leaders to identify what is causing the crime problem and to develop *effective* strategies that will result in real solutions. It is incumbent upon this Committee and the Council to identify and accurately diagnose the problem, determine whether the proposed legislation will *effectively* address that problem, and ensure that the proposed solutions do not cause avoidable collateral damage. In engaging in that careful analysis, data, evidence, and history should be our guides.

There are some provisions of the proposed legislation that appropriately strengthen existing law. For example, several provisions strengthen our gun laws by more specifically addressing machine guns and ghost guns, and strengthen domestic violence laws by making strangulation a felony assault and by requiring the earlier collection of DNA evidence in sexual assault cases for uploading to CODIS. Other provisions will helpfully close loopholes, by, for example, extending existing protections for taxi drivers to also cover ride share drivers, broadening protections for Metro station managers to also cover line employees, and requiring contractors and volunteers who work in schools to abide by the laws pertaining to sexual abuse of children by someone in a position of trust. Because we believe, on balance, these provisions may help improve public safety in DC, OAG encourages the Council to pass those specific provisions into law.

Several provisions of this proposed legislation, however, are problematic. They default back to the flawed assumption that easier and lengthier incarceration—both pretrial and after adjudication—will improve public safety. In doing so, the provisions fail to heed the painful lessons our history teaches: that unnecessary or unnecessarily lengthy incarceration does not make us safer. Instead, it undermines public safety, devastates people and communities, and exacerbates racial inequality. Perhaps most critically, none of the proposed provisions address the underlying issues that are driving the increase in crime.

Given OAG's role as the chief juvenile justice prosecutor, I will focus most of my comments on why the Council should not adopt the proposed changes to the statute governing juvenile pre-trial detention. I will then very briefly address the proposed changes to the Second Look Amendment Act.

Juvenile Pre-Trial Detention

The proposed changes to the juvenile detention statute presume that the recent uptick in juvenile crime is caused by not detaining enough children pre-adjudication. That is not the case. OAG prosecutors are prosecuting juvenile delinquency cases every day, including gun cases, carjackings, armed robberies, assaults with deadly weapons and homicides. We do not divert these serious cases, and we recognize that pre-trial detention in these cases is often necessary to protect public safety. When that is the case, our prosecutors move the Superior Court to securely detain the child pre-trial. And, under the existing statute, the judge must detain the child if she determines the child presents a danger to the community. Under the existing statute, the judge must presume there is a threat to public safety if the child is accused of certain serious and violent crimes. OAG prosecutors are applying the existing legal standard every day, and our informed view is that the current detention statute does not need to be fixed or changed.

What is very concerning about the current situation is that we younger and younger children are being arrested for the first time for very serious offenses. We must tackle that phenomenon head on. Changing the juvenile pretrial detention statute will not have any impact on addressing these

very young first-time offenders. Again, we are not experiencing widespread difficulty securing pretrial detention for these first-time offenders under the current statutory scheme.

Importantly, the District's juvenile pretrial detention statute was amended just six years ago. At that time, the Council carefully considered and passed amendments allowing for tailored decision making based on the specific facts of the case and the specific circumstances of the child. The 2017 amendments thoughtfully balanced the need to protect public safety and the very real costs—to the child and to public safety—of placing children in secured detention, particularly before they have been adjudicated. The 2017 legislation recognized the practical, legal, and constitutional problems created by over-crowding in DC's juvenile detention facilities.

Against this relatively recent legislative backdrop, the proposed legislation, without any careful analysis or evidentiary support, will result in more children being locked up pre-trial, even where they pose no threat to public safety. It does so by allowing judges to detain children for their own safety and by significantly expanding the crimes that create a presumption that a child must be detained. I urge the Council to reject this approach.

First, morally and constitutionally, locking up children for their own safety is wrong. In the United States, we do not incarcerate people—and certainly not children—because they might be in danger of becoming a victim of a crime. Our job is to protect them from harm, not punish them because they might be harmed. Locking up children does not protect them; to the contrary, detention places their safety and well-being at risk. Incarcerating a lower-risk child with those who do present a public safety risk increases the risk that child will engage in more serious crime. The decision to separate a child from their family, from their school, and from their normal lives carries serious negative consequences. Accordingly, that separation should only happen when there is a legitimate and significant risk to public safety.

Second, we cannot ignore the long and dark chapter of our City's history that only recently closed with the settlement of the *Jerry M* consent decree. For over 35 years, the District was under a consent decree arising out of the deplorable, unsafe conditions in its secure juvenile detention facilities. One of the lessons of that consent decree is that pre-trial detention works best when the population is small and manageable. Otherwise, conditions deteriorate, placing children and staff at significant risk of harm.

The proposed changes to the statute risk recreating the same conditions that prompted the *Jerry M* consent decree. Prior to 2017, when the juvenile detention statute allowed for the detention of children for their own safety, the Youth Services Center (YSC) was consistently over-capacity. Once the Council changed the statute to remove that provision, the population at YSC significantly decreased, helping to improve conditions. In connection with the 2020 termination of the *Jerry M* consent decree, the Executive Office of the Mayor established an independent office to monitor DYRS' secure facilities to ensure that the progress made during implementation of the consent decree would be sustained. Importantly, the Executive Director of that independent office, the Office of Independent Juvenile Justice Facilities, recently warned in testimony before the Council:

"If the population of [YSC] were to increase significantly with the current workforce, it would place extreme pressure on the agency's ability to operate the facilities safely."[1]

Third, it is well-established that incarcerating children rarely reduces crime and, in fact, can do the opposite. For decades, researchers have studied this issue. Study after study has shown that detention increases recidivism.[2] Incarcerating young people drives them deeper into crime, reduces the chances they will reenroll in or finish school, removes them from protective factors, and harms their physical and mental health.[3] Youth who are incarcerated have higher rates of re-arrest compared with youth who are placed on probation or given other community alternatives to confinement.[4] And because Black children are much more likely to become involved in the criminal justice system, increasing the incarceration of youth exacerbates racial inequality. Finally, incarcerating youth is not an effective deterrent: data show that declines in youth incarceration do not result in increases in youth crime.[5]

These national studies have been confirmed locally. In 2017, the Council tasked the Criminal Justice Coordinating Council (CJCC) with studying the causes of youth crime in the District. In its report, issued in 2020, the CJCC said: "While the juvenile justice system is intended to rehabilitate children, involvement in the system, particularly secure detention, is well-established to have lasting negative effects on youth, such as increased risk of adult incarceration, decreased likelihood of high school graduation and success in the labor market, and worsening of mental health disorders."[6]

The proposed changes to the juvenile pre-trial detention statute fail to balance the known and serious harms caused by increased juvenile detention against the speculative, unidentified benefit of locking up more youth pre-trial. The proposed changes appear intended to respond to what is sometimes misleadingly and disparagingly referred to as a "revolving door of juvenile justice," a colorful phrase for when children are released after being arrested by the police. The legal standard a police officer must meet before arresting someone is probable cause—meaning the police officer must have a reasonable belief that the person being arrested committed a crime. The probable cause standard for making an arrest is considerably lower than proof beyond a reasonable doubt—the standard prosecutors must meet to charge and prove criminal guilt. In OAG's experience, when

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[1] Testimony Of Mark Jordan, Executive Director, Office of Independent Juvenile Justice Facilities Oversight, Department Of Youth Rehabilitation Services Performance Oversight Hearing before the Committee On Recreation, Libraries & Youth Affairs, February 13, 2023.

[2] *See, e.g.,* Why Youth Incarceration Fails: An Updated Review of the Evidence, Richard Mendel, The Sentencing Project, March 1, 2023, available at https://www.sentencingproject.org/reports/why-youth-incarceration-fails-an-updated-review-of-the-evidence; The Dangers of Detention: The Impact of Incarcerating Youth in Detention and Other Secure Facilities, A Justice Policy Institute Report By Barry Holman and Jason Ziedenberg, November 28, 2006, available at https://justicepolicy.org/wp-content/uploads/justicepolicy/documents/dangers_of_detention.pdf

[3] Id.

[4] Id.

[5] Id.

[6] Criminal Justice Coordinating Council, "A Study of the Root Causes of Juvenile Justice System Involvement Report," Prepared by Kaitlyn Sill, PhD, Statistician November 2020, available at https://cjcc.dc.gov/sites/default/files/dc/sites/cjcc/CJCC%20Root%20Cause%20Analysis%20Report_Compressed.pdf

young people who have been arrested for serious crimes are subsequently released, it is usually not because the existing statutory standard for pre-trial detention cannot be met. Rather, it is because there is not enough evidence to prosecute, so the charges are dropped, or "no papered," unless and until enough evidence is obtained to prove them. I want to emphasize, under my leadership, OAG prosecutes all serious, violent cases—including all carjacking and gun cases—when we have enough, constitutionally acquired, admissible evidence to prove the case beyond a reasonable doubt. If there is not enough evidence to prove the case, we don't prosecute the case and the child is released. That's precisely what prosecutors with integrity working in a constitutional system must do. The alternative—locking up people for crimes where there is not enough evidence to prove them—is antithetical to the fundamental principles of our constitutional system. We do a disservice to our constitutional system by denigrating that reality as "revolving door" justice.

After a crime has occurred, we work closely with the Metropolitan Police Department (MPD) to ensure we build strong cases. In addition to collaborating with MPD detectives to marshal evidence after a child has been arrested and booked, we have established a 24-hour hotline that MPD officers can call in real time from the scene of a crime or arrest to speak to a prosecutor to make sure all necessary evidence is lawfully collected. We also have established a multi-jurisdictional task force to facilitate effective prosecution of cases that cross jurisdictional borders, and we are working to include more jurisdictions in that task force. OAG leadership meets regularly with MPD, as well as with the U.S. Attorneys Office, to discuss how our respective agencies are working together to successfully investigate and prosecute serious crimes and to identify and resolve any impediments to effective investigations and prosecutions.

But investigation and prosecution, by definition, occurs after a crime has already happened. If we want to make DC safer, we need to prevent crime *before* it happens, and to do that, we have to address root causes. The CJCC has already developed a roadmap to do just that. It conducted a rigorous analysis to identify the drivers of youth crime in the District and recommended concrete solutions to address them.[7] The CJCC report makes the following clear: to effectively reduce youth crime, we must invest in programs that address the underlying causes of crime. There are several ways the District could do this in the short term. First, we should establish a process that works across agencies to identify and intervene with at-risk youth and, where appropriate, their families, before they commit a crime, are arrested or become system involved. Agencies with information and expertise—DCPS, CFSA, DHS, DBH, and DYRS—should convene to identify the child's needs and provide community based, supportive, wraparound services to the child and their family. Second, we need to ensure children have access to high quality services to address their trauma and mental health needs—needs that were compounded during the pandemic. We can do this by, among other things, funding sufficient counselors in schools, and by creating a high-quality residential psychiatric treatment facility in the District. Third, recognizing that the drivers of youth violence are frequently different than those of adult violence, we should invest in violence interruption programs specifically tailored to youth.

[7] Id.

Changes to the Incarceration Reduction Amendment Act

I will turn now briefly to the proposed changes to the Incarceration Reduction Amendment Act, the law that currently allows judges to modify the sentences of people who were sentenced for crimes they committed when they were young and who have served at least 15 years in prison, but only when the judge finds that the person is not a danger and that the interests of justice warrant a sentence modification. The changes to IRAA in the proposed legislation will make it more difficult for DC residents who have served long prison sentences to avail themselves of the relief IRAA provides and to come home.

Since the law was passed in 2017, 155 DC residents have come home. The vast, vast majority—more than 93 percent—have not been charged with a crime and are contributing in important ways to our city. Many are working to convince young people not to make the mistakes they made. Some have served as mentors and credible messengers, working to reduce gun violence in their communities, including working on our Cure the Streets teams. The Office of Attorney General has benefitted from having returning citizens working as paralegals, investigators and clerks. When I speak to these men—some of whom testified today—I am struck by their genuine remorse, their resilience, and all the human potential that was locked away for years with them. The provisions in this proposed bill will make it less likely that those who have served long sentences for crimes they committed when they were young, who no longer pose a danger and who have something valuable to give back to our community, will be able to come home and make a positive contribution to the District. Keeping them locked up in the Federal Bureau of Prisons, often thousands of miles away from their families and friends, will not make us safer or stronger.

Conclusion

At OAG, we are keenly aware that violent crime is on the rise in the District, a trend sadly mirrored in communities across the country. We talk with victims of crime everyday and the pain and trauma that violent crime visits on their lives informs our work day-in and day-out. While the draft legislation contains some helpful proposals, its overemphasis on incarceration—pretrial detention, longer sentences and diminished IRAA relief—is not going to make DC safer or stronger.

I and the nearly 700 professionals working at OAG are committed to working with the Council, the Mayor and the executive agencies, with our federal and state law enforcement partners, and with the community to develop a comprehensive and proactive plan that addresses the actual drivers of crime. We must come together to focus on issues like ramping up access to mental health services in our schools, addressing barriers to school attendance, developing violence interruption programs specifically focused on youth, and addressing risk factors like housing instability and access to economic opportunities for children at risk of involvement in the criminal justice system.

Under my leadership, OAG will not give up on kids or on doing all that we can to ensure that all DC kids, no matter where they live or where they go to school, grow up healthy, hopeful and on the path to discover, pursue and realize their dreams. Hopeful children are safer children—to themselves and those around them. By committing ourselves to positive youth development and proactive investments to keep children and their families away from the criminal justice system, and by resisting the temptation to double down on failed carceral responses, we can together ensure a safer and stronger Washington, DC.

TESTIMONY OF JONATHAN GREENE, MANAGER OF PUBLIC REALM OPERATIONS
CAPITOL RIVERFRONT BID

COUNCIL OF THE DISTRICT OF COLUMBIA
COMMITTEE ON THE JUDICIARY AND PUBLIC SAFETY

THE SAFER STRONGER AMENDMENT ACT OF 2023

June 27, 2023

Good morning, Chair Pinto, members of the Committee, and staff to the Committee. My name is Jonathan Greene, and I am the Manager of Public Realm Operations for the Capitol Riverfront Business Improvement District (BID).

I am testifying today on behalf of our Capitol Riverfront community – our BID board of directors, our neighborhood businesses and employees, and visitors to Capitol Riverfront – in support of **The Safer Stronger Amendment Act of 2023**. We remain concerned with the levels of violent crimes in our neighborhood, and across the District of Columbia, including:

- Fatal and non-fatal shootings;
- Assaults, often armed and often in broad daylight;

- Robberies, including a series of which have targeted construction workers who are working on projects to build up our neighborhoods;
- And a disturbing and sustained increase in carjackings.

It is our understanding that many of the crimes have been committed by juveniles or repeat offenders, and that too frequently these individuals are released fairly quickly back into the communities of the District pending trial. More needs to be done to protect the public from these perpetrators of crime and we believe **The Safer Stronger Amendment Act of 2023** begins to address these gaps in our enforcement and legal systems.

As a neighborhood with a high density of both residential and commercial uses, sustained increases in crime can impact Capitol Riverfront on many levels, often with a cascading effect:

- The perception of safety is diminished, and residents feel unsafe doing simple tasks such as walking in the neighborhood or going to the grocery store.
- That change in perception can impact visitor attendance at sporting events, restaurants, music venues, and outdoor activations in our neighborhoods.

- An unsafe neighborhood can lead to declining residential leasing and ownership, ultimately leading to a devaluation of residential buildings, leading to a loss of tax revenues.
- A lowered perception of safety may even delay a return to the workplace by employees in this submarket or cause future office tenants to go to other markets.

Due to the series of violent crimes in Capitol Riverfront this past fall, the BID has sought additional means to partner with MPD District 1 (PSAs 105 and 106). We have received excellent support from Commander Tasha Bryant, Captain Kevin Harding, Lieutenant Kenneth Taylor, and Sergeant Anthony Walsh as we discuss possible ways to reduce future incidents of violent crime.

As a result of these discussions the BID, MPD, and our stakeholders are implementing several programs to assist in crime prevention, the investigations of crimes, and the apprehension of criminals. These include:

- Utilizing Reimbursable Detail Officers along the Half Street, SE, and N Street, SE public realm of the ballpark district of our neighborhood.
- Strengthening communications among the BID, private security companies, and MPD.
- Working with MPD to keep the community informed on crime events, statistics, and possible solutions through PSA 105/106 meetings.

- Encouraging property owners to install more security cameras on their buildings that can assist in the identification of criminals and their arrests.

But more must be done in the criminal justice system. These strategies will not be as effective if we do not have stronger laws regarding the arrest, prosecution, and legal detention of apprehended criminals before trial. Stronger penalties for the illegal possession of firearms and for violent crimes committed will send a message that the DC Government and MPD are serious about public safety and the prosecution of criminals.

Safety and security for a city's residents are foundational responsibilities of local governments. We strongly urge the Council to adopt and enact recommendations contained in **The Safer Stronger Amendment Act of 2023** as put forth by Mayor Bowser.

Thank you for the opportunity to testify. I would be happy to answer any questions you may have.

D.C. Criminal Code Reform Commission

Testimony on the "Female Genital Mutilation Prohibition Act of 2023"

COMMITTEE ON THE JUDICARY & PUBLIC SAFETY HEARING
June 27, 2023

DISTRICT OF COLUMBIA CRIMINAL CODE REFORM COMMISSION
441 FOURTH STREET, NW SUITE 1C001 SOUTH
WASHINGTON, DC 20001
PHONE: (202) 442-8715

Introduction

Thank you for the opportunity to provide testimony to the Committee on the Judiciary and Public Safety for the record of the public hearing on the "Female Genital Mutilation Prohibition Act of 2023", held on June 27, 2023. My name is Jinwoo Park and I am the Executive Director of the District's Criminal Code Reform Commission (CCRC). I am presenting testimony today on behalf of the CCRC. The CCRC is a small, independent District agency focused on developing recommendations to reform the criminal statues in the District.

The CCRC takes no position at present on the substantive merits of whether to create a separate offense to specifically address Female Genital Mutilation (FGM) or cutting of persons under care as proposed in the "Female Genital Mutilation Prohibition Act of 2023.". Instead, this testimony analyzes potential ambiguities and questions related to the language of the proposed bill and offers some possible solutions. The CCRC has not fully researched comparable laws in other jurisdictions or explored all constitutional questions related to the bills at this time.[1]

Protections Under Current and Federal Law

The proposed FGM bill seeks to establish criminal liability for female genital mutilation of children involving "persons under care" which, under the bill's current language, includes adults under a guardianship or conservatorships. Although the CCRC found no examples of prosecutions for FGM-type conduct in District case law, the practice of non-consensual FGM on persons under the age of 18[2] and adults under care is likely punishable under District statutes guarding against bodily injury such as the assault, aggravated assault, or cruelty to children.[3] The maximum penalty ranges for those offenses range from 180

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[1] The CCRC gave testimony on a prior version of this bill in 2022. A copy of the prior testimony can be found at: https://ccrc.dc.gov/node/1587676

[2] While parents have a large degree of discretion in decision regarding their children, it is well-established that a State may exercise "constitutional control over parental discretion in dealing with children when their physical or mental health is jeopardized." *Parham v. J. R.,* 442 U.S. 584, 603 (1979); s*ee also New York v. Ferber*, 458 U.S. 747, 756-57 (1982) ("It is evident beyond the need for elaboration that a State's interest in 'safeguarding the physical and psychological well-being of a minor' is 'compelling.'"); *Prince v. Massachusetts*, 321 U.S. 158, 170 (1944) ("Parents may be free to become martyrs themselves. But it does not follow they are free, in identical circumstances, to make martyrs of their children before they have reached the age of full and legal discretion when they can make that choice for themselves."). The DCCA has also held that the District cruelty to children statute, which criminalizes engaging in conduct that causes or creates a grave risk of bodily injury to a child, does not require malice (acting out of a desire to inflict pain rather than out of genuine effort to correct or care for the child). *Jones v. United States*, 813 A.2d 220, 224 (D.C. 2002).

[3] *See* D.C. Code § 22-404 (assault statute punishing common law assault); D.C. Code § 22-404.01 (aggravated assault statute punishing knowingly or purposely causing "serious bodily injury" to another person); D.C. Code § 22-1101 (cruelty to children statute punishing conduct that creates a grave risk of bodily injury to a child irrespective of malice). A prior version of the federal FGM statue was also struck down in part because the court found that the prohibited practice was a criminal assault and there are at least a few examples of assault statutes being used to criminalize FGM in other states. *See United States v. Nagarwala*, 350 F. Supp. 3d 613, 628 (E.D. Mich. 2018) (striking down a prior version of federal law criminalizing FGM on the grounds that "as despicable as [FGM] may be, it is essentially a criminal assault" prosecutable only by local jurisdictions absent a nexus to Congressional power); *id*. (also stating: "The comparison of FGM to healthcare is unsuitable. FGM is a form of physical assault, not anything approaching a healthcare service.");*Adem v. State*, 300 Ga. App. 708, 708, 686 S.E.2d 339, 340 (Ga. 2009) (affirming convictions of father for first degree cruelty to children and aggravated battery for removing his daughter's clitoris); *Byrd v. State*, 251 Ga. App. 83, 84, 553 S.E.2d 380, 382 (Ga. 2001) (holding severing a portion of the victim's clitoris constituted evidence from which a jury could find serious disfigurement).

days to 15 years in prison depending on the level of bodily injury and whether the actor is charged under an assault statute or the cruelty to children statute.[4] In addition, there is a female genital mutilation offense in federal law applicable to conduct where the jurisdictional nexus is satisfied.[5] The penalty under federal law is 10 years.

Bill Does Not Apply to Children

Based on the tolling provision under subsection (e) it appears the intent of the bill is to cover protect children and persons under guardianship. However, the bill as written would *not apply to children*. Rather, the FGM bill proposed here would establish an additional, new offense applicable only to actors: (1) who knowingly perform FGM on "a person under care"; (2) who, as guardians, knowingly consent to, permit, or otherwise facilitate FGM on a "person under care"; or (3) who knowingly remove or facilitate the removal of a "person under care" for the purpose of facilitating FGM. The term "person under care" is defined as an "individual under a conservatorship or guardianship." The bill defines the terms "conservatorship" and "guardianship" by cross referencing Title 21, but Title 21's definitions *only apply to adults*.[6] Under the cross-referenced definitions, a minor cannot qualify as a "person under care."

If the Committee intends for the bill to cover cases in which the victim is a minor, the statute could be re-written to separately include children under the definition of "persons under care."

With respect to cases involving guardians or conservators, it should be noted that current District law explicitly limits the authority of court appointed guardians to consent to certain procedures absent court approval including to the "removal of a bodily organ" (e.g., the clitoris).[7] Neither the current D.C. Code nor District case law expressly address if and when a person charged with an offense may defend against criminal charges on the grounds that they were acting lawfully as a court appointed guardian. Thus, beyond criminalizing performing, facilitating, or consenting to the performance of FGM on a person under care, this bill would clarify when a guardian could lawfully authorize or facilitate FGM on a person under care and would clearly establish that guardianship or the effective consent of a guardian is not a defense to FGM. However, a person acting without court approval in providing consent for certain procedures would clearly be acting beyond their authority under current law.

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[4] The recommendations in the Revised Criminal Code would have similarly criminalized the practice of non-consensual forms of FGM under the RCCA's assault, criminal abuse of a minor, criminal neglect of a minor, criminal abuse of a vulnerable adult or elderly person, and criminal neglect of a vulnerable adult or elderly person statutes. The maximum penalties for conduct constituting FGM under the RCCA ranged from 1 year to 12 years, again depending on the statute, age of the victim, and level of injury. *See* RCCA § 22A-1202 (assault); RCCA §§ 22A-1501, 1504 (Abuse and Neglect of Vulnerable persons). Although the RCCA penalties appear to be somewhat lower than those in the current D.C. Code, this difference may have reflected the different way the RCCA and the current D.C. Code calculate "back up time". The RCCA penalties did not include the additional years of back up time, while the current D.C. Code penalties do include backup time. (Compare RCCA § 205(b) with D.C. Code § 24–403.01(b-1).) Functionally, the 12 year statutory maximum under the RCCA (with an additional 3 years backup time) was equivalent to a current 15 year statutory maximum under the D.C. Code (from which the 3 years backup time must be subtracted to determine the maximum a judge may impose at sentencing).

[5] 18 U.S.C. § 116. Prosecutorial authority for both the proposed offense and the federal offense rests with the Office of the United States Attorney for the District of Columbia.

[6] D.C. Code § 21-2401.02. ("'Conservator'" means a person appointed by the court to administer the property of *an adult*, including a person appointed under §§ 21-2001 to 21-2077." "'Guardian'" means a person appointed by the court to make decisions regarding the person of *an adult*, including a person appointed under §§ 21-2001 to 21-2077) (emphasis added).

[7] *See e.g.*, D.C. Code § 21-2047.01 (a)(1).

Notably, while current statutes and case law do not discuss guardianship in relation to assaultive conduct such as FGM, the RCCA proposed a new Special Responsibility for Care, Discipline, and Safety Defense, that clarifies when a parent or guardian may use parenthood or guardianship as a defense to any offense committed against a person or any property offense.[8] Pursuant to the proposed statute, a guardian defense would *not* be available if the conduct exceeds the authority of the actor's guardianship over a complainant, *as determined under civil law*. Consequently, under the RCCA proposal, a guardian could not defend against an assault, an abuse of a vulnerable adult charge, or a neglect of a vulnerable adult charge based on FGM on the grounds that they had guardianship over the person unless their conduct was otherwise authorized by civil law. Further, the RCCA's guardian defense is not available unless: (1) the conduct is done with the intent to safeguard or promote the welfare of the complainant; (2) the conduct is reasonable under all the circumstances; *and* (3) the conduct either does not create as substantial risk or, or cause death or serious bodily injury or is the performance or authorization of a lawful cosmetic or medical procedure.[9] These provisions would preclude a court appointed guardian from using guardianship as a defense to authorizing or performing FGM on a person under care under the circumstances this bill seeks to criminalize. A combination of assault offenses and limitations to any applicable defenses could adequately criminalize FGM and related conduct.

Specific Considerations Regarding Bill Language

The Bill May Improperly Infringe on Bodily Autonomy of Persons Under Care

The proposed bill may not adequately protect the First Amendment and Due Process rights of an adult person under care. Insofar as it provides an exception for persons under care who request a sex reassignment procedure, the proposed bill recognizes that persons deemed incapacitated under guardianship statutes have and retain substantive and procedural due process rights with respect to bodily autonomy even when placed under guardianship. District law also generally presumes that persons under a guardianship are capable of making health-care decisions absent an additional certification of incapacity.[10]

The bill may improperly criminalize an array of elective cosmetic and medical procedures. The bill permits acts constituting FGM in instances that would protect the physical health of the person under care, including sex reassignment procedures. However, because the bill defines "FGM" broadly to include "pricking" and "piercing" this would exclude a number of cosmetic procedures. For example, consensual genital piercing would constitute a crime under this bill, as piercings do not protect physical health.[11] The bill makes exceptions for certain types of medical procedures that are "*necessary* to preserve or protect the physical health of the patient[.]". Under the text of this statute, an *elective* cosmetic procedure, even when

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[8] *See* RCCA § 22A-408. Special Responsibility for Care, Discipline, or Safety Defenses.

[9] If it is unclear whether various types of FGM procedures constitute a "lawful cosmetic or medical procedure" the Special Responsibility for Care, Discipline, and Safety Defense, or commentary accompanying the statute, could be re-drafted to clarify that certain FGM procedures are *not* lawful.

[10] *See* D.C. Code § 21-2203. Presumption of capacity. ("An individual shall be presumed capable of making health-care decisions unless certified otherwise under § 21-2204. Mental incapacity to make a health-care decision shall not be inferred from the fact that an individual: [] (3) Has a conservator or guardian appointed pursuant to § 21-1501 et seq. or § 21-2001 et seq.").

[11] Notably, clitoral hood piercing for non-medical and non-religious purposes is not uncommon but falls within the definition of FGM in the FGM bill. Categorical prohibition and criminalization of such a piercing of a person under care, without any due process protections, may implicate the due process right to privacy in addition to the First Amendment's guarantee of freedom of religion. Similarly, a prohibition related to acts labeled FGM but not practices such as penile circumcision for non-medical reasons may constitute grounds for an equal protection challenge.

performed by a licensed medical professional, could constitute FGM. For example, if person has a deformity of their genitalia that does not cause any adverse health effects, a cosmetic procedure is not necessary to protect the patient's health, and would constitute a crime under this bill.

To address these concerns and still accomplish the bill's purpose of prohibiting a guardian from imposing FGM on a person under care who may be incapable of meaningful consent, the Council may wish to consider revising the civil laws related to the powers and limitations of guardians in Title 21 of the District Code.[12] By clarifying guardian authority with respect to FGM in the statutes addressing guardianship and providing persons under care an opportunity to be heard by a court, the Council would also be clarifying the applicability of a guardian-type defense to the assault and other relevant statutes absent passage of a defense such as the former RCCA's Special Responsibility for Care, Discipline, or Safety Defense statute while protecting the rights of persons under care. Additionally, the Council may consider broadening the exceptions contained in paragraph (d) of the FGM bill text to include procedural protections such as allowing a person under care to petition a court for permission to undergo an elective procedure.

The proposed bill may unconstitutionally prohibit interstate travel or unintentionally support interjurisdictional abortion restrictions.

In addition to criminalizing FGM within the District, the proposed bill criminalizes knowingly removing or facilitating the removal of a person under care from the District for the purpose of facilitating female genital mutilation of the person under care. The bill does not define the term "remove" and it is not clear what the scope of covered conduct is under this provision. Prohibitions that restrict travel to another state may raise constitutional issues given that at least some of the conduct falling under the definition of FGM in the proposed bill could be lawful in other jurisdictions. For example, the District prohibits body piercing of persons under the age 18 with the exception of ear piercing. Another state may permit a minor to obtain a genital piercing with or without parental consent. Under the proposed bill, "removing" or "facilitating the removal" of the minor from the District for the purpose of allowing them to get a piercing lawful under the laws of another state would be a 10 year felony under the proposed bill. This could implicate the constitutional right to interstate travel. Although the District has an interest in the health and welfare of its citizens, the Supreme Court has said "a State does not acquire power or supervision over the internal affairs of another State merely because the welfare and health of its own citizens may be affected when they travel to that State."[13]

It is unclear whether or to what degree, a jurisdiction can criminalize conduct or attempted conduct in another jurisdiction when that conduct is *legal in that jurisdiction*. For example, Justice Breyer noted in his dissenting opinion in *Dobbs v. Jackson Women's Health Org.*[14], which struck down *Roe v. Wade*, that *Dobbs* would create significant questions about interstate conflicts. He wrote:

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[12] *E.g.*, D.C. Code § 21-2047.01 places other limitations on guardians such as limiting the power "to consent to an abortion, sterilization, psycho-surgery, *or removal of a bodily organ* except to preserve the life or prevent the immediate serious impairment of the physical health of the incapacitated individual, unless the power to consent is expressly set forth in the order of appointment or after subsequent hearing and order of the court." D.C. Code § 21-2047.01(a)(1). Although this provision already limits the power of a guardian to consent to some of the conduct under the bill's definition of FGM, the Council could amend this statute to include further limitations on the power of a guardian, specifically with respect to conduct falling under the definition of FGM.

[13] *Bigelow v. Virginia*, 421 U.S. 809, 824 (1975).

[14] 142 S. Ct. 2228 (2022).

> "Can a State bar women from traveling to another State to obtain an abortion? Can a State prohibit advertising out-of-state abortions or helping women get to out-of-state providers? Can a State interfere with the mailing of drugs used for medication abortions? The Constitution protects travel and speech and interstate commerce, so today's ruling will give rise to a host of new constitutional questions."[15]

Although non-consensual FGM and abortion care are not comparable, the District's criminalization of the "removing or facilitating the removal" of a person under care from the District for the purpose of facilitating a procedure that may be deemed legal and consensual in another jurisdiction may unintentionally undermine the District's attempt to make the District a sanctuary for safe and legal abortions as well as gender-affirming care. By criminalizing removal or facilitation of removal of a person for FGM, the Council could unintentionally provide legal support for the attempts of other jurisdictions to criminalize abortion care, gender-affirming care, or other conduct performed legally in the District on residents of another state.

Additional textual considerations

First, the FGM bill uses unnecessarily gendered language in the introduction and text of the bill. The practice of FGM is not limited to women and girls as transgender men and boys as well as non-binary persons with vulvas could be subjected to the practice. For transgendered or non-binary victims subjected to mutilation of the vulva, referring to *female* genital mutilation in a prosecution of the persons responsible could be an additional indignity that compounds the trauma and/or discourages victims from coming forward. While it seems likely the purpose of using the term "female" rather than simply referring to "genitallia" is to exclude circumcision of the penis from the proscribed conduct, the Council could avoid labeling genitalia as female or male by substituting the term "vulva" or a list of the specific parts of the genitalia that the bill aims to protect, *i.e.*, the clitoris, the prepuce, the labia minor, labia majora, vaginal orifice, mons pubis, perineum, or any other part of the vulva.

Second, the rationale for inclusion of the term "conservator" appears unclear. Pursuant to D.C. Code § 21-2401.02(2), a "conservator" is "a person appointed by the court to administer the property of an adult, including a person appointed under §§ 21-2001 to 21-2077." Because a conservator has power over property and does not have power or duties over the person or health care decisions, it is not clear that a conservator could have legal custody or control of a "person under care" stemming from the conservatorship. Notably, the proposed language defines "conservator" but does not otherwise use the term "conservator" in the statute. The Council could delete the references to "conservator" as well as the term "person under care" and use the phrase "person under care of guardian" in the text of the statutes. Subsection (a)(1) could be amended to read: "Knowingly performs female genital mutilation on a *person under care of a guardian or under 18 years of age.*" Since "guardian" is also a defined term that carries the same meaning as provided in D.C. Official Code § 21-2401.02(3), this language would be sufficient to cover adults under court-ordered guardianship.

Third, the meaning and scope of "consents to, permits, or otherwise facilitates" is unclear, especially in light of the lack of nexus between the guardian and person under care. Although "consent"

[15] *Id.* at 2337.

and "otherwise facilitate" appear to require some affirmative action on the part of the guardian or parent, "permits" appears to punish a failure to block the actions of another without limitation. Additionally, as written, the text applies to a guardian who consents to, permits or otherwise facilitates female genital mutilation of a person under care but does not specify that the person under care be under the guardianship of that particular guardian. In other words, a parent or guardian of person X would seemingly be liable for consenting, permitting, or otherwise facilitating FGM of person Y even though their guardianship powers were irrelevant to person Y and their consent would carry no legal significance. To clarify the action required, the Council may consider striking the term "permit" and clarifying that person be under the care of the guardian who consents or otherwise facilitates the FGM of the person under care.

Fourth, the proposed statue may benefit from grading to distinguish different levels of harm. The proposed statute covers multiple types of conduct, all defined as FGM, which could result in drastically different levels of harm. For example, the removal of the clitoris would result in permanent disfigurement and bodily disfunction,[16] whereas a ritual pricking[17] could be extremely mild and not cause any lasting or serious bodily injury. Should FGM conduct be prosecuted as assault or cruelty to children, the potential punishment would vary depending on the severity of the conduct in order to provide a more proportionate penalty. For example, forms of FGM such as removal of the clitoris or labia that cause "serious bodily injury"[18] would fall under the aggravated assault statute and be punishable by up to 10 years imprisonment while conduct such as ritual pricking which did not cause "significant bodily injury"[19] or "serious bodily injury" would fall under the simple assault statute and be punishable by 180 days imprisonment. If the Council does not wish to rely on assault offenses to criminalize FGM, it may consider similarly grading this new offense based on the level of bodily injury rather than treating a ritual pricking the same as permanent removal of the bodily organ. Treating a person who knowingly engages in conduct designed to avoid serious bodily injury as less culpable than a person who knowingly causes serious bodily injury is consistent with the goal of ensuring proportionality in the criminal code.

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[16] The removal of the clitoris would constitute "serious bodily injury" and create liability under the current aggravated assault statute. *See* D.C. Code § 22-404.01. Similarly, the removal of the clitoris would constitute destroying, amputating, or permanently disabling a member or organ of a person's body and qualify as first degree assault in the RCCA. *See* RCCA § 22A-1202.

[17] *See* L. Amede Obiora, *Bridges and Barricades: Rethinking Polemics and Intransigence in the Campaign Against Female Circumcision,* 47 CASE W. RES. L. REV. 275, 288 (1997) (stating: "The ritualized marking of female genitalia begins with the mildest forms of the procedures, where the clitoris is barely nicked or pricked to shed a few drops of blood. This procedure is innocuous and has a strictly symbolic connotation."). Some scholars have also noted that permitting "symbolic nicking of the clitoral tissue . . . so that the children can be part of the tradition which practices FC without undergoing a full genital surgery" may be more effective in persuading persons to abandon the practice of FGM than criminal laws. Holly Maguigan, *Will Prosecutions for "Female Genital Mutilation" Stop the Practice in the U.S.?*, 8 TEMP. POL. & CIV. RTS. L. REV. 391, 408–09 (1999) (stating; "The countries which have achieved greatest success with education and outreach are those in which there has been a tradition of female genital surgeries and which do not criminalize all forms of female genital surgeries.").

[18] "Serious bodily injury" means an "injury that involves a substantial risk of death, unconsciousness, extreme physical pain, protracted and obvious disfigurement, or loss or impairment of a bodily member or function." *Jackson v. United States*, 970 A.2d 277, 279 (D.C. 2009).

[19] "Significant bodily injury" means an injury that requires hospitalization or immediate medical attention. D.C. Code. § 22-404(a)(2). Assaultive conduct that causes "significant bodily injury" is punishable as felony assault which is a 3-year felony. *Id.*

D.C. Criminal Code Reform Commission

Testimony on "The Stronger Safer Amendment Act of 2023"

COMMITTEE ON THE JUDICARY & PUBLIC SAFETY HEARING
June 27, 2023

DISTRICT OF COLUMBIA CRIMINAL CODE REFORM COMMISSION
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I. Introduction

Good afternoon, Councilmember Pinto, and thank you for allowing me to testify on behalf of the Criminal Code Reform Commission regarding B25-0291, the "Stronger Safer Amendment Act of 2023" ("the bill"). Please note that the CCRC is not providing testimony on all provisions of the bill, including those related to door camera incentives, changes to Sentencing Commission membership, changes related to the Criminal Justice Coordinating Council, DNA collection rules, or extradition for persons charged with misdemeanors.

II. Changes under Title II "Safe Schools and Safe Students."

A. Subtitle A. Changes to the Anti-Sexual Abuse Act of 1994

The bill proposes changes to two current D.C. Code sex offense statutes: 1) The definition of "significant relationship" in D.C. Code § 22-3001; and 2) The first degree sexual abuse of a secondary education student offense in D.C. Code § 22-3009.01. The definition and the offense both specify various individuals that are prohibited from engaging in otherwise consensual sexual activity, either with a minor over the age of 16 years,[1] or with a secondary education student under the age of 20 years.

The revisions ensure that the specified individuals include contractors, consultants, and volunteers are included within the scope of sex offenses relating to sexual acts with students. From a policy standpoint, the revisions have merit, and the RCCA made similar recommendations. However, the proposed drafting maintains ambiguities in the current statutory language as to the scope of the specified individuals. The CCRC will discuss each proposed revision separately, with an emphasis on clarifying scope.

The definition of "significant relationship"

Under current District law, a minor that is at least 16 years of age cannot consent to nonforceful sexual activity if the other person is: 1) At least 18 years of age; and 2) In a "significant relationship" with the minor.[2] Thus, the definition of "significant relationship" determines whether otherwise legal sexual activity is a criminal offense.

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[1] The term "significant relationship" is used in enhancement and misdemeanor sexual abuse of a child or minor; focusing on felony offenses

[2] These are two of the requirements for the current sexual abuse of a minor statutes. D.C. Code §§§ 22-3009.01; 22-3009.02. The third and final requirement is that the minor must be under 18 years of age. D.C. Code § 22-3001(5A) (defining "minor" for the current D.C. Code sexual abuse offenses as a "a person who has not yet attained the age of 18 years.").

Given the definition of "minor" as a person under 18 years of age, the sexual abuse of a minor offenses could theoretically apply to minors under the age of 16. However, the D.C. Code considers such a minor to be a "child" and has separate sexual abuse of a "child" offenses. D.C. Code §§ 22-3001(3) (defining a "child" as "a person who has not yet attained the age of 16 years."); 22-3008 and 22-3009 (first degree and second degree sexual abuse of a child offenses). Thus, in practice, the sexual abuse of a minor statutes will likely never be applied to minors under the age of 16 years.

The current definition of "significant relationship" is several subsections long.[3] The bill proposes replacing the phrase "Any employee or contractor" in current subsection (D) with the phrase "Any employee, contractor, consultant, or volunteer". However, the phrase "Any employee or contractor" doesn't appear in current subsection (D).

It is likely that the recommendation is intended to replace the phrase "Any employee or *volunteer*", which does appear in subsection (D). With this revision, the subsection would read:

> "Any employee*, contractor, consultant,* or volunteer of a school, church, synagogue, mosque, or other religious institution, or an educational, social, recreational, athletic, musical, charitable, or youth facility, organization, or program, including a teacher, coach, counselor, clergy, youth leader, chorus director, bus driver, administrator, or support staff, or any other person in a position of trust with or authority over a child or a minor."

As a policy matter, the Council may wish to clarify that subsection (D) of the definition of "significant relationship" includes contractors and consultants. The current statutory language is unclear on this point, and there is no case law.

However, the proposed drafting maintains an ambiguity that exists in current subsection (D) as to scope. The current statutory language specifies "any" employee or volunteer of the specified institutions, which suggests that having a specific job title is sufficient. However, the subsection then lists specific individuals, such as a teacher or chorus director, that are likely to have authority over a minor, and concludes with "or any other person *in a position of trust with or authority over a minor*" (emphasis added). The latter part of the definition makes it unclear if having a specified job is sufficient, or if the person must actually be in a position of trust or authority over the minor.

Adding contractors and consultants to subsection (D), as the proposed revision seems to do, would maintain this current ambiguity and actually compound it. Even if the current subsection (D) is read broadly to include "any" employee or volunteer of the specified institutions or organizations, these individuals may have at least some contact with a minor in a school setting.

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[3] D.C. Code § 22-3001(10):

> "Significant relationship" includes:
>
> > (A) A parent, sibling, aunt, uncle, or grandparent, whether related by blood, marriage, domestic partnership, or adoption;
> > (B) A legal or de facto guardian or any person, more than 4 years older than the victim, who resides intermittently or permanently in the same dwelling as the victim;
> > (C) The person or the spouse, domestic partner, or paramour of the person who is charged with any duty or responsibility for the health, welfare, or supervision of the victim at the time of the act; and
> > (D) Any employee or volunteer of a school, church, synagogue, mosque, or other religious institution, or an educational, social, recreational, athletic, musical, charitable, or youth facility, organization, or program, including a teacher, coach, counselor, clergy, youth leader, chorus director, bus driver, administrator, or support staff, or any other person in a position of trust with or authority over a child or a minor.

In contrast, contractors and volunteers could easily have no connection or a fleeting connection to the school setting, such as construction contractors[4] or volunteers for a single event.

The CCRC recommends separating out these different groups of people, as the equivalent definition in the RCCA did. The equivalent RCCA definition[5] specified, in relevant part:

> (E) A religious leader described in § 14-309;[6]
> (F) A coach, not including a coach who is a secondary school student; a teacher, counselor, principal, administrator, nurse, or security officer; provided, that such an actor is an employee, contractor, or volunteer at the school at which the complainant is enrolled or at a school where the complainant receives educational services or attends educational programming;
> (G) Any employee, contractor, or volunteer of a school, religious institution, or an educational, social, recreational, athletic, musical, charitable, or youth facility, organization, or program, that exercises supervisory or disciplinary authority over the complainant; or

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[4] For example, an 18 year old construction contractor who supervises work inside a school building and engages in otherwise consensual sexual contact with a 17 year old student could be convicted of First Degree Sexual Abuse of a Minor regardless of their level of interaction, including if they knew each other from outside the school setting. The offense does not require that the sexual activity occur on school grounds, so any sexual activity would be prohibited, regardless of location.

[5] The equivalent RCCA term was "position of trust with or authority over" and it was defined as:

> "'Position of trust with or authority over' means a relationship to a complainant that is:
> (A) A parent, grandparent, great-grandparent, sibling, or a parent's sibling, or an individual with whom such a person is in a romantic, dating, or sexual relationship, whether related by:
> (i) Blood or adoption; or
> (ii) Marriage, domestic partnership, either while the marriage or domestic partnership creating the relationship exists, or after such marriage or domestic partnership ends;
> (B) A half-sibling related by blood;
> (C) A person acting in the place of a parent under civil law, the current spouse or domestic partner of such a person, or an individual with whom such a person is in a romantic, dating, or sexual relationship;
> (D) Any person, at least 4 years older than the complainant, who resides intermittently or permanently in the same dwelling as the complainant;
> (E) A religious leader described in § 14-309;
> (F) A coach, not including a coach who is a secondary school student; a teacher, counselor, principal, administrator, nurse, or security officer; provided, that such an actor is an employee, contractor, or volunteer at the school at which the complainant is enrolled or at a school where the complainant receives educational services or attends educational programming;
> (G) Any employee, contractor, or volunteer of a school, religious institution, or an educational, social, recreational, athletic, musical, charitable, or youth facility, organization, or program, that exercises supervisory or disciplinary authority over the complainant; or
> (H) A person responsible under civil law for the health, welfare, or supervision of the complainant.

RCCA § 22A-101, definition of "position of trust with or authority over". *See* Revised Criminal Code Act of 2021, Enacted Version, (available at https://lims.dccouncil.gov/Legislation/B24-0416) for more information.

[6] A "religious leader described in § 14-309" is a "priest, clergyman, rabbi, or other duly licensed, ordained, or consecrated minister of a religion authorized to perform a marriage ceremony in the District of Columbia or duly accredited practitioner of Christian Science." D.C. Code § 14-309.

(H) A person responsible under civil law for the health, welfare, or supervision of the complainant.

This, or similar drafting, distinguishes between persons whose roles necessarily involves a degree of authority over students, and those whose roles do not. Within these different categories, the definition specifies contractors and volunteers to ensure that they are included.

The CCRC would be able to assist the Council in revising some or all of the current definition of "significant relationship", as well as advise the Council how any changes interact with the proposed revision to first degree sexual abuse of a secondary education student, discussed next.

First degree sexual abuse of a secondary education student

The current D.C. Code first degree sexual abuse of a secondary education student statute prohibits specified individuals from engaging in sexual activity with a student under 20 years of age that is enrolled in the same school or school system.[7] The current specified individuals are "[a]ny teacher, counselor, principal, coach, or other person of authority" in a secondary school.[8] The proposed new language would add "contractor", "consultant", and "volunteer" to this list so that it reads "[a]ny teacher, counselor, principal, coach, *contractor, consultant, volunteer* or other person of authority" (emphasis added).

As a policy matter, the Council may wish to clarify that contractors, consultants, and volunteers fall within the scope of the current statute. The current statutory language is unclear on this point, and there is no case law. The RCCA made a similar recommendation.[9]

However, the proposed drafting maintains an ambiguity that exists in the current statute as to scope. The current statute specifies "any" teacher, counselor, principal, coach, which suggests that having a specific job title is sufficient. However, the statute then lists "or other person of authority". The latter part of the definition makes it unclear if having a specified job is sufficient, or if the person must actually exercise authority over the minor.

Adding contractors, consultants, and volunteers to the statute, as the bill proposes, would maintain this current ambiguity and actually compound it. Even if the statute is read broadly to include "any" teacher, counselor, principal, or coach, these individuals may have at least some contact with the student in the school setting. In contrast, contractors, consultants, and volunteers could have little or no connection to the school setting, such as construction contractors[10] or volunteers

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[7] D.C. Code § 22-3009.03. The statute in its entirety is:

> Any teacher, counselor, principal, coach, or other person of authority in a secondary level school who engages in a sexual act with a student under the age of 20 years enrolled in that school or school system, or causes that student to engage in a sexual act, shall be imprisoned for not more than 10 years, fined not more than the amount set forth in § 22-3571.01, or both.

[8] D.C. Code § 22-3009.03.

[9] RCCA § 22A-2303, Sexual Abuse by Exploitation. *See* Revised Criminal Code Act of 2021, Enacted Version, (available at https://lims.dccouncil.gov/Legislation/B24-0416) for more information.

[10] For example, a construction contractor who supervises work inside a school building or on school grounds would be prohibited from engaging in otherwise consensual sexual activity with a student enrolled at the school or in the same school system regardless of their level of interaction, including if they knew each other from outside the school

for a single event. Given that the statute applies to students that are at least 18 years of age, but under 20 years of age,[11] the proposed language could even prohibit similarly aged student volunteers from engaging in otherwise consensual sexual activity.[12] Such a broad offense arguably infringes on the autonomy of adults who are also secondary education students.

The CCRC recommends removing contractors, consultants, and volunteers as standalone categories and instead requiring that they are persons of authority: "[a]ny teacher, counselor, principal, coach, or other person of authority in a secondary level school, *working as a contractor, consultant, or volunteer*". The CCRC further recommends including "employee" to make clear they are included: "[a]ny teacher, counselor, principal, coach, or other person of authority in a secondary level school, *working as an employee, contractor, consultant, or volunteer*".[13]

In addition, the Council may wish clarify the meaning of "other person of authority" in the current statute. It is undefined, and as discussed, makes the scope of the statute unclear. The RCCA deleted this phrase entirely and expanded the list of specified individuals.[14] This approach avoids fact-specific inquiries into the relationship between the listed individuals and the student.

The CCRC is able to assist the Council with any of the above drafting changes, or others, as well as advise the Council how any changes interact with the proposed revision to the definition of "significant relationship", discussed above.

Finally, the CCRC recommends that, whatever changes the Council makes to first degree sexual abuse of a secondary education student, they also make to second degree sexual abuse of a

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setting. The offense does not require that the sexual activity occur on school grounds, so any sexual activity would be prohibited, regardless of location.

[11] The current sexual abuse of a secondary education student statutes require that the student be "under the age of 20 years". D.C. Code §§ 22-3009.03; 22-3009.04. The current D.C. Code sexual abuse provisions define a "minor" as a person under the age of 18 years, and a "child" as a person under the age of 16 years. D.C. Code §§ 22-3001(5A) (defining "minor" for the current D.C. Code sexual abuse offenses as a "a person who has not yet attained the age of 18 years."); 22-3001(3) (defining a "child" as "a person who has not yet attained the age of 16 years.").
Given the definitions of "child" and "minor", it is theoretically possible that the sexual abuse of a secondary education statutes could apply to persons under 18 years of age or under 16 years of age. However, the D.C. Code has separate sexual abuse offenses for a "minor" and a "child", making it highly unlike the secondary education statutes would ever be applied in practice.

[12] For example, a 19 year-old student volunteering in the school library would be prohibited from engaging in otherwise consensual sexual activity with another student at that school that is also 19 years of age. The offense does not require that the sexual activity occur on school grounds, so any sexual activity would be prohibited, regardless of location.

[13] The Council could replace "consultant" with "employee" since it is arguably unclear how they differ, or the Council could include both terms. The equivalent RCCA offense read "working as an employee, contractor, or volunteer". RCCA § 22A-2303, Sexual Abuse by Exploitation. *See* Revised Criminal Code Act of 2021, Enacted Version, (available at https://lims.dccouncil.gov/Legislation/B24-0416) for more information.

[14] The RCCA added administrators, nurses, and security officers to the list of individuals, and also excluded coaches that are also students:

> "[A] coach, not including a coach who is a secondary school student; a teacher, counselor, principal, administrator, nurse, or security officer at a secondary school, working as an employee, contractor, or volunteer".

RCCA § 22A-2303, Sexual Abuse by Exploitation. *See* Revised Criminal Code Act of 2021, Enacted Version, (available at https://lims.dccouncil.gov/Legislation/B24-0416) for more information.

secondary education student (D.C. Code § 22-3009.04). The offenses differ only in the type of conduct prohibited[15] and penalty.

B. Subtitle B, "Criteria for Detaining Children" – Changes to D.C. Code § 16-2310

The bill changes the scope of a presumption that minors in juvenile proceedings should be detained. Current law, states that courts should use "the least restrictive settings necessary, with a preference *at all times* for the preservation of the family[.]" Given that clear purpose *codified in law*, the Council should exercise caution in expanding the use of juvenile detention.

First, the presumption is broadened to include situations in which the *juvenile poses no risk of harm to others,* but where there is concern about harm to the juvenile. For example, if the juvenile is undergoing a mental health crisis, and there is a risk of self-harm. This is beyond the scope of the CCRC's expertise, but the Committee should carefully consider whether detention in juvenile facilities is the best way to treat children who are undergoing these types of mental health crises.

Second, the Bill expands the range of offenses that are subject to the presumption of detention. Under the bill, any dangerous crime or crime of violence is now subject to the presumption. The presumption could apply to: acting as a go-between to distribute a controlled substance; shoplifting (which in almost all instances constitutes burglary); engaging in sex work as a repeat offender; or pickpocketing. These are not inherently violent offenses, and the presumption creates a risk that juveniles who have engaged in this conduct will be inappropriately detained.

III. Changes Under Title III. Illegal Discharge of a Firearm; Possession of Firearm Ammunition and Penalties

Sec. 301 of the bill proposes changes to multiple changes to different sections of the D.C. code that address firearms and ammunition.

D.C. Code § 22-4503 (unlawful possession of a firearm)

The bill would amend the offense definition and penalties for the unlawful possession of a firearm.

First, this bill proposes making it a felony to knowingly possess a firearm where the serial number has been removed, obliterated, or altered. The proposal includes a penalty of 5 years maximum in prison and a soft minimum of 2 years. The same penalty would apply to someone who receives or possesses a firearm or ammunition if they know or having reasonable cause to believe that it was stolen.

[15] First degree sexual abuse of a secondary education student prohibits a "sexual act", and second degree prohibits "sexual conduct". D.C. Code §§ 22-3009.03; 22-3009.04. "Sexual conduct" is not defined and it appears to be a typo. The statute should instead prohibit a "sexual contact" in keeping with the lower gradations of all the other current sexual abuse statutes. It may be possible to fix this typo if revisions are made to the second degree statute.

Undefined Mental States

Although this new offense specifies mental states, these terms are not defined. The language "having reasonable cause to believe" is especially vague. This language could reasonably be interpreted to mean either recklessness (i.e. that the defendant must have been aware of a substantial risk that the firearm was stolen), or negligence (i.e., the defendant was not aware of a substantial risk the firearm was stolen, but *should* have been aware given that they had reasonable cause to believe it was stolen).

The RCCA included an offense that criminalized possessing a ghost gun.[16] That offense required that an actor knowingly possessed the gun, but with *reckless* as to the fact that it was a ghost gun. The CCRC recommends adding a similar mental requirement to the proposed amendment.

Overlap with Existing Offenses

Current law has a number of provisions that address largely overlapping conduct. Under D.C. Code § 22–4512 it is explicitly unlawful to actively change, alter, remove, or obliterate the name of the maker, model, manufacturer's number, or other mark or identification on any pistol, machine gun, or sawed-off shotgun. No mental state exists in this statute which was first implemented in 1932. The statute states that possession of such an altered firearm is prima facie evidence that the possessor was the person who made the alteration. A violation of this provision carries a one year maximum penalty.[17]

Possession of a firearm which has had the serial number removed, obliterated, or altered is already criminalized under the current offense commonly known as possession of a prohibited weapon ("PPW").[18] PPW covers possession of "ghost guns," which are defined to include any "[f]irearm, including a frame or receiver, that lacks a unique serial number engraved or cast on it by a licensed manufacturer or importer in accordance with federal law, assigned by the agency of a State and permanently engraved or cast on the firearm, or otherwise placed on the firearm in compliance with § 7-2502.02."[19] PPW carries a 1 year maximum sentence, or a 10 year sentence if the defendant has a prior felony conviction. Possessing a gun with an altered serial number would constitute possession of a ghost gun, *and* the separate new offense.

Under current law, carrying a pistol outside of a home or place of business without a license ("CPWL") carries the same maximum penalty of 5 years.[20] In all likelihood, persons carrying guns without proper serial numbers would not have a license to carry that firearm and could also be charged with CPWL.

Possession of a firearm by a person with a prior felony, regardless of whether possession occurs in or outside of the home, constitutes a separate offense commonly known as Felon in Possession

[16] RCC § 22A-5103(a)(2)(E).
[17] D.C. Code § 22–4515.
[18] D.C. Code § 22-4514
[19] D.C. Code § 22-4501(2B); 7-2501.01 (9B)(A).
[20] D.C. Code § 22-4504 (a)(1).

("FIP").[21] FIP is punishable by up to 10 years, or 15 years if the prior conviction was for a crime of violence.

Possession of an unregistered firearm, even within a person's home, is also separately criminalized and carries a maximum penalty of 1 year.[22]

Current law also prohibits receiving stolen property, if that person buys, receives, possesses, or obtains control of stolen property, knowing or having reason to believe that the property was stolen.[23] The penalty for the offense is a maximum of 7 years where the property is worth more than $1,000 and 180 days if the property is worth less than that.[24]

With regard to the penalty that is noted in paragraph (c-1) the CCRC recommends more clarity as to whether the intent is a mandatory minimum of 2 years or whether that is a minimum that can be suspended. The language, as written, refers to a soft minimum in D.C. Code § 22-801(b) (Burglary) but it refers to a mandatory minimum with almost identical language in D.C. Code § 22-2104(a) (1st degree murder). This lack of clarity could lead to confusion both with considering plea offers and at sentencing.

D.C. Code. § 22-4503.01 (unlawful discharge of a firearm)

The next section that this bill seeks to amend covers the offense of an unlawful discharge of a firearm.

This bill proposes making the unlawful discharge of a firearm a felony that carries a 2 year maximum penalty. Legitimate self defense and other lawful conduct is excepted from the offense but there is no mental state that must be proven in order to be convicted under this statute. Under current law, a violation of current D.C. Code § 22-4503.01 is subject to a maximum penalty of 1 year of incarceration and a $2,500 fine.[25] A violation of 24 DCMR §§ 2300.1 – 2300.3 is subject to a fine of $300 and is not punishable by jail time. This proposed change switches this offense from a misdemeanor to a felony. As a result, it would be prosecuted by the U.S. Attorney's Office. Currently it is prosecuted by the Office of the Attorney General. No changes are being made to the definition of the offense.

The RCCA included an analogous reckless endangerment with a firearm offense. This offense specified relevant culpable mental states, and defined specific locations and circumstances in which discharging a firearm constitutes the offense. The Committee should consider adopting the RCCA's reckless endangerment with a firearm offense as an alternative to the penalty change proposed in the bill.

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[21] D.C. Code § 22-4503.
[22] D.C. Code § 7–2507.06(a)(2)(B).
[23] D.C. Code § 22–3232.
[24] D.C. Code § 22–3232 (c)(1) and (2).
[25] D.C. Code §§ 22-4515; 22-3571.01.

D.C. Code. § 22-4514 (possession of dangerous weapons)

The next section that this bill seeks to amend covers the offense and penalty for possession of dangerous weapons.

The bill proposes the increase of penalties for the possession of machine guns, sawed-off shot guns, and ghost guns from 1 year to 5 years. All of these terms are currently defined in D.C. Code § 7–2501.01 and no changes are being made to those definitions in this bill. No change is being sought to the elements of the offense either, only to the penalty.

The RCCA included an offense that criminalized possession of these types of firearms, and was subject to a four year maximum penalty.[26] The proposed offense included machine guns, sawed-off shotguns, and ghost guns but also included assault weapons and restricted explosives in its list of weapons that qualified for the first degree version of the offense that was eligible for the four year maximum. That offense required a mental state that the actor knowingly possessed the prohibited item and that they did so, reckless to the fact of what the item was. The CCRC would recommend a similar change to the offense listed in this statute as well.

Sec. 302. 7-2502.07 (Penalties for miscellaneous ammunition and firearm offenses)

The next section that this bill seeks to change penalties for multiple offenses related to firearms control.

Amendment to Subsection (a)(3)(A)

The first change seeks to amend D.C. Code § 7-2507.06(a)(3)(A) to apparently clarify that penalties under subsection (a)(3)(A) would not be affected be the penalty provision under subsection (a)(4). However, it is unclear why this new language is necessary. Subsection (a)(3)(A) addresses the penalty for possessing multiple restricted pistol bullets while subsection (a)(4) addresses the penalty for possessing a large capacity ammunition feeding device. Given that they address different offenses there would not be any relation between these two subsections as they are currently written. While it is possible that both offenses could be charged in the same case, a judge would decide whether or not to run sentences concurrently or consecutively. Overall it does not appear that this change will have any effect on the outcome of any cases.

New Subsection (a)(5)

The section of the bill also would add a new subsection (a)(5) to D.C. Code § 7-2507.06. This addition seeks to create a felony offense for possessing a firearm with the intent to sell it or to make it available for sale. The proposal includes a penalty of 10 years maximum in prison and a soft minimum of 2 years. Under current law, the simple possession of an unregistered firearm carries a maximum penalty of 1 year.[27] The actual sale of a firearm to a minor carries a maximum

[26] RCCA § 22-5103.
[27] D.C. Code § 7–2507.06(a)(2)(B).

penalty of 10 years under current law.[28] The proposed paragraph 5 references section 501 of the act which includes the regulations for lawful transfers or sale of a firearm. The act it is referring to is the Firearms Control Regulations Act of 1975. Rules on the lawful sale and transfer of firearms are now codified in D.C. Code § 7–2505.02.

The proposed change with the new subsection (a)(5) would affect cases where a person did not have a prior felony conviction that would have already subjected them to a 10 year maximum sentence. This change would increase the maximum penalty for the highest charge for a non-felon who carried their firearms with intent to sell outside of a home or place of business. For someone who possessed a single firearm with an intent to sell it but was inside their home, this change would allow the government to charge this person with a ten year felony instead of a one year misdemeanor offense.

The RCCA included an offense for the unlawful sale of a pistol that included a 2 year maximum sentence.[29] In that offense an actor could be convicted if it was proven that they knowingly sold a pistol and were reckless to the fact that the person was either of unsound mind, a minor, or a convicted felon.

The RCCA included an offense for the unlawful transfer of a firearm that included a 2 year maximum sentence.[30] In that offense an actor could be convicted if it was proven that they knowingly transferred a firearm to another person without following any other regulations about the transfer of a firearm. The proposed RCCA section had an exclusion for a licensed firearm dealer.

The RCCA included an offense for the sale of a firearm without a license that included a 2 year maximum sentence.[31] In that offense an actor could be convicted if it was proven that they knowingly sold, exposed for sale, or possessed with intent to sell a firearm when they did not have a license to do so. Similarly, the CCRC recommends including mental state of knowing for the new illegal sale offense created under the bill.

With regard to the penalty that is noted at the end of the proposed new subsection (a)(5), the CCRC recommends more clarity as to whether the intent is a mandatory minimum of 2 years or whether that is a minimum that can be suspended. The language, as written, refers to a soft minimum in D.C. Code § 22-801(b) (Burglary) but it refers to a mandatory minimum with almost identical language in D.C. Code § 22-2104(a) (1st degree murder). This lack of clarity could lead to confusion both with considering plea offers and at sentencing.

New Subsection (a)(6)

The section of the bill also seeks to add a new subsection (a)(6) to D.C. Code § 7-2507.06 (a). This addition appears to attempt to increase the penalty for the possession of ammunition when the person has a prior felony conviction. However, this new subsection does not change penalties

[28] D.C. Code § 7-2507.06 (a)(1).
[29] RCCA § 22-5113.
[30] RCCA § 22-5114.
[31] RCCA § 22-5115.

as compared to current law. The proposed subsection (a)(6) sets a maximum penalty of one year when the defendant has a prior felony conviction. The current maximum penalty for the possession of ammunition with or without a prior felony conviction is already one year.

New Subsection (b)(1A)

This bill also adds a paragraph (b)(1A) to D.C. Code § 7-2507.06 that removes the discretion of the United States Attorney's Office and the Office of the Attorney General from offering administrative remedies to firearms offenses in cases where the defendant has a prior felony conviction. The listed offenses are currently prosecuted by the Office of the Attorney General when there is no additional charge that would make it the purview of the United States Attorney. CCRC takes no position on this change.

IV. Title IV. Penalty Enhancements.

The bill proposes three new penalty enhancements for certain crimes: 1) When the victim is a vulnerable adult; 2) When the victim is a passenger on a mass transit vehicle; and 3) When the victim is located on property administered by the Director of the Department of Parks and Recreation. Each proposed enhancement permits up to 1½ times the maximum fine otherwise authorized, 1½ times the maximum term of imprisonment otherwise authorized, or both, consistent with several current penalty enhancements.[32] The bill also expands the existing penalty enhancement for taxicab drivers[33] to include additional transportation providers, and the existing penalty enhancement for operators of a mass transit vehicle or Metrorail station manager[34] to include any Metrorail station employee.

The CCRC discusses each proposed penalty enhancement below, with a focus on clarifying the drafting for individual enhancements should the Council move forward. However, many of the CCRC recommendations are best done as part of a wholistic revision of what this testimony will refer to as the "Subtitle II penalty enhancements"—the existing penalty enhancements in Subtitle II of Title 22 for victims that are: 1) senior citizens;[35] 2) minors;[36] 3) taxicab drivers;[37] and 4) transit operators or Metrorail station managers.[38] The bill revises the existing penalty enhancements for taxicab drivers and transit operators or Metrorail station managers and introduces new penalty enhancements to Subtitle II, but does not revise the existing penalty enhancements for senior citizens or minors. This piecemeal approach leads to several inconsistencies that are discussed below. The CCRC recommends revising the Subtitle II penalty enhancements and, as a part of that revision, incorporating many of the bill's proposed penalty enhancements. Wholistic revision would improve the clarity, consistency, and proportionality of the proposed and existing Subtitle II penalty enhancements. The CCRC would be able to assist the Council in such a wholistic revision.

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[32] E.g., D.C. Code § 22-3751.01.
[33] D.C. Code § 22-3751.
[34] D.C. Code § 22-3751.01.
[35] D.C. Code § 22-3601.
[36] D.C. Code § 22-3611.
[37] D.C. Code § 22-3751.
[38] D.C. Code § 22-3751.01.

The CCRC notes as a general matter that the absence of a penalty enhancement for a class of victims should not be construed as a lack of concern for that class of victims. For example, under the bill or current law, there are no enhancements for assaulting nurses in the emergency room. This does not mean that the Council believes it is acceptable to assault nurses in the ER, as this conduct is still criminalized. Enhancements should identify cases that are particularly heinous, culpable, or dangerous, and especially when the penalties for the *unenhanced* version of the offense are insufficiently severe.

It is unclear if the proposed penalty enhancements will have any significant effect on actual sentences imposed. The CCRC analyzed seven similar penalty enhancements under current law. These enhancements include bias-motivated crimes, and crimes when the victim was a minor, a metro transit officer, a senior citizen, a taxi cab driver, or was vulnerable due to age or mental or physical infirmity. The CCRC reviewed every case from 2010-2019 in which a person was charged with one or more of these enhancements.

These current enhancements are used very infrequently. In most cases, when these enhancements were charged, they were ultimately dismissed. During the 10 year period from 2010-2019, there were about 10 cases per year in which a person was convicted under one of the penalty enhancements.

The data show that even when current enhancements were used, the resulting sentences are almost always lower than the maximum allowable sentence for the unenhanced offense.[39] The data do show an effect on the *median* sentence. The effect varies depending on the enhancement and the underlying offense, but generally the median sentenced for an enhanced offense is roughly 3 months to 4 years higher than the median for an unenhanced offense. Overall, the median sentence when a conviction applies to any given offense increases by roughly 22% of the unenhanced maximum sentence for that offense.[40]

However, it's unclear exactly whether and how the enhancements are causing this change. Sample sizes are small and there may be other factors, such as the defendants' criminal history scores, that caused the difference in sentences. Even if there were no statutory enhancements, committing a crime against a minor, a vulnerable elderly adult, are facts that the government could raise at sentencing, and that a judge could take into consideration. It is possible that the higher median

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[39] There was one exception across the entire decade in which the resulting sentence was slightly higher than the unenhanced maximum. However, under the data use agreement with D.C. Superior Court, the CCRC is prohibited from publicly sharing details of any individual case.

[40] For example, if the unenhanced maximum sentence for an offense is 10 years, on average the median sentence for that offense when subject to an enhancement increases by roughly 2.2 years as compared to the median sentence for that offense not subject to an enhancement. Similarly, if the maximum sentence for a given offense is 5 years, the median sentence for that offense when subject to an enhancement increases by approximately 1.1 years as compared to the median sentence for that offense not subject to an enhancement.

To reach this figure, the CCRC looked at the median sentences for offenses when subject to an enhancement and not subject to an enhancement. The change in sentence was then translated into a percentage of the unenhanced maximum sentence allowed for that given offense. The CCRC then calculated a weighted average to reach the overall average of 22%.

sentences are due to the greater inherent wrongfulness of these select cases. Finally, there may be a selection bias effect when analyzing cases in which a person was convicted under an enhancement. In most cases, penalty enhancements are dismissed. The cases in which they survive to conviction may be cases that are either especially egregious, or in which the defendants refused more favorable plea terms and received a more serious sentence after being convicted at trial. Therefore, sentences may have been higher in these cases even if there had been no statutory enhancement.

Proposed new penalty enhancement #1: For a "vulnerable adult"

The bill proposes a new penalty enhancement for a "crime of violence"[41] or a "dangerous crime"[42] against a "vulnerable adult". The current D.C. Code has special offenses for criminal abuse of a vulnerable adult,[43] criminal neglect of a vulnerable adult,[44] and financial exploitation of a vulnerable adult,[45] but no broadly applicable penalty enhancement.

As a policy matter, the Council may wish to expand protections for vulnerable adults with a free-standing penalty enhancement. The RCCA recommended including penalty enhancements for a wide array of offenses if the complainant was a vulnerable adult.[46] However, the CCRC recommends several changes to the bill's proposed language to improve its clarity. These changes could be done piecemeal, but as stated above, would be best done as part of a wholistic revision of the Subtitle II penalty enhancements.

First, the CCRC notes that including all offenses that are a "dangerous crime" could make the penalty enhancement overly broad. The bill applies the new penalty enhancement to both a "crime of violence"[47] and a "dangerous crime",[48] as those terms are defined in Title 23. Offenses in the

[41] D.C. Code § 23-1331(4).
[42] D.C. Code § 23-1331(3).
[43] D.C. Code § 22-933.
[44] D.C. Code § 22-934.
[45] D.C. Code § 22-933.01.
[46] The RCCA broadly included as an enhancement that the complainant was a "protected person", a term defined to include "vulnerable adults."
[47] D.C. Code. § 23-1331(4) ("The term 'crime of violence' means aggravated assault; act of terrorism; arson; assault on a police officer (felony); assault with a dangerous weapon; assault with intent to kill, commit first degree sexual abuse, commit second degree sexual abuse, or commit child sexual abuse; assault with significant bodily injury; assault with intent to commit any other offense; burglary; carjacking; armed carjacking; child sexual abuse; cruelty to children in the first degree; extortion or blackmail accompanied by threats of violence; gang recruitment, participation, or retention by the use or threatened use of force, coercion, or intimidation; kidnapping; malicious disfigurement; manslaughter; manufacture or possession of a weapon of mass destruction; mayhem; murder; robbery; sexual abuse in the first, second, or third degrees; use, dissemination, or detonation of a weapon of mass destruction; or an attempt, solicitation, or conspiracy to commit any of the foregoing offenses.").
[48] D.C. Code. § 23-1331(3) ("The term 'dangerous crime' means: (A) Any felony offense under Chapter 45 of Title 22 (Weapons) or Unit A of Chapter 25 of Title 7 (Firearms control); (B) Any felony offense under Chapter 27 of Title 22 (Prostitution, Pandering); (C) Any felony offense under Unit A of Chapter 9 of Title 48 (Controlled Substances); (D) Arson or attempted arson of any premises adaptable for overnight accommodation of persons or for carrying on business; (E) Burglary or attempted burglary; (F) Cruelty to children; (G) Robbery or attempted robbery; (H) Sexual abuse in the first degree, or assault with intent to commit first degree sexual abuse; (I) Any

definition of "crime of violence" are inherently violent, or have a high likelihood of violence. In contrast, offenses in the definition of "dangerous crime" often do not, and if they do, they are also included in the definition of "crime of violence."[49] Including all offenses that are a "dangerous crime" in the penalty enhancement would enhance the penalty for offenses that are generally much less serious than a "crime of violence." It would also create ambiguity because it is unclear if many of the "dangerous crime" offenses, such as felony weapon offenses in Chapter 45 of Title 22, felony drug offenses under Chapter 9 of Title 48, and felony fleeing from an officer in a motor vehicle, have an identifiable victim. The Council could address these issues by: 1) Limiting the enhancement to a "crime of violence"; and 2) If it wishes to include any offenses that are a "dangerous crime", adding them in individually. The CCRC makes this recommendation for all proposed penalty enhancements in the bill, and, if there were a wholistic revision, for the existing Subtitle II penalty enhancements.[50]

Second, the proposed affirmative defense seems to contain an error, and, more generally, the CCRC would recommend deleting the defense and instead requiring a culpable mental state for the fact that the victim is a "vulnerable adult". The proposed defense applies if defendant "could not have known or determined the age of the victim because of the manner in which the offense

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felony offense established by the Prohibition Against Human Trafficking Amendment Act of 2010 [D.C. Law 18-239], or any conspiracy to commit such an offense; or (J) Fleeing from an officer in a motor vehicle (felony).").

[49] The following offenses in the definition of "dangerous crime" are included in the definition of "crime of violence": 1) Arson or attempted arson of any premises adaptable for overnight accommodation of persons or for carrying on business; 2) Burglary or attempted burglary; 3) Cruelty to children; 4) Robbery or attempted robbery; 5) Sexual abuse in the first degree, or assault with intent to commit first degree sexual abuse.

[50] The current Subtitle II penalty enhancements apply to different sets of offenses. The senior citizen penalty enhancement applies to:

> Abduction, arson, aggravated assault, assault with a dangerous weapon, assault with intent to kill, commit first degree sexual abuse, or commit second degree sexual abuse, assault with intent to commit any other offense, burglary, carjacking, armed carjacking, extortion or blackmail accompanied by threats of violence, kidnapping, malicious disfigurement, manslaughter, mayhem, murder, robbery, sexual abuse in the first, second, and third degrees, theft, fraud in the first degree, and fraud in the second degree, identity theft, financial exploitation of a vulnerable adult or elderly person, or an attempt or conspiracy to commit any of the foregoing offenses.

The penalty enhancement for minors applies to the offenses that are a "crime of violence", as defined in Title 23:

> The term "crime of violence" means aggravated assault; act of terrorism; arson; assault on a police officer (felony); assault with a dangerous weapon; assault with intent to kill, commit first degree sexual abuse, commit second degree sexual abuse, or commit child sexual abuse; assault with significant bodily injury; assault with intent to commit any other offense; burglary; carjacking; armed carjacking; child sexual abuse; cruelty to children in the first degree; extortion or blackmail accompanied by threats of violence; gang recruitment, participation, or retention by the use or threatened use of force, coercion, or intimidation; kidnapping; malicious disfigurement; manslaughter; manufacture or possession of a weapon of mass destruction; mayhem; murder; robbery; sexual abuse in the first, second, or third degrees; use, dissemination, or detonation of a weapon of mass destruction; or an attempt, solicitation, or conspiracy to commit any of the foregoing offenses.

D.C. Code §§ 22-3611(c)(2); 23-1331(4).

Finally, the penalty enhancements for taxicab drivers, transit operators, and Metrorail station managers apply to:

> The provisions of §§ 22-3751 [taxicab driver penalty enhancement] and 22-3751.01 [transit operator and Metrorail station manager penalty enhancement] shall apply to the following offenses or any attempt or conspiracy to commit any of the following offenses: murder, manslaughter, aggravated assault, assault with a dangerous weapon, mayhem or maliciously disfiguring, threats to do bodily harm, first degree sexual abuse, second degree sexual abuse, third degree sexual abuse, fourth degree sexual abuse, misdemeanor sexual abuse, robbery, carjacking, and kidnapping.

was committed". However, the current Title 22 definition of "vulnerable adult",[51] which the bill adopts, requires that the person be at least 18 years *and* have certain physical or mental limitations. As drafted, the defense would essentially create strict liability when the defendant "could not have known or determined" the vulnerable adult's *physical or mental limitations* due to the manner in which the offense was committed,[52] but allow the defense when the defendant "could not have known or determined" the vulnerable adult's *age*.[53] Applying strict liability as to whether the adult has a physical or mental limitation seems contrary to the intent of the defense.[54] The CCRC would recommend revising the text to read:

> (b) It is an affirmative defense that the accused knew or reasonably believed that the victim was not a vulnerable adult at the time of the offense, or could not have known or determined *that* ~~the age of~~ the victim *was a vulnerable adult* because of the manner in which the offense was committed. This defense shall be established by a preponderance of the evidence.

The amended text broadens the scope of the defense, but there are two larger issues. First, it is as an affirmative defense, the bill places the burden on the defendant to prove they believed the victim was not a vulnerable adult, or that they could not have known the victim was a vulnerable adult. The CCRC recommends that in the alternative the enhancement be drafted to require a culpable mental state as to the victim's status as a vulnerable adult. Second, the mental states in the proposed affirmative defense, "knew" and "reasonably believed" are unclear. They are not defined and there are no general definitions for these terms in the current code. If the Subtitle II penalty enhancements were revised wholistically, perhaps standard culpable mental states could be adopted for these and other new penalty enhancements from the bill. The RCCA penalty enhancement required a "reckless" culpable mental state for the fact the victim was a vulnerable adult, but the Council could consider other culpable mental states, including "knowledge" or even "negligence", although negligence is generally disfavored. The CCRC would be able to assist the Council in drafting with culpable mental states.

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[51] Both the proposed bill and the RCCA penalty enhancement maintained the current definition of "vulnerable adult" that applies to the current criminal abuse, criminal neglect, and financial exploitation statutes. [cite] The bill's exact definition is: "a person who is 18 years of age or older and has one or more physical or mental limitations that substantially impairs the person's ability to independently provide for their daily needs or safeguard their person, property, or legal interests."

[52] For example, if the defendant runs down the street towards the victim and snatches the victim's purse, the defendant likely could determine that the victim was at least 18, but, in some instances, would not be able to determine that the victim had the required physical or mental limitations. As currently drafted, the defense would seem to not apply, and the person would be liable.

[53] For example, if a defendant extorts a vulnerable adult, knowing that the victim is over the age of 18, but with no way of knowing that the adult had any physical or mental limitations, the defendant could not satisfy the requirements of the affirmative defense and the enhancement would apply.

[54] The ambiguity may be due to the entire defense, including this provision, being taken from the existing Subtitle II penalty enhancement for crimes against senior citizens, which is based entirely victim's age. D.C. Code § 22-3601(c) ("It is an affirmative defense that the accused knew or reasonably believed the victim was not 65 years old or older at the time of the offense, or could not have known or determined the age of the victim because of the manner in which the offense was committed. This defense shall be established by a preponderance of the evidence.").

Proposed new penalty enhancement #2: For a passenger of a mass transit vehicle

The bill adds a new penalty enhancement for a "crime of violence"[55] or a "dangerous crime"[56] against a "passenger of a mass transit vehicle". The bill defines a "passenger" as "a person who is traveling on a mass transit vehicle or waiting at a marked mass transit vehicle boarding location, such as a bus stop or Metrorail station."[57]

The CCRC would repeat two of the recommendations discussed for the bill's other proposed penalty enhancements: 1) Standardize the list of applicable offenses and apply it to the current Subtitle II penalty enhancements and any new enhancements from the bill; and 2) Require a culpable mental state for the fact that the victim is a "passenger" on a mass transit vehicle.

However, more generally, the proposed passenger penalty enhancement is overly broad, and the Council should consider not including this enhancement in final legislation. The proposed passenger penalty enhancement is presumably intended to target crimes of opportunity or crimes that may be particularly dangerous in a mass transit setting. However, as drafted, the penalty enhancement applies to any enumerated offense against a passenger, even if it isn't a crime of opportunity or a crime that is particularly dangerous in a mass transit setting. For example, a felony assault between romantic partners on a Metro train would be subject to this enhancement.

As compared to a victim that is elderly, has a certain job, etc., the facts of an offense in a mass transit setting will vary considerably. Was the train crowded? Was any bystander to the offense injured or threatened? Did the defendant and victim know each other? It is not clear why assaulting someone who is waiting at a bus station is categorically worse than assaulting someone on the sidewalk. A penalty enhancement will not capture these nuances, but sentencing in individual cases can. In the above hypothetical, a domestic felony assault that occurs on a crowded Metro train may warrant a higher sentence than a domestic felony assault on an empty train. The same analysis applies to crimes of opportunity or crimes that are particularly dangerous in a mass

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[55] D.C. Code § 23-1331(4).

[56] D.C. Code § 23-1331(3).

[57] The bill's definition of "passenger" conflicts with the plain language of the enhancement. The proposed enhancement reads, in relevant part, "Any person who commits an offense enumerated in D.C. Official Code § 23-1331(3) or 23-1331(4) against a passenger of a mass transit vehicle . . ." The plain language of the proposed enhancement is clear. However, the bill defines "passenger" to include individuals waiting to board, which is broader than the plain language reading "a passenger of a mass transit vehicle". In addition, the proposed enhancement would be included as a new subsection of D.C. Code § 22-3751.01, which codifies the existing penalty enhancement for a transit operator of a "mass transit vehicle". D.C. Code § 22-3751.01 defines "mass transit vehicle" as "any publicly or privately owned or operated commercial vehicle for the carriage of 6 or more passengers, including any Metrobus, Metrorail, Metroaccess, or DC Circulator vehicle or other bus, trolley, or van operating within the District of Columbia." This is a narrowly tailored definition to the actual vehicle, as opposed to a boarding location.
For substantive reasons, the CCRC recommends the Council not move forward with the proposed passenger penalty enhancement, but if the Council did, it seems unnecessary to codify a separate definition of "passenger" that complicates the plain reading of the statute. The proposed penalty enhancement could instead read:

> (a-1) Any person who commits an offense enumerated in D.C. Official Code § 23-1331(3) or 23-1331(4) against a *person who is traveling on a mass transit vehicle or waiting at a marked mass transit vehicle boarding location, such as a bus stop or Metrorail station,* ~~passenger~~ of a mass transit vehicle may be punished by a fine of up to one and 1/2 times the maximum fine otherwise authorized for the offense and may be imprisoned for a term of up to one and 1/2 times the maximum term of imprisonment otherwise authorized by the offense, or both.".

transit setting. If a stranger robs a passenger on a crowded Metro train, the victim might be unaware of the taking, calling into question whether a categorical penalty enhancement is warranted. A categorical penalty enhancement is not necessary to ensure that sentences capture the severity of a given case.

In addition, as noted above, the current Subtitle II penalty enhancements are rarely, if ever charged, and, when they are, the sentences do not go above the unenhanced maximum. The proposed passenger penalty enhancement would likely be rarely, if ever charged, and would likely not increase the imposed penalties above the unenhanced maximums.

Proposed new penalty enhancement #3: For Department of Parks and Recreation property

The bill adds a new penalty enhancement for a "crime of violence"[58] or a "dangerous crime"[59] against a person that is "located on a property administered by the Director of the Department of Parks and Recreation".

The CCRC would repeat two of the recommendations discussed for the bill's other proposed penalty enhancements: 1) Standardize the list of applicable offenses and apply it to the current Subtitle II penalty enhancements and any new enhancements from the bill; and 2) Require a culpable mental state for the fact that the victim is located on property administered by the Director of DPR.

In addition, the scope of the proposed DPR penalty enhancement is ambiguous, and the Committee should consider narrowing the definition of "property". The bill defines "property" as "any park, field, court, play area, facility, or building, and the associated grounds, parking lot, and adjacent areas in public space, including sidewalks and streets." The enumerated locations—"park, field, court, play area, facility, or building"—are reasonably well-defined locations. The remainder of the definition, however, is ambiguous. First, it is unclear what "associated grounds" encompasses. Is it the land that surrounds one of the enumerated locations? If so, is there a point when such land is so far removed from an enumerated location it is no longer "associated"? Second, "adjacent areas in public space" is unclear. It is unclear what these areas are, other than sidewalks and streets, which the definition specifically includes.

The Committee could improve the clarity of the proposed penalty enhancement by narrowing the definition of "property" to areas that are reasonably well-defined, such as "park, field, court, play area, facility, or building" in the current drafting. To include surrounding areas, the Council could possibly specify "any associated grounds or public space" within some distance of the enumerated locations, similar to the current drug-free school zone offense.[60] This would codify a clear standard as opposed to the vague qualifiers "associated" and "adjacent". The CCRC could assist the Council in revising the definition of "property".

[58] D.C. Code § 23-1331(4).
[59] D.C. Code § 23-1331(3).
[60] D.C. Code § 48-904.07a.

Expanded penalty enhancement #1: For a "transportation provider"

The bill expands the current D.C. Code penalty enhancement for taxicab drivers[61] to include additional transportation providers. Specifically, the bill expands the current penalty enhancement to include persons who operate: 1) A "public vehicle-for-hire", as defined in D.C. Code § 50-301.03;[62] and 2) A "private vehicle-for-hire", as defined in D.C. Code § 50-301.03.[63]

As a policy matter, the Council may wish to expand the current taxicab driver penalty enhancement to include additional public vehicle-for-hire operators, such as limousine drivers, and private vehicle-for-hire operators, such as Uber drivers. Although, as discussed earlier, the current taxicab driver penalty enhancement is rarely charged, the revisions still fill a gap in current law, and the RCCA made similar recommendations.[64]

The CCRC would repeat two of the recommendations discussed for the bill's other proposed penalty enhancements: 1) Standardize the list of applicable offenses and apply it to the current Subtitle II penalty enhancements and any new enhancements from the bill;[65] and 2) Require a culpable mental state for the fact that the victim is a "transportation provider".

In addition, the bill does not appear to incorporate the correct Title 50 definitions for private and public vehicle-for-hire operators. The bill incorporates the definition "private vehicle-for-hire",[66] but that definition details the requirements for "a class of transportation service" and does not

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[61] D.C. Code § 22-3751:

> Any person who commits an offense listed in § 22-3752 against a taxicab driver who, at the time of the offense, has a current license to operate a taxicab in the District of Columbia or any United States jurisdiction and is operating a taxicab in the District of Columbia may be punished by a fine of up to one and 1/2 times the maximum fine otherwise authorized for the offense and may be imprisoned for a term of up to one and 1/2 times the maximum term of imprisonment otherwise authorized for the offense, or both.

[62] D.C. Code § 50-301.03(17) (defining "public vehicle-for-hire" as "a class of transportation service by motor vehicle for hire in the District, including a taxicab, limousine, or sedan-class vehicle, that provides for-hire service exclusively using operators and vehicles licensed pursuant to this subchapter and § 47-2829.").

[63] D.C. Code § 50-301.03(16A) (defining "private vehicle-for-hire" as "a class of transportation service by which a network of private vehicle-for-hire operators in the District provides transportation to passengers to whom the private vehicle-for-hire operators are connected by digital dispatch.").

[64] RCCA § 22A-101 (142).

[65] The proposed transportation provider penalty enhancement does not revise the list of offenses to which the enhancement applies, leaving it as it is in current law:

> "The provisions of §§ 22-3751 [taxicab driver penalty enhancement] and 22-3751.01 shall apply to the following offenses or any attempt or conspiracy to commit any of the following offenses: murder, manslaughter, aggravated assault, assault with a dangerous weapon, mayhem or maliciously disfiguring, threats to do bodily harm, first degree sexual abuse, second degree sexual abuse, third degree sexual abuse, fourth degree sexual abuse, misdemeanor sexual abuse, robbery, carjacking, and kidnapping."

D.C. Code § 22-3752.

This is inconsistent with other proposed penalty enhancements in the bill, which apply to offenses that are a "crime of violence" or "dangerous crime".

[66] D.C. Code § 50-301.03(16A) (defining "private vehicle-for-hire" as "a class of transportation service by which a network of private vehicle-for-hire operators in the District provides transportation to passengers to whom the private vehicle-for-hire operators are connected by digital dispatch.").

mention individual operators or vehicles. Under the proposed definition, a "transportation provider" would be defined as a person who operates a "a class of transportation service[s]", not a person who operates a *vehicle* used to perform such services. Title 50 separately defines "private vehicle-for-hire operator", and this appears to be the correct definition: "an individual who operates a personal motor vehicle to provide private vehicle-for-hire service in contract with a private vehicle-for-hire company."[67] The new drafting could read:

> "(b) For the purposes of this section, the term "transportation provider" means *a private vehicle-for-hire operator or* a person who operates within the District of Columbia a public vehicle-for-hire ~~or private vehicle-for-hire~~, as those terms are defined in section 4 of the District of Columbia Taxicab Commission Establishment Act of 1985 (D.C. Law 6-97; D.C. Official Code § 50-301.03).".

Expanded penalty enhancement #2: For a "Metrorail station employee"

The bill expands the current penalty enhancement for certain crimes against a "transit operator" operating a "mass transit vehicle" or against a "Metrorail station manager".[68] Specifically, the bill proposes expanding the enhancement to include any "Metrorail station employee", defined as "any person who performs a [sic] services for the Washington Metropolitan Area Transit Authority or works in a Metrorail station." It is unclear whether the definition intends to include all individuals who perform services for WMATA, regardless of location, or it is limited to individuals who perform services for WMATA at a Metrorail station.

The CCRC would repeat two of the recommendations discussed for the bill's other proposed penalty enhancements: 1) Standardize the list of applicable offenses and apply it to the current Subtitle II penalty enhancements and any new enhancements from the bill;[69] and 2) Require a culpable mental state for the fact that the victim is a "Metrorail station employee".

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[67] D.C. Code § 50-301.03(16C).

[68] D.C. Code § 22-3571.01. The current penalty enhancement has the following definitions:

> "(b) For the purposes of this section, the term:
> (1) 'Mass transit vehicle' means any publicly or privately owned or operated commercial vehicle for the carriage of 6 or more passengers, including any Metrobus, Metrorail, Metroaccess, or DC Circulator vehicle or other bus, trolley, or van operating within the District of Columbia.
> (2) 'Metrorail station manager' means any Washington Metropolitan Area Transit Authority employee who is assigned to supervise a Metrorail station from a kiosk at that station.
> (3) 'Transit operator' means a person who is licensed to operate a mass transit vehicle.

D.C. Code § 22-3751.01(b).

[69] The proposed transportation provider penalty enhancement does not revise the list of offenses to which the enhancement applies, leaving it as it is in current law:

> "The provisions of §§ 22-3751 and 22-3751.01 [penalty enhancement for transit operators and Metrorail station managers] shall apply to the following offenses or any attempt or conspiracy to commit any of the following offenses: murder, manslaughter, aggravated assault, assault with a dangerous weapon, mayhem or maliciously disfiguring, threats to do bodily harm, first degree sexual abuse, second degree sexual abuse,

As a policy matter, the Committee may wish to expand the current penalty enhancement beyond mass transit vehicle drivers and Metrorail station managers. However, the proposed definition is overly broad, and the Committee should consider narrowing it or omitting it from a final bill. It would enhance offenses against individuals that may have a tenuous connection, or no connection, to Metro or mass transit and who aren't subject to the same risks as a driver or station manager. For example, would an individual selling flowers at the entrance to a Metro station or a contractor hired to clean a Metro station or fix a fare machine be included? Metropolitan Police Department (MPD) officers, Metro Transit Police Department officers, and other law enforcement officers could potentially be included, even though they have special protection under other offenses in the current Code.[70]

The proposed definition does require, in part, that the person perform services "for" WMATA. However, it is unclear if this means the person must be a WMATA employee, or if a broader relationship, like "for the benefit of" WMATA, would suffice.[71] Regardless, at least for Metrorail station employees, this part of the definition is subsumed by the alternative requirement "or works in a Metrorail station."

The current penalty enhancement appears to cover the most visible and at-risk individuals in mass transit settings. If there are additional individuals the Council wants to include, it would be clearest to list them. If this is not possible, or if the Council wants a categorical inclusion, the CCRC would recommend narrowing the definition to WMATA employees at a Metrorail station: "Metrorail station employee" means any ~~person who performs a services for the~~ Washington Metropolitan Area Transit Authority *employee that* ~~or~~ works in a Metrorail station." This, combined with a culpable mental state required for the employee's status, would improve the proportionality of the penalty enhancement.

V. Title V Rebuttable Presumption for Adult Pre-Trial Detention; GPS Data for Prosecution

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> third degree sexual abuse, fourth degree sexual abuse, misdemeanor sexual abuse, robbery, carjacking, and kidnapping."

D.C. Code § 22-3752.
This is inconsistent with other proposed penalty enhancements in the bill, which apply to offenses that are a "crime of violence" or "dangerous crime".

[70] For example, the current D.C. Code assault on a police officer statute defines "law enforcement officer" as "any officer or member of any police force operating and authorized to act in the District of Columbia, including any reserve officer or designated civilian employee of the Metropolitan Police Department, any licensed special police officer, any officer or member of any fire department operating in the District of Columbia, any officer or employee of any penal or correctional institution of the District of Columbia, any officer or employee of the government of the District of Columbia charged with the supervision of juveniles being confined pursuant to law in any facility of the District of Columbia regardless of whether such institution or facility is located within the District, any investigator or code inspector employed by the government of the District of Columbia, or any officer or employee of the Department of Youth Rehabilitation Services, Court Services and Offender Supervision Agency, the Social Services Division of the Superior Court, or Pretrial Services Agency charged with intake, assessment, or community supervision." D.C. Code § 22-405.

[71] In contrast, the current definition of "Metrorail station manager" requires that the person be a WMATA "employee", which would support a plain language reading that "for" WMATA is meant to be broader.

The bill proposes amending D.C. Code § 23-1322(c), the District's pretrial detention statute, to add a rebuttable presumption of future dangerousness when the defendant has a prior conviction for a crime of violence in cases where the person is charged with committing a new "crime of violence" as defined by D.C. Code § 23-1331(4). The stated purpose of this amendment is to: "Provide greater discretion for the Courts to determine who should be held pre-trial, including defendants previously convicted of a violent crime while they await trial for a new violent crime."[72]

The CCRC notes that: (1) judges unquestionably have discretion under current D.C. Code § 23-1322 to order the pretrial detention of all persons falling under the proposed presumption and the new presumption would not establish authority to hold any persons that cannot be held under current law; (2) judges are already required by statute to consider prior criminal history in making hold decisions and uniformly consider prior convictions for crimes of violence along with all other prior convictions in making detention decisions; (3) the proposed presumption will likely have the greatest impact in cases where the prior conviction is least likely to be probative of future dangerousness. If the Council chooses to enact a new presumption, the CCRC recommends that any new presumption based on prior convictions contain a temporal component to ensure the presumption is more rationally related to the question of whether any combination of conditions of release that could be imposed to ensure the safety of the community. Further, the CCRC recommends that any new presumption based on prior convictions be limited to prior convictions where the prior offense or the circumstances of the prior offense would have given rise to a presumption of future dangerousness under § 23-1322(c) if newly charged.

Proposed presumption

The proposed presumption would apply when a person is charged with a "crime of violence" and has a prior conviction for a "crime of violence." The term crime of violence is a defined term in D.C. Code § 23-1331(4).[73] The proposed presumption would apply categorically to all offenses included in the definition of "crime of violence" including those committed under circumstances that would not have previously given rise to a presumption of dangerousness. A categorical approach also means that the proposed presumption would apply irrespective of (1) the nature and facts of the newly charged offense or offense underlying the prior conviction including whether there was actual or threatened violence, and (2) the person's role in the newly charged offense or offense underlying the prior conviction. There is also no temporal component to the proposed presumption meaning that the preposed presumption would apply irrespective of the passage of time since the prior conviction and irrespective of the person's age at the time of conviction. Accordingly, the presumption would broadly establish the same presumption regarding

[72] *See* https://mayor.dc.gov/release/mayor-bowser-announces-new-safer-stronger-dc-legislation.

[73] Crime of violence "means aggravated assault; act of terrorism; arson; assault on a police officer (felony); assault with a dangerous weapon; assault with intent to kill, commit first degree sexual abuse, commit second degree sexual abuse, or commit child sexual abuse; assault with significant bodily injury; assault with intent to commit any other offense; burglary; carjacking; armed carjacking; child sexual abuse; cruelty to children in the first degree; extortion or blackmail accompanied by threats of violence; gang recruitment, participation, or retention by the use or threatened use of force, coercion, or intimidation; kidnapping; malicious disfigurement; manslaughter; manufacture or possession of a weapon of mass destruction; mayhem; murder; robbery; sexual abuse in the first, second, or third degrees; use, dissemination, or detonation of a weapon of mass destruction; or an attempt, solicitation, or conspiracy to commit any of the foregoing offenses." D.C. Code § 23-1331(4).

dangerousness for persons convicted of crimes drastically different in terms of seriousness, culpability, and record of rehabilitation.[74]

Current authority to detain based on prior criminal history

Presently, judges have the statutory authority to order pretrial detention of all persons covered by the proposed presumption. At a preventative detention hearing held pursuant to current D.C. Code § 23-1322, a presiding judge is required by statute to "determine whether any condition or combination of conditions set forth in § 23-1321(c) will reasonably assure the appearance of the person as required and the safety of any other person and the community."[75] If at the end of the hearing, "the judicial officer finds by clear and convincing evidence that no condition or combination of conditions will reasonably assure the appearance of the person as required, and the safety of any other person and the community, the judicial officer shall order that the person be detained before trial."[76]

In making the determination as to whether any combination of conditions will reasonably assure the safety of the community and the person's return to court, a judge is not only permitted but *required* by current law to consider evidence on the history and characteristics of the person charged. D.C. Code § 23-1322(e)(3)(A) has an enumerated list of things a just must consider specifically including "past conduct" and "criminal history".[77] In practice, prior criminal convictions, especially convictions for crimes of violence, are given substantial weight by judges and judges universally address the criminal history or lack of criminal history contained in the bail sheet in making detention decisions.[78] The D.C. Court of Appeals has also stated that prior criminal

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[74] For example, the proposed presumption would create the same presumption with respect to dangerousness for a person charged with armed carjacking less than one year after a conviction for robbery as it would for a person charged with second degree burglary more than thirty years after a conviction for felony assault.

[75] D.C. Code § 23-1322(b)(1).

[76] D.C. Code § 23-1322(b)(2).

[77] Current D.C. Code § 23-1322(e) reads:

> (e) The judicial officer shall, in determining whether there are conditions of release that will reasonably assure the appearance of the person as required and the safety of any other person and the community, take into account information available concerning:
>
> (1) The nature and circumstances of the offense charged, including whether the offense is a crime of violence or dangerous crime as these terms are defined in § 23-1331, or involves obstruction of justice as defined in § 22-722;
>
> (2) The weight of the evidence against the person;
>
> (3) The history and characteristics of the person, including:
>
> (A) The person's character, physical and mental condition, family ties, employment, financial resources, length of residence in the community, community ties, past conduct, history relating to drug or alcohol abuse, criminal history, and record concerning appearance at court proceedings; and
>
> (B) Whether, at the time of the current offense or arrest, the person was on probation, on parole, on supervised release, or on other release pending trial, sentencing, appeal, or completion of sentence for an offense under local, state, or federal law; and
>
> (4) The nature and seriousness of the danger to any person or the community that would be posed by the person's release.

[78] In every case, the Pretrial Services Agency produces what is known as a "bail sheet" listing, *inter alia*, any pending charges of the person, prior convictions, and bench warrant history. The bail sheet is always given to the judge for review at the detention hearing and is given substantial weight by judges.

history "must be given substantial weight" because of its importance to the question of future dangerousness.[79]

Although current § 23-1322(c) contains numerous statutory presumptions pertaining to the nature of the offense or a person's criminal history while on pretrial release, none of those presumptions are prerequisites to detention. Pursuant to current § 23-1322(b)(2), a judge presiding over a detention hearing has the discretion to order pretrial detention if, after taking into account all the evidence, the judge finds "by clear and convincing evidence that no condition or combination of conditions will reasonably assure the appearance of the person as required, and the safety of any other person and the community" regardless of whether a statutory presumption applies. In practice, persons with prior convictions for crimes of violence who are charged with a new crime of violence are held pending trial in many, if not most, cases and even misdemeanor or non-crime of violence convictions are relied upon by judges in hold decisions.[80] Therefore, the creation of the proposed presumption would not create discretion to detain any persons who are not already subject to pretrial detention under the current statute.

The role of the presumption in § 23-1322 detention hearings

To evaluate how the proposed presumption might affect detention hearings, it is also important to understand exactly what a presumption does and does not do. The existence of a presumption does not compel detention and, as noted above, the absence of a presumption does not compel release. In most serious cases, a presumption will make no difference in a detention decision because the facts and history of the person are such that the judge will detain the person with or without a presumption. Presumptions in cases with low-risk defendants, however, can tip the balance in favor of detention even where the presumption is of marginal predictive value.[81]

The current and proposed presumptions are rebuttable presumptions. As a matter of law, when the statutory rebuttable presumption is triggered, the presumption temporarily shifts a burden of *production* to the defense to rebut the presumption by offering some credible evidence contrary to the statutory presumption. Once some evidence is presented, the burden of *persuasion* is on the government to establish that despite the presumption being rebutted, clear and convincing evidence demonstrates that no conditions of release will reasonably assure the appearance of the person as required and the safety of any other person and the community. Even when the presumption is rebutted, the judge is supposed to consider the fact of the presumption along with the other

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[79] *See Pope v. United States*, 739 A.2d 819, 827 (D.C. 1999) (stating "A defendant's past conduct is important evidence—perhaps the most important—in predicting his probable future conduct. Substantial weight must therefore be accorded to the presence in (or absence from) the defendant's record of convictions of dangerous crimes or a history of violent conduct.") (internal citations omitted).

[80] It is also worth noting that the rearrest rate for persons released on pretrial supervision is very low. In 2022, the re-arrest rate in D.C. of person's released under pretrial supervision by the Pretrial Services Agency was 7%. *See* Pretrial Services Agency for the District of Columbia, *FY 2018-2022 – Fact Sheet-Arrest-Free Rates for DC Defendants Under Pretrial Supervision*, available at https://www.psa.gov/?q=FactsFigures. The target rate for Pretrial Services is 12% meaning that fewer people were rearrested than expected in 2022. The mid-year report for 2023 indicates that the re-arrest rate is even lower at 5%. *See* Pretrial Services Agency for the District of Columbia, *FY 2023 Mid-year Key Performance Indicators*, available at www.psa.gov.

[81] *See generally*, Amaryllis Austin, *The Presumption for Detention Statute's Relationship to Release Rates,* FED. PROBATION, September 2017.

statutory factors in D.C. Code § 23-1322(e) in determining whether there is any combination of conditions of release that would ensure the safety of the community.[82] As a matter of law, the critical question for preventative detention is not whether there is a presumption but whether the judge believes the evidence establishes that there are no conditions of release that will ensure the safety of a person or the community. Ultimately, a statutory presumption can be given as much weight as the judge deems appropriate.

Persons likely to be affected by the proposed presumption

There are currently eight presumptions in D.C. Code § 23-1322(c) with respect to future dangerousness. As noted, the proposed presumption would create a ninth paragraph in § 23-1322(c) to establish a presumption for persons charged with a crime of violence who have one or more previous convictions for a crime of violence. Due to substantial overlap between the proposed presumption and the existing presumptions, a large number of persons covered by the new proposed presumption will be covered by a presumption in existing law.

As an initial matter, current law already establishes presumptions for the most serious crimes of violence. For example, the first presumption in § 23-1322(c)(1) applies whenever a person is charged with a crime of violence while armed. This means the proposed presumption would establish a presumption that did not otherwise exist only for *unarmed* crimes of violence. Generally, though not always, unarmed crimes of violence are less serious and less probative of future dangerousness than armed crimes of violence. Several other presumptions are triggered based on the nature of circumstances of the charges. Many firearms offenses, including carrying a pistol without a license and felon in possession offenses, already trigger a presumption. Since all persons with prior convictions for crimes of violence charged with these firearms offenses and other enumerated offenses already fall within the § 23-1322(c) presumptions, the proposed presumption would have a lesser, or negligible, impact on those cases. Because presumptions already exist for some of the most serious cases, the proposed presumption's greatest impact would be seen in less serious cases or cases without aggravating factors.

Ultimately, the only persons who would be covered solely by the new presumption are those who (1) are charged with *unarmed* crimes of violence not otherwise covered by the statute based on the serious nature of the offense, and (2) have a prior conviction for a crime of violence that was not committed while on release pending trial. The cases arising where a presumption in current law does not already come into play will most often be cases with less serious charges where the person's prior conviction has no direct nexus to compliance with conditions of release. Consequently, the proposed presumptions most profound impact could be in cases where detention is less likely to be necessary to ensure the safety of the community.

[82] *Cf. In re D.R.J.,* 734 A.2d 162 (D.C. 1999) (discussing *United States v. Jessup*, 757 F.2d 378, 381 (1st Cir.1985) (Breyer, J.)).

Addition of temporal component

In federal law, there is an analogous "previous violator presumption" in the pretrial detention statute.[83] Similar to the proposed presumption, the federal "previous violator presumption" applies to prior convictions for certain offenses. Unlike the proposed presumption, however, the presumption has two additional requirements that must be established before a presumption is triggered. First, the federal previous violator presumption requires that the prior offense have been committed while on release pending trial.[84] Second, the federal previous violator presumption requires that a period of not more than five years has elapsed since the date of conviction, or the release of the person from imprisonment, whichever is later.[85]

Both current District law and the proposed bill are broader than the federal law with respect to the timing of the offense and convictions that the criteria. Like federal law, current District law creates a presumption for prior convictions for crimes of violence only when committed on release pending trial. Unlike federal law, however, neither current District law nor the proposed presumption contains a temporal requirement to establish a nexus between the past conviction and current or future dangerousness. This means that dated convictions where a person may have lived in the community without incident for years or even decades post release from supervision would establish a presumption of future dangerousness despite the fact that the person had an established track record of living in the community without incident post-conviction. This is true even when the past conviction did not involve actual violence. Such a case is in stark contrast to someone who may have been released from supervision recently (within months or a few years) and had already been rearrested for a new crime of violence.

If the Council proceeds with a new presumption for prior convictions, the Council may consider adding a temporal component linked to the date of conviction or release from imprisonment similar to the one in federal law to ensure that the new presumption has clear relationship to *future* dangerousness. A temporal component linked to the date of conviction or release from imprisonment would expand the scope of § 23-1322(c)(4) which does not currently cover offenses committed while under supervision post-conviction to cover such offense.[86] While this would constitute a smaller expansion than the proposed presumption, it would remove prior convictions that may be too attenuated in time to be truly probative of future dangerousness from the presumption. For the reasons explained above, this change would not impact a judge's obligation to consider dated prior convictions or authority to rely on them in finding future dangerousness in cases where the judge deems the prior convictions probative of future dangerousness despite the passage of time.

[83] 18 U.S.C. § 3142(e)(2).
[84] 18 U.S.C. § 3142(e)(2)(B).
[85] 18 U.S.C. § 3142(e)(2)(C).
[86] The maximum term of supervised release under D.C. Code § 24-403.01 is five years, or if applicable, the length of the sex offender registration period.

Other technical considerations

In § 501(b)(1)-(2), the proposed amendment deletes the word "or" and replaces it in the following paragraph with the word "and." Currently, the use of the word "or" makes the provisions in (b)(1)-(b)(8) alternative triggers of the presumption. The use of the word "and" here would mean that all nine of the triggers would have to be met to trigger the presumption, something unlikely to occur. The change from "or" to "and" thus appears unintentional.

GPS Data for Prosecution

The bill would add language stating that judges *shall* admit GPS data for the purposes of determining guilt. Under current law, judges already can admit such data. The DCCA has clearly held that data from a GPS monitor that is worn as a condition of probation, even when it is not specifically court ordered, is not an unreasonable search and is therefore admissible.[87]

The CCRC agrees the DCCA case law should be codified in statute, but the CCRC recommends that this provision be amended to state that GPS data *may* be admitted, as this is a more accurate description of current law, and avoids confusion in cases in which the data should *not* be admitted.

There may be situations in which a judge would still deem GPS data inadmissible. A judge could rule GPS data inadmissible if there were reliability concerns. In addition, under the law of evidence judges may deny admission of relevant evidence if unfair prejudicial effect substantially outweighs the relevance.[88] For example, if based on other evidence in the case, there is no question that the defendant was at the scene of the alleged crime, then the prejudicial effect of introducing GPS data may outweigh its probative value. For example, consider an assault case in which the defendant agrees that he was at the scene of the crime, but was acting in self defense. In that case as there is no dispute as to whether the defendant was at the scene of the alleged crime, the GPS data has limited probative value. In such a case, a trial judge could deem that admitting GPS data, which would inform the jury that the defendant was under supervision at the time would have an unfair prejudicial effect that substantially outweighs the minimal probative value.

These cases may be rare, and in most cases, the GPS data will be admissible. But the word "shall" may change current law or at least create a tension with evidence law, and create confusion for judges about when to admit the data.

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[87] *United States v. Jackson*, 214 A.3d 464, 467 (D.C. 2019).

[88] *Johnson v. United States*, 683 A.2d 1087, 1099 (D.C. 1996) (*en banc*) (adopting Federal Rule of Evidence 403, under which relevant evidence may be excluded if the danger of unfair prejudice substantially outweighs the probative value).

VI. Title VII. Updated Definition of "Significant Bodily Injury" to Include Strangulation

The current D.C. Code has three main assault offenses of increasing severity: 1) Simple assault, which can be satisfied by slight injury;[89] 2) Felony assault, which requires intermediate "significant bodily injury";[90] and 3) Aggravated assault, which requires the highest "serious bodily injury".[91]

The bill codifies a definition of "significant bodily injury" that includes: 1) injury from strangulation or suffocation;[92] 2) any loss of consciousness; and 3) For injuries other than strangulation, suffocation, or loss of consciousness, lowers the severity required under DCCA case law.

The RCCA also defined "significant bodily injury" to include injuries resulting from strangulation and suffocation, and brief loss of consciousness. The CCRC supports amending the provision in the bill to modify the definition of "significant bodily injury" in a similar fashion.

VI. Title XI. Incarceration Reduction Amendment Act

The bill proposes several changes to the Incarceration Reduction Act, (or "IRAA"). The CCRC included its own set of revisions to IRAA as part of the RCCA, and the CCRC still supports those

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[89] The current simple assault statute states "Whoever unlawfully assaults, or threatens another in a menacing manner, shall be fined not more than the amount set forth in § 22-3571.01 or be imprisoned not more than 180 days, or both." D.C. Code § 22-404(a)(1). An extensive body of District case law establishes the different types of prohibited conduct for an "assault", including unwanted touchings that do not result in pain or physical impairment. *See, e.g., Perez Hernandez v. United States*, 286 A.3d 990 (D.C. 20222) (rehearing en banc).
However, most relevant for this discussion, the District of Columbia Court of Appeals has stated "[i]t is firmly established in our case law that the injury resulting from or threatened by an assault may be extremely slight. There need be no physical pain, no bruises, no breaking of the skin, no loss of blood, no medical treatment." *Dunn v. United States*, 976 A.2d 217, 220 (D.C. 2009).

[90] The current felony assault statute states:

> "Whoever unlawfully assaults, or threatens another in a menacing manner, and intentionally, knowingly, or recklessly causes significant bodily injury to another shall be fined not more than the amount set forth in § 22-3571.01 or be imprisoned not more than 3 years, or both. For the purposes of this paragraph, the term "significant bodily injury" means an injury that requires hospitalization or immediate medical attention."

D.C. Code § 22-404(a)(2).

[91] The current aggravated assault statute states:

> (a) A person commits the offense of aggravated assault if:
> (1) By any means, that person knowingly or purposely causes serious bodily injury to another person; or
> (2) Under circumstances manifesting extreme indifference to human life, that person intentionally or knowingly engages in conduct which creates a grave risk of serious bodily injury to another person, and thereby causes serious bodily injury.
> (b) Any person convicted of aggravated assault shall be fined not more than the amount set forth in § 22-3571.01 or be imprisoned for not more than 10 years, or both.
> (c) Any person convicted of attempted aggravated assault shall be fined not more than the amount set forth in § 22-3571.01 or be imprisoned for not more than 5 years, or both.

D.C. Code § 22-404.01.
Ignoring mayhem/disfigurement

[92] The letter accompanying the bill states that the bill "enhances protections for domestic violence survivors with the creation of a felony offense of strangulation". It would be more accurate to say that the bill ensures that strangulation satisfies the existing felony assault offense.

changes. The changes to IRAA under the RCCA did not include the changes proposed under this bill, and CCRC opposes changing IRAA as proposed under the bill.

As we understand, the goal of the changes to IRAA are intended to increase judicial discretion in both *whether* to modify a sentence, and *which types of information* the judge may consider in making IRAA determinations. However, under current law, judges already have immense discretion both as to whether to grant applications, and what types of information they may consider. The current IRAA statute lists factors that judges must consider when reviewing IRAA applications, and includes a catch-all provision directing judges to consider "*[a]ny other information* the court deems relevant to its decision."[93] Even when judges do decide that a sentence should be modified, they also have complete discretion to determine *how and to what degree* the sentence should be modified.

Therefore, it does not appear that the proposed changes to IRAA meaningfully increase judicial discretion, and may lead to increased confusion.

"May" vs. "Shall"

Under current law, if a judge finds that the applicant does not pose a danger to any person and that the interests of justice warrant a sentence modification, then the judge *shall* modify the applicant's sentence.[94] The bill would change the word "shall" to "may." However, this only arises *if judges first find that the applicant is not a danger to any person and the interest of justice* warrant a modification. Under current law, judges have complete discretion to find that an applicant is a danger to another person or that the interests of justice do *not* warrant a sentence modification, and reject the IRAA application. It would be bizarre, and under the terms of the statute *unjust* for a judge to decline to modify a sentence when they have already found the interest of justice warrant a modification.

The use of the word "may" could also create confusion. The IRAA statute provides detailed guidance as to factors judges should consider in determining whether the interests of justice warrant a sentence modification. However, under this revision, there is no guidance as to whether a judge, having made that finding, should actually modify a sentence.

Because this revision does not meaningfully increase judicial discretion, but does create the possibility for confusion, the CCRC recommends retaining the current language.

Nature of the Offense

The bill would change the IRAA statute to allow judges to consider the nature of the offense when making their determinations. However, under the catch-all provision under current law judges are already permitted to consider the nature of the offense. Under current law, it is very common in IRAA applications for the government to raise the nature of the offense as a relevant factor, and that judges take it into account. This change is unnecessary in order to allow judges to consider this information.

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[93] D.C. Code § 24-403.03 (c)(11).
[94] D.C. Code § 24-403.03 (a)(2).

Although judges may already consider the nature of the offense, changing the statute to include it as an enumerated factor could signal to judges that the nature of the offense should be given larger importance than under current law.

Omitting "brutal or cold blooded nature" of the Offense

Under current law, a factor judges must consider is the "[t]he diminished culpability of juveniles and persons under age 25" . . . "despite the brutality or cold-blooded nature of any particular crime[.]"[95] The bill would remove this "brutality or cold-blooded nature" language. In drafting the IRAA statute, the Council did not come up with this language on its own; rather this language is taken from the Supreme Court's opinion in *Roper v. Simmons*, in which the court held that the death penalty could not be imposed for crimes committed while the defendant was a minor.[96] The Court stated that "[a]n unacceptable likelihood exists that the brutality or cold-blooded nature of any particular crime would overpower mitigating arguments based on youth [.]"[97]. The Court recognized that due to human emotion and biases, the brutality or cold-blooded nature of the offense could lead judges to inappropriately disregard the diminished culpability of youth. The current statute adopts the wisdom articulated by the Court and provides guidance to judges that allows them to exercise their discretion.

This is particularly important, because due to the 15 year minimum requirement before eligibility, most IRAA applicants will have been convicted of brutal offenses, such as forms of homicide. Changing the statute may indicate to judges that their discretion should be limited to cases in which the offense was *not* brutal or cold-blooded, and that despite an applicants' rehabilitation, that they should not modify a sentence in such cases.

Adding "Remorse" as a factor

Under current law, judges are guided to consider whether the IRAA applicant is not a danger to the safety of any person or the community and that the interests of justice warrant a sentence modification. The bill would add as a factor whether the applicant expresses "remorse." Under current law, judges already can and do consider remorse in deciding whether an applicant is a danger to the community and if the interests of justice warrant modification.

However, adding remorse as an independent factor, apart from how it relates to rehabilitation, may create significant problems in some cases. Some IRAA applicants may claim actual innocence, and these applicants would express *no remorse*. Other applicants may have been convicted under unduly harsh laws in effect at the time of their trials. One rationale for IRAA is that attitudes change, and what may have been considered a just sentence at the time it was imposed will no longer be considered just decades into the future. For example, some IRAA applicants have been convicted of first degree murder under the felony murder doctrine, even when the government concedes that they did not kill anyone, know anyone would be killed, or

[95] D.C. Code § 24-403.03 (c)(10).
[96] *Roper v. Simmons*, 543 U.S. 551 (2005).
[97] *Id.* at 573.

help anyone kill anyone. In these cases, an applicants may feel a degree or remorse, though not remorse typically commensurate with the offense of which they were convicted.

Community Impact Statements

The bill would allow judges to consider community impact statements. Under current law, judges already can take community impact statements into account, though it's unclear how often community impact statements are actually offered.

This revision to the bill creates the potential for confusion. The bill cites to DC Code statute that governs community impact statements at *sentencing*.[98] The term "community" is defined as "a formal or informal association or group of people living, working, or attending school in the same place or neighborhood and sharing common interests arising from social, business, religious, governmental, scholastic, or recreational associations."[99] A member of a community affected by a crime can introduce a statement for consideration by a sentencing judge. In those cases, the offense would've occurred fairly recently; for example a person who attends school where a crime was committed could submit a community impact statement on behalf of the school as a "community."

In the context of IRAA applications, it may be less clear who constitutes a member of a community affected by a crime. IRAA applicants are required to serve at least 15 years of their sentence before they are eligible to apply. Given passage of time between the offense and conviction and time needed to prepare an IRAA application, many applications will be made nearly 20 years or more after the original offense. If a crime is committed at a school, can a school official who wasn't even employed at the time of the offense still submit a community impact statement on behalf of the school? If the Committee wishes to include community impact statements as a factor in IRAA cases, the Committee should consider clarifying who constitutes a member of the community given the lengthy passage of time.

This concludes my testimony, and I am happy to answer any questions you may have.

[98] D.C. Code § 23-1904 (f)(1).
[99] D.C. Code § 23-1905 (1).

The proposed Safer Stronger Amendment Act of 2023 is a reinvigoration of the 1990s era racialized characterization of marginalized youth and particularly black and Latino youth as "super predators."

Extended sentencing before trial is race baiting and fear mongering and has long been proven incontrovertibly ineffective. It is predestined to make our nation's capital more unsafe.

The Washington Interfaith Network and the District citizens and faith leaders who support its community Public Safety and Black Equity Through Homeownership campaigns, stand in solidarity against measures such as the proposed Safer Stronger Amendment Act of 2023. It creates another systemic barrier to prosperity and social well-being for the District's most vulnerable citizens; its youth.

Evidence-based research clearly demonstrates that investment in youth programs and supports prevent crime. Diversion programs, prohibiting incarceration and detention for low level offenses, increased wrap-around programs, investment in out-of-school time programs and supporting expanded summer youth employment, as well as LIMITING not extending pretrial detention, serve to prevent crime and are measures that rehabilitate our youth.

Measures like the proposed Safer Stronger Amendment Act of 2023 are not only destined to fail but predestine many youth to a life of crime or social and economic instability. In its 2023 report "Why Youth Incarceration Fails: An Updated Review of The Evidence, Richard Mendel of the Sentencing Project posits succinctly "incarceration undermines public safety, damages youth physical and mental health, impedes their educational and career success, and often exposes youth to abuse. Moreover, "youth incarceration is plagued by racial and ethnic disparities."

The evidence is overwhelming. The Safer Stronger Amendment Act of 2023 will fail. The proposed outcomes of public safety and welfare will not be achieved.

The District's leaders need only look towards concrete measures that have already been proposed such as The Strategic Gun Violence Reduction Plan which proposes investing in the 300 youth the city has already identified as offenders.

Why are the leaders of the District proposing and supporting legislation that will clearly achieve an outcome that will increase crime rather than reduce it?

Renowned justice advocate, Bryan Stevenson of the Equal Justice Initiative, has successfully demonstrated mass incarceration (of black youth in particular) over the course of two centuries is nothing more than a progressive evolution from legal enslavement to a new form of slavery of black youth, and black men and women, by subjugation through mass incarceration.

The choice District leaders must make is clear. Will the District of Columbia, our nation's capital, invest in youth or endorse and authorize a systemic measure that perpetuates this nation's legacy of institutionalized enslavement and oppression of black youth?

The District of Columbia must take a stand beyond creation of a plaza dedicated to Black lives and demonstrate through effective policies of prevention and rehabilitation that it truly believes that black youth and their lives matter.

Thank you for your attention.

Sincerely,

Celeste M. Bryant, MSW

Co-Chair Black Equity Through Homeownership (BETH) campaign of the Washington Interfaith Network and Strategy Team Board Member

Co leader of WIN Social Justice at Metropolitan AME Church in Ward 2

Testimony of Santha Sonenberg

June 27, 2023

Prepared for the

PUBLIC HEARING ON

BILL 25-291, "THE SAFER STRONGER AMENDMENT ACT OF 2023

COUNCILMEMBER BROOKE PINTO, CHAIRPERSON
COMMITTEE ON THE JUDICIARY AND PUBLIC SAFETY
John A. Wilson Building
1350 Pennsylvania Avenue, N.W.
Washington, D.C. 20004

I am Santha Sonenberg, a resident of Ward Three, and a 43-year resident of D.C. I am a 1979 graduate of Wesleyan University and a 1983 graduate of Georgetown University Law Center, and have spent 40 years in D.C. practicing criminal law in the local and federal courts, including for more than two years as Chief of the Juvenile Section at OAG, as an Attorney Advisor at the United States Department of Justice's (hereinafter "DOJ's") Office of the Pardon Attorney, as an Assistant Federal Public Defender for most of the 1990's, and at the Public Defender Service for an aggregate of more than twenty years (during most of the 1980's and from 1998 through 2015), where, among other positions, I was Chief of the Trial Division. I have been both a visiting and an adjunct professor during two different tenures at the Georgetown University Criminal Justice Clinic and E. Barrett Prettyman Graduate Program, and in recent years have handled, and supervised a number of IRAA cases. For the past five years I have also taught trial advocacy at Harvard Law School. I am Vice President of the Board of the Sentencing Project and also am a survivor of violent crime.

As both a Ward Three resident and as someone versed in issues of adolescent brain development, and sentencing I strongly urge the Council to reject the proposed amendments to the IRAA and to the juvenile detention statute.

Proposed Amendments to the IRAA Statute

The proposed amendments to the IRAA statute should be rejected for several reasons:

First, they ignore the data regarding the successful, indeed, impressive, transition of so many, many IRAA recipients serving their communities and living peacefully with their loved ones – a number of whom I have been privileged to represent or in whose cases I have been privileged to be directly involved. These IRAA recipients are mature adults who have overcome significant challenges and contribute to our communities as changemakers, business owners, dedicated employees, devoted fathers, violence interrupters, and vibrant community members who make the District of Columbia a better place in which to live and work, and a better place to visit. The amendments would ignore data regarding the tremendous successes of IRAA in its current form.

Second, science supports maintaining IRAA in its current form. Over the last 20 years I have presented in various national and international settings on IRAA-related issues, namely adolescent brain development and mitigation at sentencing, including at the DOJ's Indigent Defense Symposium in 2010, the Annual Forensic Science Conference regarding issues in D.C. Superior Court, also in 2010, and the International Academy on Law and Mental Health in Rome in 2019. As much as a non-scientist can, I have developed an expertise in the substantive bases for what scientists, doctors and the U.S. Supreme Court have recognized about youth development. Adoption of the amendments would ignore that well-founded and substantiated science. Specifically, as the Supreme Court repeatedly has recognized, young people – which as we now know includes those under 25 1) are more impulsive due to the fact that the pre-frontal cortex of the brain, responsible for executive functioning and forethought, is the last to develop, and that before that the amygdala, or emotional portion of the brain, is paramount; 2) are more susceptible to peer pressure, resulting in doing things in a group and with others, that they otherwise would not do; and

3) most importantly, have a capacity for change is greater than that of full-fledged adults,[1] hence the expression, "you can't teach an old dog new tricks." But you CAN teach young people new tricks, and certainly none of us are the same people at 40, 45, or 65, that we were when we were 18, 20 or 25.

In contrast, the proposed amendments are born of fear and false narratives and address concerns that do not exist, and the issues on which they touch are more than adequately addressed in the current IRAA. The current IRAA process is equitable and very deliberative. It is an extremely labor-intensive process that allows the voices of all affected to be heard and provides judges with wide discretion within the bounds of fairness and the law. Turning briefly to the five proposed amendments:

Reverting from "shall" to "may" to describe when an IRAA petition ought to be granted encourages arbitrary decision-making and bias and ignores that the eleven factors a judge is required to consider, in determining that an individual is not a danger and that the interests of justice warrant a reduction in sentence, already significantly circumscribe how a judicial determination is to be made. This is especially true since judicial discretion is already "baked into" the existing IRAA through enumeration of the eleven factors, particularly the "catch-all" 11th factor, *i.e.*, "any other information the court deems relevant to its decision."

Regarding the "nature of the offense" the Council already has rejected a proposal made in 2020 that it be an enumerated factor, acknowledging that consideration of that as a factor only exacerbates the racial injustice of the criminal legal system where 98% of incarcerated emerging adults are Black. Additionally, a focus on the nature of the offense ignores both that anyone who received a sentence such that they have served 15 years necessarily was convicted of an extremely

[1] *Roper v. Simmons*, 543 U.S. 551, 569-570 (2005). *See also*, *Miller v. Alabama*, 567 U.S. 460, 471 (2012); *Graham v. Florida*, 560 U.S. 48, 68 (2010)

serious offense and ignores the importance of rehabilitation and the brain development of young people I previously referenced. In the words of the Supreme Court, "an unacceptable likelihood exists that the brutality or cold-blooded nature of any particular crime would overpower mitigating arguments based on youth as a matter of course."[2]

Adding "remorse" as a factor is wholly improper as it would penalize those who exercise their constitutional right to assert their innocence and flies in the face of the fact that were this to be a requirement, 15 of the 21 D.C. exonerees on the National Registry of Exonerations would have been precluded from petitioning for relief under IRAA.

Finally, adding community impact statements is unwarranted and ill-advised because there is a diversity of opinions and many of the community voices are those of recent arrivals to this jurisdiction. It is unreasonable and unjust to prioritize their views over the views of those who were present when the offenses were committed and who were directly impacted. Including community impact statements as an IRAA factor would not represent a true reflection of the impact of a specific offense and would threaten to become a distraction since so many different people are impacted by incarceration -- including the families of both the IRAA petitioner and the complainants/decedents. I also can attest to the positive support given by two complainants in a violent case I handled, both as the original attorney and as the IRAA counsel. The complainants in that case provided resoundingly strong support for granting the IRAA petition. Indeed, they were appalled at how long my client had served incarcerated and recounted all that had transpired in their lives in the intervening nearly two decades, while he was -- in their words – in a cage. So strong was their support of my client, that they offered to assist him transitioning back to the community upon his release. The words of those directly impacted are entirely different than allowing the community at large to weigh in.

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[2] *Roper v. Simmons*, *supra*, 543 U.S. at 573. *See also*, *Graham v. Florida*, *supra*, 560 U.S at 78.

Proposed Amendments to the Juvenile Detention IRAA Statute

The proposed amendments to the juvenile detention statute should be rejected for several reasons:

At the outset, it is critical to appreciate the nature of offenses charged in juvenile court and how minor they can be. For example, a child who takes another's backpack on the school playground can be charged with robbery. The efficacy of mediation and restorative justice for transgressions by young people generally far outweighs anything offered by prosecution.[3] Not only does it prevent the damage done to the violator by prosecution, but it heals and teaches both the transgressor about empathy and the person harmed about forgiveness.[4] In so doing it also reduces the risk of retaliatory behavior, thereby serving as a preventative measure against additional illegal behavior.

Moreover, it is also essential to understand the profound and devastating effects even a single day in juvenile detention has on a young person. The ramifications for a minor are immense and long-lasting.[5] It is a fallacy to suggest that detention of a minor is for the child's "own good,"

---

[3] William Haft, *More Than Zero: The Cost of Zero Tolerance and the Case for Restorative Justice in Schools*, 77 DENV. U. L.REV. 795, 808 (2000) (there is some evidence indicating that "recidivism rates are lower for juveniles whose offenses are addressed through victim-offender mediation than through the traditional juvenile justice system" and "[t]he benefits to victims are equally important"); Maggie Gertz, *The Road Less Traveled: Using ADR to Help Reform First-Time Juvenile Offenders*, 8 CARDOZO J. CONFLICT RESOL. 339, 368-369 (Fall, 2006) ("Adopting mediation and other alternative dispute resolution techniques within the juvenile justice system as an alternative to incarceration will create a secure future and help eliminate a great proportion of the criminal element from society. The time has come to abandon the old paradigm and embrace a new one. If politicians and communities alike would acknowledge that punitive measures do not provide children with appropriate opportunities for their future success, then they will see that punishment of low-level juvenile offenders is not the answer and, in effect, accomplishes just the opposite.")

[4] William Haft, *More Than Zero: The Cost of Zero Tolerance and the Case for Restorative Justice in Schools*, *supra*, 77 DENV. U. L.REV. at 804-805 ("Retributive responses often repress and isolate, not only the offender, but also the victim and the surrounding community . . . [T]he restorative paradigm for justice is oriented to the victim and to the community as well.")

[5] Rebecca Stark, *Children Behind Bars: A Path to Reducing Pre-Adjudicative Detention in the Juvenile Justice System*, 35 J. CIV. RTS. & ECON. DEV. 149, 153 (Winter, 2022) ("pre-trial detention of young

when the damage done to a youngster is so severe. To amend the statute to allow detention of a minor for her/his "own good," is to turn back the clock to a bygone era in the District's handling of juvenile offenders and to further damage youngsters already in a fragile state, thereby increasing the likelihood of recidivism. I practiced in that bygone era and can attest to recently having seen a former juvenile client of mine from the 1980's as a middle-aged man being held at the D.C. Detention Center. Clearly going back to past times is not in the interest of the community nor is it in the interest of youth who engage in illegal behavior.

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offenders -- even when necessary -- is exceedingly harmful to those young offenders. The harms reach nearly every aspect of that juvenile's life and can have lasting effects. Specifically, '[p]retrial detention impedes the exercise of children's due process rights, negatively impacts their physical and mental health, and leads to social [and economic] effects that last their entire lives.'") (citations omitted)

The Honorable Brooke Pinto, Chairwoman
Committee on the Judiciary
Council of the District of Columbia

Hearing on B25-291, the Safer Stronger Amendment Act of 2023

Statement for the Record
Kristy Love
Executive Director
Criminal Justice Coordinating Council

Tuesday, June 27, 2023

Chairwoman Pinto and members of the committee, I am pleased to submit a statement for the record regarding Title IX of B25-291, the Safer Stronger Amendment Act of 2023. If enacted, the legislation would require the CJCC to report quarterly on criminal justice programs, processes and outcomes, including those pertaining to diversion, alternative dispositions and sentencing agreements.

CJCC is an independent agency that serves as a forum for identifying challenges and generating solutions to enhance public safety and the fair administration of justice in the District of Columbia. CJCC's Executive Director and staff work on behalf of our 19 members, who represent the executive, legislative and judicial branches of both the District and federal governments. Our members have identified four priority areas on which to focus the CJCC's efforts. They include: (1) Violent Crime; (2) Juvenile Justice; (3) Substance Abuse and Mental Health; and (4) Adult Reentry. CJCC staff support our members in accomplishing their goals through our four core functions: (1) automated information sharing; (2) research and analysis; (3) interagency collaboration; and (4) training and technical assistance.

With respect to research and analysis, CJCC is the home of the District's Statistical Analysis Center (SAC), whose primary functions, per Mayor's Orders 2001-58 and 2004-45, include "collect and analyze data in support of public policy to include, but not limited to, public safety, criminal justice, and corrections statistics." The SAC consists of five staff—two statisticians, one data scientist, and two policy and research analysts—who have extensive experience conducting research and analysis to inform public policy decision-making. On average, the SAC generates more than 150 research and analytical products each year. The products range from monthly updates on trends with respect to violent crime, juvenile justice and the District's detained population, to more extensive research on topics such as risk factors that increase the likelihood of juvenile justice system involvement and outcomes for those sentenced under the Youth Rehabilitation Amendment Act.

The CJCC also launched the Justice Statistical Analysis Tool (JSAT) (dcjsat.net) in 2018, which is a one-stop-shop for justice system stakeholders, as well as the public, for information on trends at each stage of the justice system. CJCC is in the process of transitioning JSAT to the cloud to increase functionality and enhance the user experience.

In May 2023, the National Institute of Corrections, an agency within the US Department of Justice, issued the National Standards for Criminal Justice Coordinating Councils, which provides a comprehensive framework for the formation and ongoing management of CJCCs across the country. Standard 10 pertains to Data and Research and calls upon CJCCs to: (1) establish data metrics that track system performance and strategic goals and (2) at minimum, produce annually a system performance report that informs the community. The National Institute of Corrections also generated guidance regarding Evidence-Based Decision Making, which is a disciplined approach to using data and research to inform and guide decision-making across the justice system. An essential component of evidence-based decision-making is to establish a criminal justice system collaborative, such as a CJCC, and for that collaborative to track performance metrics across the 13 key decision points in the justice system: (1) Arrest; (2) Pretrial status; (3) Diversion and deferred prosecution; (4) Charging; (5) Plea decisions; (6) Sentencing; (7) Institutional interventions; (8) Institutional/parole release; (9) Reentry planning; (10) Probation and parole; (11) Community behavior change interventions; (12) Noncompliance response; and (3) Jail and prison discharge.

While the CJCC has made great strides in providing timely and relevant research and analysis on criminal justice issues, we are always seeking opportunities to enhance the utility of our evaluative efforts; and to do so in a way that meets and exceeds national standards and best practices. We believe that reporting on metrics regarding diversions, alternative dispositions, and sentencing agreements, as called for in the proposed legislation, as well as other key decision points in the justice system is in keeping national standards for CJCCs and evidence-based decision-making. We look forward to working with our CJCC members to craft meaningful justice system performance metrics, and any accompanying data sharing protocols, to help ensure that our justice system is, in fact, enhancing public safety while also being fair to victims and justice-involved persons.

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Testimony Before the District of Columbia Council
Committee on the Judiciary and Public Safety
June 27, 2023

Public Hearing:
Bill 25-291, the Safer Stronger Amendment Act of 2023

Danielle Robinette
Policy Analyst
Children's Law Center

Introduction

Good afternoon, Chairwoman Pinto, members of the Committee, and staff. My name is Danielle Robinette, and I am a policy analyst at Children's Law Center. I am testifying today on behalf of Children's Law Center which believes every child should grow up with a strong foundation of family, health and education and live in a world free from poverty, trauma, racism and other forms of oppression. Our more than 100 staff – together with DC children and families, community partners and pro bono attorneys – use the law to solve children's urgent problems today and improve the systems that will affect their lives tomorrow. Since our founding in 1996, we have reached more than 50,000 children and families directly and multiplied our impact by advocating for city-wide solutions that benefit hundreds of thousands more.

In our *Guardian Ad Litem* (GAL) program, Children's Law Center attorneys are appointed by DC Superior Court judges to represent District children who have open neglect proceedings in family court. We make sure their perspectives and wishes are heard and their best interests are prioritized. Our representation includes advocating for the supports and services children need to heal from the traumas that brought them into the child welfare system and to leave the foster care system safe, healthy and learning. Our GALs are appointed "'to appear on behalf of the child and represent [their] best interests' in any proceeding 'wherein the custody of a child is in question.'"[1] Our

comments are grounded in the experiences of our attorneys and clients who navigate the court system every day.

First, we support the proposed expansion of protections for students who may be abused by adults at school. However, we have serious concerns about the proposed expansion of pretrial detention of children, ostensibly for their own protection. We find it difficult to imagine a set of circumstances in which incarceration is in a child's best interest, especially given the serious risk of harm that pretrial detention poses to children. Instead, we strongly urge the Council to support children and youth in the juvenile justice system through meaningful investments in DC's public behavioral health system.

Support for Expanded Protections for Schoolchildren

Children's Law Center supports the addition of contractors, consultants, and volunteers to the definition of "significant relationship" in DC Code § 22-3001(10)(D) and to the list of persons with authority over secondary education students while at school in DC Code § 22-3009.03.[2] This amendment recognizes that schools may solicit contractors, consultants, and/or volunteers who are on campus and interact closely with students. A student's relationship with and trust in these adults is not meaningfully different simply because the adult is not directly employed by the school. As such, these individuals may develop significant relationships with students comparable to teachers, counselors, coaches, etc. and, in rare cases, may use their positional power to coerce and abuse students. These amendments to the law will ensure that any adult working or

volunteering at a school, regardless of their employer, can be held accountable for any inappropriate action taken against students.

Opposition to Incarcerating Children for Their Own Protection

Under current law, a child shall not be placed in pretrial detention unless a judge determines that the child poses a risk of significant harm to the person or property of others, or if there is reason to believe the child will not appear at their next court hearing.[3] The Safer Stronger Amendment Act of 2023 proposes adding language to DC Code § 16-2310(a)(1) that would find pretrial detention of a child is required to protect that child from significant harm.[4] Children's Law Center opposes this addition to the Code.

As introduced, the new language at § 16-2310(a)(1) imagines a situation in which pretrial detention of a child is required to protect that child despite no finding that the child poses a significant risk to the person or property of others.[5] In such a scenario, the judge is asked to order pretrial detention for the child's own good. As an organization with nearly three decades of experience representing the best interests of children with unique and complex needs, it is difficult for us to imagine a set of circumstances in which incarceration is in a child's best interest. At best, this provision is an unnecessary addition to the Code that judges may never find appropriate to use. At worst, it creates a slippery slope upon which judges feel an obligation to detain children even when they pose no significant risk to the community. The latter result is particularly worrying given the evidence that pretrial juvenile detention has a criminogenic effect on children. One study

found that "pretrial detention was associated with a 33% increase in felony recidivism and 11% increase in misdemeanor recidivism within one year."[6] Another study found that "juvenile detention significantly harms critical outcomes [… and] leads to a 31% decline in the probability of high school graduation, and a 25% increase in the probability of an adult arrest."[7] For these reasons, Children's Law Center opposes the legislation's proposed addition of "or of the child" to DC Code § 16-2310(a)(1). Instead, we strongly urge the Council to consider alternative methods of supporting DC children by meeting their behavioral health needs.

Support Children and Youth in the Juvenile Justice System through Meaningful Investments in DC's Public Behavioral Health System

If the District's goal is to protect children from harm, there are myriad supports that ought to be explored before incarceration is considered. In December 2021, Children's Law Center, alongside community-based partners and healthcare experts, published *A Path Forward – Transforming the Public Behavioral Health System for Children, Youth, and their Families in the District of Columbia* ("*A Path Forward*") (*see* Appendix). This extensive report makes dozens of recommendations for transforming DC's public behavioral health system for children into a system that provides appropriate, equitable, and high-quality behavioral health services throughout the continuum of care for children in DC.[8] Specifically, *A Path Forward* makes four recommendations to better support youth in the juvenile justice system:

- Increase access to affordable, high-quality behavioral health services and social service supports for justice-involved youth and their families[9];
- Ensure continuity of behavioral health services and supports upon reentry into the community[10];
- Implement training to individuals and organizations working with at-risk and justice involved youth[11]; and,
- Increase peer support and mentoring opportunities for justice-involved youth.[12]

Each of these recommendations is "informed by best practices around the country, feedback, and input from expert stakeholders across the District and focus groups conducted with District youth and caregivers."[13]

Additionally, the report makes several recommendations that would bolster DC's behavioral health system as a whole and support children before they become involved in the juvenile justice system. Below are just a few of the recommendations for DC government agencies and the DC Council which could better protect and support children in their communities:

- Prioritize and support the development of a sustainable data system that routinely captures and analyzes data on prevalence, incidence, severity, risk factors, social determinants, functional outcomes, and access to care for behavioral health conditions[14];
- Develop an updated strategic plan for children's behavioral health[15];
- Establish an Interagency Council on Behavioral Health that aligns with the Collaborative Governance Model[16]; and,
- Adequately fund the School-Based Behavioral Health (SBBH) Expansion Program.[17]

Children's Law Center believes that "[c]hildren flourish when they receive the right behavioral health care at the right time."[18] If the goal of the suggested addition of "or of

the child" to DC Code § 16-2310(a)(1) is to protect children from potential harm, we strongly urge the Council and the relevant executive agencies to focus instead on reforming DC's public behavioral health system to better meet the needs of children and families. Our team and partners stand ready to support these efforts, which are as complex as they are critical. We appreciate the efforts the Council has made to start the systemic change

Thank you for this opportunity to testify and I welcome any questions.

[1] Superior Court of the District of Columbia, "Practice Standards for Guardians ad Litem in Custody and Related Consolidated Cases," at 1, *available at*: https://www.dccourts.gov/sites/default/files/2017-09/Order14-01-GALPracticeStandards.pdf (citing D.C. Code § 16-918(b)).
[2] *See* Safer Stronger Amendment Act of 2023 (as introduced) at line 84-90, *available at*: https://lims.dccouncil.gov/downloads/LIMS/53020/Introduction/B25-0291-Introduction.pdf?Id=161560.
[3] *See* DC Code § 16-2310(a)(1)-(2).
[4] *See* Safer Stronger Amendment Act of 2023 (as introduced), *supra* note 4, at line 91-96.
[5] *See id.*, at lines 95-96.
[6] Sarah Cusworth Walker & Jerald R. Herting, "The Impact of Pretrial Juvenile Detention on 12-Month Recidivism," 66 Crime & Delinquency 1865, 1865 (2020), *available at*: https://journals.sagepub.com/doi/pdf/10.1177/0011128720926115
[7] E. Jason Baron, et al., National Bureau of Economic Research, "Pretrial Juvenile Detention" (Working Paper 29861), at 20, *available at*: https://www.nber.org/system/files/working_papers/w29861/w29861.pdf
[8] *A Path Forward – Transforming the Public Behavioral Health System for Children and their Families in the District*, at 21, (December 2021), *available at*: https://childrenslawcenter.org/wp-content/uploads/2021/12/BHSystemTransformation_Final_121321.pdf. This report is released by Children's Law Center, Children's National Hospital, the District of Columbia Behavioral Health Association, Health Alliance Network, Early Childhood Innovation Network, MedStar Georgetown University Hospital Division of Child and Adolescent Psychiatry, Parent Watch, and Total Family Care Coalition.
[9] *Id.*, at 176.
[10] *Id.*, at 177.
[11] *Id.*, at 178.
[12] *Id.*
[13] *Id.*, at 11.
[14] *Id.*, at 40.
[15] *Id.*, at 41.
[16] *Id.*
[17] *Id.*, at 66.
[18] *Id.*, at 11.

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APPENDIX

Report:
A Path Forward – Transforming the Public Behavioral Health System for Children, Youth, and their Families in the District of Columbia

A Path Forward

Transforming the Public Behavioral Health System for Children, Youth, and their Families in the District of Columbia

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Children's National

DISTRICT OF COLUMBIA BEHAVIORAL HEALTH ASSOCIATION

EARLY CHILDHOOD Innovation Network

HEALTH ALLIANCE NETWORK

MedStar Georgetown University Hospital Division of Child and Adolescent Psychiatry

PARENT WATCH

Total Family Care Coalition

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Special thanks to Alyssa Khan (CLC) for her leadership in drafting the report. Thank you also to Shaakira Parker (CNH), Jennifer Salach (CLC), Alana Aronin (CNH), Samantha Hamburger (CNH) and Leah Castelaz (CLC) for significant research, writing, and editing contributions. Thank you to Tami Weerasingha-Cote (CLC), Olivia Soutullo (CNH), and Julia DeAngelo (CNH) for their initial outlining and identifying references for the report.

We would also like to thank Sharra E. Greer (CLC), Sarah Barclay Hoffman (CNH and ECIN), Mark LeVota (DCBHA), Jenise "Jo" Patterson (Parent Watch and ECIN), and Gail Avent (TFCC and ECIN) for their thought leadership and editing contributions to this report. We also acknowledge with gratitude contributions from Lee Beers (CNH and ECIN), Matt Biel (MGUH and ECIN), and Ambrose Lane Jr. (Health Alliance Network and ECIN).

We are extremely grateful for the youth, parents, and caregivers who participated in the family engagement focus groups. Thank you to Gail Avent (TFCC) in collaboration with the Children's Law Center and Parent Watch for the work done to coordinate and facilitate the focus groups.

Finally, we want to thank the many public and private stakeholders, who strengthened the report through their input, review, and feedback on this report.

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List of Acronyms

A-CRA	Adolescent Community Reinforcement Approach
ACE	Adverse Childhood Experiences
ACRA	Adolescent Community Reinforcement Approach
ACT	Assertive Community Treatment
ADD/ADHD	Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder
AHRQ	Agency for Healthcare Research and Quality
ASD	Autism Spectrum Disorder
ASL	American Sign Language
ASTEP	Adolescent Substance Abuse Treatment
BHIS	Behavioral Health Information System
BHO	Behavioral Health Organizations
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CARES Act	Coronavirus Aid, Relief, and Economic Security Act
CBI	Community Based Intervention
CBO	Community-Based Organizations
CCBHC	Certified Community Behavioral Health Clinics
CCPEP	Children's Comprehensive Psychiatric Emergency Program
CDC	The Centers for Disease Control and Prevention
CEHRT	Certified Electronic Health Record Technology
CFR	Code of Federal Regulations
CFSA	Child and Family Services Agency
ChAMPS	Child and Adolescent Mobile Psychiatric Service
CHIP	Children's Health Insurance Program
CHW	Community Health Workers
CJCC	Criminal Justice Coordinating Council
CMS	Centers for Medicare and Medicaid Services
CoCM	Collaborative Care Management
CoP	Community of Practice
CoRIE	Community Resource Information Exchange
CPP	Child Parent Psychotherapy
CRISP	Chesapeake Regional Information System for our Patients
CSA	Core Service Agency
CSS	Court Social Services
CYSHCN	National Care Coordination Standards for Children and Youth with Special Health Care Needs
DBH	Department of Behavioral Health
DBHIDS	Philadelphia's Department of Behavioral Health and Intellectual Disabilities Services

DC	District of Columbia
DC Health	Department of Health
DC MAP	District of Columbia Mental Health Access in Pediatrics
DC SEED	District of Columbia Social, Emotional and Early Development
DC:0-5	The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood
DCHA	DC Hospital Association
DCMR	District of Columbia Municipal Regulations
DCPCA	DC Primary Care Association
DCPS	DC Public Schools
DHCF	Department of Health Care Finance
DHS	Department of Human Services
DYRS	Department of Youth and Rehabilitation Services
EBP	Evidence-based Practice
ECMHC	Early Childhood Mental Health Consultation
ED	Emergency Department
EHR	Electronic Health Record
ENS	Encounter Notification Service
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
FFS	Fee for Service
FFT	Functional Family Therapy
FMAP	Federal Medical Assistance Percentage
FQHC	Federally Qualified Health Centers
FSMHC	Free-Standing Mental Health Clinics
FY	Fiscal Year
HCBS	Home and Community Based Services
HFW	High Fidelity Wraparound
HIE	Health Information Exchange
HIS	Health Information System
HIT	Health Information Technology
HPSA	Health Professional Shortage Area
HRLA	Health Regulation & Licensing Administration
HRSA	US Health Resources and Services Administration
iCAMS	Integrated Care Application Management System
ICH	Interagency Council on Homelessness
IDEA	Individuals with Disabilities Education Act
IECMH	Infant and Early Childhood Mental Health
IEP	Individualized Education Program

LANE	Low Acuity Nonemergent
LEP/NEP	Limited or Non-English-Proficient
LGBTQIA+	Lesbian, Gay, Bisexual, Trans/Transgender, Queer or Questioning, Asexual
MCAC	DC Medical Care Advisory Committee
MCO	Managed Care Organization
MCPAP	The Massachusetts Child Psychiatry Access Project
MD	Medical Doctor
mHealth	Mobile Health
MHGPS	My Health GPS
MHPAEA	Mental Health Parity and Addiction Equity Act
MHRS	Mental Health Rehabilitation Services
MPD	Metropolitan Police Department
MST	Multi-Systemic Therapy
NCQA	National Committee for Quality Assurance
NLHEC	National LGBTQIA+ Health Education Center
OHR	Office of Human Rights
OSSE	Office of the State Superintendent of Education
OWB	Office of Well Being
P4P	Pay-for-Performance
PASS	Parent and Adolescent Support
PCCM	Psychiatric Collaborative Care Management
PCIT	Parent Child Interaction Therapy
PCP	Primary Care Provider
PIECE	Parent Infant Early Childhood Enhancement
PMAD	Perinatal Mood and Anxiety Disorder
PRTF	Psychiatric Residential Treatment Facility
SAMHSA	Substance Abuse and Mental Health Services Administration
SDOH	Social Determinants of Health
SED	Serious Emotional Disturbance
SMI	Serious Mental Illness
SOC	System of Care
SUD	Substance Use Disorder
TAY	Transition Age Youth
USCDI	United States Core Data for Interoperability
VBP	Value-Based Purchasing
WHO	World Health Organization
WPATH	World Professional Association for Transgender Health
YRBS	Youth Risk Behavior Survey

EXECUTIVE SUMMARY

The public behavioral health system for children and families in the District of Columbia (DC) needs to take a new path forward. The system fails to provide timely, accessible, high quality, culturally appropriate, or affordable care to thousands of children who need it - with devastating consequences.

This report, *A Path Forward-Transforming the Public Behavioral Health System for Children, Youth, and their Families in the District of Columbia*, is a blueprint for creating a successful public behavioral health system, one that supports children and families and, in doing so, strengthens our entire community.

The recommendations in this report build on the commitment shown by the District's leaders – investments and improvements led by the Mayor, government agency leaders, and the DC Council. It is informed by the expertise and experiences of youth, parents, experts, and best practices from across the country.

A Path Forward is the result of work begun in 2017, when several organizations came together with a shared purpose: to develop a plan of action to ensure DC children and families had the behavioral health supports and services they need to thrive. This informal coalition includes leaders from Children's Law Center, Children's National Hospital, the District of Columbia Behavioral Health Association, Early Childhood Innovation Network, Health Alliance Network, MedStar Georgetown University Hospital Division of Child and Adolescent Psychiatry, Parent Watch, and Total Family Care Coalition.

Many important executive, legislative, and public-private efforts have been launched since the coalition began its work. The dramatic increase in school-based behavioral health programs demonstrates a city-wide understanding of the importance of meeting children where they are. The integration of behavioral health into managed care contracts and the District's successful application for a Medicaid waiver to cover additional services shows a commitment to tackling key structural and funding barriers. These are just a few improvements made in the past few years.

However, our community has also suffered the devastating effect of a worldwide pandemic. Even before the pandemic, approximately 1 in 5 DC children – more than 20,000, were reported to have a mental, emotional, developmental, or behavioral problem.[i] Additionally, 47% of DC's children have had adverse childhood experiences (ACEs), including being exposed to violence and living with family members with severe mental health or substance use disorders.[ii] The pandemic has only exacerbated many of those experiences and created new traumas. Due to COVID-19, children have faced unprecedented levels of disruption, isolation, and toxic stress. Family engagement focus groups conducted to inform this report support these findings, with many youth speaking about the impact of the COVID-19 pandemic on their behavioral health.

Our current system does not meet the needs of children and families. A teenager who participated in a focus group conducted for this report stated, "I feel like one of the main challenges, the main mental health challenges that is currently being faced by the DC youth, I feel like, is the lack of resources." This is an accurate observation—one of the significant obstacles children in the District's behavioral health system face is the lack of an adequate supply or range of behavioral health supports. Furthermore, services are often fragmented and inaccessible because of the

[i] *NSCH Interactive Data Query (2016 – 2018). Data Resource Center for Child and Adolescent Health. Accessed November 2, 2020. https://www.childhealthdata.org/browse/survey*
[ii] *Building Community Resilience: Washington, DC. Building Community Resilience Collaborative. March 2018. https://publichealth.gwu.edu/sites/default/files/downloads/Redstone-Center/DC%20BCR%20Snapshot%20-%204.5.18.pdf*

scarcity of a particular kind of service or provider, the treatment location, inadequate transportation, long wait times, and insufficient care coordination. An effective and complete continuum should include promoting behavioral health, prevention of mental illnesses and substance use disorders, early identification, treatment, recovery and rehabilitation services, and long-term supports.

This report offers concrete, actionable recommendations in the six domains that the World Health Organization identifies as necessary to a functioning public health system: leadership and governance, financing, workforce, service delivery, information and communications, and technology. There is also a section addressing the needs of children whose situations require special attention. The recommendations range from including youth and caregivers at every level of decision-making to technical changes to professional licensing requirements, from the addition of specific treatment modalities to investments in technology to support better coordination.

These recommendations were informed by best practices around the country, feedback, and input from expert stakeholders across the District and focus groups conducted with District youth and caregivers. Abbreviated recommendations, along with suggested implementing agencies and entities, are presented below. The recommendations in each chapter have not been ranked in terms of priority and are not presented in any order.

Children flourish when they receive the right behavioral health care at the right time. If the District commits to implementing these recommendations, it can create long-lasting, systemic change that will transform behavioral health care and advance health equity for children now and in the generations to come.

Leadership & Governance

Recommendation	Suggested Implementing Bodies	For more detail, see
1. Review, strengthen, and—where possible—institutionalize collaboration with the community through documentation and assessments.	DBH, DHCF, CFSA, DC Health, DHS, MCOs	PG 40
2. Prioritize and support the development of a sustainable system that routinely captures and analyzes data on prevalence, incidence, severity, risk factors, social determinants, functional outcomes, and access to care for behavioral health conditions.	DBH, DHCF, CFSA, DC Health, DHS, MCOs	PG 40
3. Develop an updated strategic plan for children's behavioral health.	DBH, DHCF, MCOs	PG 41
4. Make all strategic plans, work plans, and performance reports regarding children's behavioral health publicly available in a timely manner.	DBH, DHCF, MCOs	PG 41
5. Establish an Interagency Council on Behavioral Health that aligns with the Collaborative Governance Model.	DC Council	PG 41
6. More clearly define the roles of DBH, DHCF, and other agencies in children's behavioral health and update DC code and regulations, as needed, in light of the upcoming behavioral health reforms.	DBH, DHCF, DC Health, CFSA, OSSE, DC Council	PG 42

Financing

Recommendation	Suggested Implementing Bodies	For more detail, see
1. Plan to move managed care organizations (MCOs) toward a fully integrated corporate model that does not allow MCOs to subcontract behavioral health services.	DHCF, DBH	PG 59
2. Avail primary care with payment and reimbursement infrastructure to optimize integrated care. We recommend the following: a. Enable Psychiatric Collaborative Care Management (PCCM) through CPT Codes 99492–99494. b. Cover discrete Z-codes to promote mental health and prevent mental health disorders. c. Continue adequate funding of DC Mental Health Access in Pediatrics (DC MAP). d. Establish mechanisms to adequately reimburse decentralized care coordination services provided by clinical and nonclinical professionals in settings where families frequent and trust. That should include expansion of Health Homes and HealthySteps.	DHCF, DBH	PG 59

3. Advance value-based, alternative payment methodologies, and/or accountable care models specific to child and adolescent behavioral health. a. Establish a pathway for creation and payment of Certified Community Behavioral Health Clinics (CCBHCs). b. Develop value-based and alternative payment models that prioritize children's social and emotional health. c. Implement VBP arrangements that adjust for social risk when linking quality measures to payment incentives. d. Conduct operational readiness assessments across government agencies, providers, and MCOs to prepare for behavioral health managed care carve-in, specifically examining VBP readiness. e. Provide education and technical assistance for MCOs, provider organizations, and the relevant staff at government agencies on VBP strategies to ensure a common understanding, consistent use of terminology, and proper implementation.	DHCF, DBH, MCOs, CSAs	PG 61
4. Strengthen reporting of access to care standards in MCOs.	DHCF, DBH, MCOs	PG 62
5. Implement transparent strategies to enforce network adequacy. Strategies to consider for enforcing network adequacy include: a. Monetary penalties for failure to meet network adequacy standards. b. A backstop dispute resolution process.	DHCF	PG 63
6. Require universal contracting for critical providers to ensure initial network adequacy immediately following the carve-in of behavioral health services into managed care programs.	DHCF, DBH, MCOs	PG 63
7. Update provider reimbursement rates that are adjusted annually for inflation, and establish a transparent rate-setting process.	DBH, DHCF	PG 64
8. Require MCOs to use standardized and simplified authorization, billing, and credentialing processes and protocols.	DHCF, MCOs	PG 64
9. Eliminate same-day billing restrictions that hinder children's access to behavioral health services.	DHCF, DBH	PG 64
10. Ensure proper clinical expertise in medical necessity determinations.	DHCF, DBH, MCOs	PG 65
11. Assess all available public and private funding streams, including Medicaid, that can support plans to address the social determinants of children's behavioral health in DC.	DHCF, DBH, DC Health, CFSA, DHS	PG 65
12. Adequately fund the School-Based Behavioral Health Expansion Program. We recommend the following: a. Establish sustainable funding mechanisms. b. Ensure sufficient clinical and nonclinical staff in all schools. c. Right-size grant or contract funding amounts. d. Build provider capacity. e. Continue investment in program evaluation.	DBH, OSSE/DCPS	PG 66
13. Adequately invest in technologies that can support and optimize the work of behavioral health service provider organizations, MCOs, and government agencies involved in children's behavioral health.	DHCF, DBH	PG 67

Service Delivery		
Recommendation	**Suggested Implementing Bodies**	**For more detail, see**
1. Establish the full continuum of psychiatric care for children, including acute care, crisis stabilization, and intensive outpatient care in the District. That includes the following services specifically for children less than 18 years: a. Crisis stabilization unit, 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).	DHCF, DBH, DC Health, CSAs, MCOs	PG 93
2. Improve services for youth at risk for or diagnosed with substance use disorders (SUD). We recommend: a. Exploring solutions to improve screening, assessment, referral and treatment, and options for improved integration of prevention and treatment services into easily accessible locations. b. Exploring the implementation of other adolescent substance use evidence-based treatments besides Adolescent Community Reinforcement Approach (ACRA). c. Standardizing screening tools for SUD. d. Integrating or co-locating substance use outpatient services with mental health services. e. Improving communication and understanding of available SUD services for youth among primary care providers (PCPs) and other clinical and nonclinical providers. f. Increasing evidence-based prevention programs for youth that target the most frequently used substances. g. Exploring opportunities for expansion of DC MAP services to include the Adolescent Substance Use and Addiction Program.	DHCF, DBH, MCOs, PCPs, ASTEP Providers	PG 93
3. Implement models and expand existing models to facilitate integrated care. We recommend: a. Piloting the implementation of the PCCM for children and track outcomes. b. Relaxing and expanding eligibility requirements for the two types of DC Health Homes. c. Establishing a pathway for creation and payment of CCBHCs.	DHCF, DBH	PG 95
4. Strengthen care coordination through increased training and reimbursement for both clinical and nonclinical providers, as well as improved and standardized directories. The following strategies are recommended: a. Ensure that all behavioral health care coordination meets the National Care Coordination Standards for Children and Youth with Special Health Care Needs. b. Standardize MCO provider directories, including directory links showing participating providers in any MCO-subcontracted behavioral health administrative organizations. c. Update the providers who are accepting new patients in directories monthly.	DHCF, DBH	PG 96

5. Improve service accessibility through the Medicaid nonemergency medical transportation.	DHCF, DBH	PG 96
6. Establish agreement and accountability on meaningful quality of care measures.	DHCF, DBH, MCOs	PG 97
7. Improve understanding of the beneficiary experience through improved measurement and reporting of the child, youth, and family experiences.	DHCF, MCOs	PG 97
8. Expand school-based behavioral health services.	DHCF, DBH	PG 98
9. Implement service delivery strategies to identify and address social determinants of health (SDOH). That should include SDOH screening for children and families that uses a trauma-informed approach at all appropriate health settings	DHCF, DBH	PG 98
10. Encourage all behavioral health service delivery organizations—across the settings of child care, school, health, and social services—to develop and implement a plan to deliver and measure culturally responsive and trauma-informed care.	DHCF, DBH	PG 99
11. Improve family-centered care. The following strategies are recommended: a. Offer educational resources to behavioral health providers with information about family caregiver needs. b. Review care management standards, hospital discharge planning, and risk-assessment procedures to ensure that they meaningfully involve family caregivers. c. Provide clinical staff with practice guidelines and supervision for how to effectively engage families/natural supports. d. Systematically collect information about family/caregiver needs within behavioral health care settings and account for them in treatment plans. e. Ensure higher reimbursement rates for family psychotherapy codes. f. Expand self-directed home and community based services (HCBS) accessibility to children with behavioral disorders to maximize the opportunity to use home-based supports in lieu of more intensive care options.	DHCF, DBH, DC Health, OSSE	PG 99
12. Continue strong work with behavioral health screening and strengthen successful connection to evaluation and/or treatment after a positive screen.	DHCF, DBH, MCOs	PG 100

Workforce

Recommendation	Suggested Implementing Bodies	For more detail, see
1. Implement strategies and incentives to create an adequate labor pool of diverse behavioral health professionals for children.	DHCF, DBH, DC Council, MCOs, OSSE, Higher Education Institutes, Provider Organizations	PG 111

2. Incorporate best practices to improve the cultural competence among providers.	DHCF, DBH, DC Health, CSAs, MCOs	PG 112
3. Conduct research to understand and monitor behavioral health workforce turnover in the District.	DHCF, DBH	PG 113
4. Implement strategies to minimize workforce turnover.	DHCF, DBH, MCOs	PG 113
5. Provide adequate support to child-serving behavioral health providers through Medicaid reform.	DHCF, DBH	PG 114
6. Implement strategies and incentives to improve distribution of children's behavioral health providers.	DHCF, DBH, DC Council, DC Health	PG 115
7. Enable integration of peer specialists, community health workers, and other nontraditional behavioral health professionals across settings.	DHCF, DBH, CSAs, MCOs	PG 115
8. Support engagement and recruitment of youth peer behavioral health specialists.	DHCF, DBH	PG 116
9. Incorporate best practices to improve the trauma-informed care and trauma responsive interventions among providers.	DHCF, DBH, CFSA, CSAs, MCOs	PG 117
10. Create and maintain a database to inform behavioral health workforce planning.	DBH, DC Health, DHCF	PG 118
11. Mandate uniform credentialing requirements and a quicker credentialing turnaround time for all MCOs.	DHCF	PG 118
12. Allow supervised practice for people seeking initial licensure waiting to complete national exams or waiting for application approval or denial, and allow provisional practice for people licensed in other jurisdictions while waiting for District license application approval or denial.	DC Health Professional Licensing Boards	PG 119

Information & Communication

Recommendation	Suggested Implementing Bodies	For more detail, see
1. Develop transparent privacy and confidentiality policies and data-sharing agreements among agencies to support information sharing among providers, MCOs, and government agencies.	DHCF, DBH, HIE Policy Board, CRISP DC, MCOs	PG 130
2. Develop a surveillance system for population-level behavioral health data and behavioral health services data for children.	DBH, DHCF, DC Health, MCOs	PG 130
3. Require uniform standards for data collection and minimal standards for reporting.	DHCF, DBH, MCOs	PG 131
4. Develop and periodically update a comprehensive behavioral health awareness strategy for children and families in DC, with leadership from DC youth and families.	Community-Based Organizations, DHCF, DBH, DC Health, OSSE, DCPS	PG 131

Technology

Recommendation	Suggested Implementing Bodies	For more detail, see
1. Implement strategies to improve participation and use of CRISP (the District's designated Health Information Exchange) by behavioral health providers. Strategies include: a. Financial incentives for provider adoption and use. b. Technical assistance to providers. c. Education and guidance for providers and patients.	DHCF, DBH, HIE Board, CRISP DC	PG 144
2. Develop and improve CRISP functionalities to meet the needs of behavioral health providers and relevant government agencies.	DHCF, DBH, HIE Policy Board, CRISP DC	PG 144
3. Remove barriers and increase incentives to collect and exchange behavioral health data through electronic health record (EHR) systems that are interoperable with CRISP.	DHCF, DBH	PG 145
4. Ensure equitable access to broadband, Wi-Fi, devices, and other components necessary for telebehavioral health use.	DHCF, DBH, Office of the Chief Technology Officer (OCTO)	PG 146
5. Provide technical assistance to the District's behavioral health providers to support the provision of ethical and high-quality telehealth services.	DHCF, DBH	PG 147
6. Encourage use of mobile health (mHealth) by behavioral health providers and MCOs.	DHCF, DBH	PG 147
7. Expedite District licensing requirements to meet the demand for telebehavioral health.	DC Health Professional Licensing Boards	PG 148
8. Ensure timely access to discharge summaries with CRISP.	DC HIE Policy Board, CRISP DC, DC Hospital Association, Hospital Organizations	PG 148

Special Populations		
Recommendation	**Suggested Implementing Bodies**	**For more detail, see**
For all special populations		
1. Maximize appropriate information exchange among the behavioral health system, foster care system, juvenile justice system, school system, and the Homeless Management Information System.	DHCF, DBH, DC Health, CFSA, DHS, DYRS, ICH, DCPS, OSSE	PG 165
Children with or at risk for Autism Spectrum Disorder (ASD)		
2. Ensure network adequacy for diagnostic and intervention services for ASD.	DHCF, DBH, MCOs	PG 166
3. Identify and implement comprehensive policy solutions that ensure adequate access to the full array of services and providers needed for ASD diagnosis and treatment.	DHCF	PG 167
4. Standardize insurance requirements for making a diagnosis of ASD across the MCOs and increase transparency and access to this information.	DHCF, MCOs	PG 167
5. Secure funding to provide ongoing training and education on ASD for frontline care providers, including primary care providers, early intervention staff, school staff, and early childhood behavioral health professionals.	DBH, DHCF, DC Health, OSSE, DCPS	PG 168
6. Support the implementation of universal, coordinated, and strategic developmental monitoring and screening practices across key agencies within the District.	DBH, DHCF, MCOs	PG 168
Children in foster care		
7. Guarantee the timeliness of service connection and integrate warm handoff best practices between CFSA and DBH for behavioral health services for children in care.	DBH, CFSA	PG 168
8. Ensure there are clear pathways to accessing care for children in foster care residing in the District and Maryland.	DBH, CFSA	PG 169
9. Provide an augmented capitation payment for children in foster care to MCOs to adequately support their increased needs.	DBH, CFSA	PG 170
10. Continue to work on the implementation of evidence-based therapeutic foster care.	CFSA	PG 170
11. Provide full transparency of specific data collection regarding medication monitoring, and publicly report those data regularly.	DBH, CFSA	PG 171
Children who experience homelessness		
12. Systematically identify children and youth using homeless shelters who are in need of behavioral health services.	DHCF, DBH, DHS	PG 171

13. Increase DHCF's and MCOs' participation in the Interagency Council on Homelessness (ICH).	DHCF, MCOs	PG 172
14. Systematically assess housing status of crisis service users.	DHCF, DBH, DC Health, MCOs	PG 172
15. Collect data on youth homelessness beyond annual point-in-time (PIT) prevalence estimates.	DHS	PG 173
16. Ensure that homeless shelter staff are adequately trained in cultural competency, anti-discrimination, anti-harassment, and trauma-informed approaches to protect the safety and well-being of LGBTQIA+ youth and children.	DHS, Youth Sub-Committee on ICH	PG 174
Children who identify as LGBTQIA+		
17. Support therapeutic interventions proven to be effective and appropriate for LGBTQIA+ youth populations, including culturally tailored treatment modalities.	DBH, DHCF, DHS, OSSE, DCPS	PG 174
18. Increase access to integrated behavioral health services for youth in gender transition.	DBH, DHCF, MCOs	PG 175
19. Improve District capacity to make data-informed decisions on behavioral health care for LGBTQIA+ youth.	DBH, DHCF, DC Council	PG 175
20. Improve cultural competency of social and health care service delivery provided to LGBTQIA+ youth.	CFSA, DYRS, CSS, DHS, DBS, OSSE, MPD, DCPS	PG 176
Youth in the juvenile justice system		
21. Increase access to affordable, high-quality behavioral health services and social service supports for justice-involved youth and their families.	DYRS, DBH, MCO, CBOs/FROs, OSSE	PG 176
22. Ensure continuity of behavioral health services and supports upon reentry into the community	DBH, DYRS, and MCOs	PG 177
23. Implement training to individuals and organizations working with at-risk and justice involved youth.	DBH, MPD, DCPS, OSSE, DC Health, CBOs	PG 178
24. Increase peer support and mentoring opportunities for justice-involved youth.	DBH, DCPS, CBOs	PG 178
Transition age youth (TAY)		
25. Increase transition-age youth-specific services and supports.	DBH, DHCF, MCOs	PG 179
26. Develop a system of care for transition-age youth to ensure care continuity.	DBH, CFSA, DCPS, DHS, CBO/FRO	PG 179
27. Increase engagement of transition-age youth in education, service planning and delivery.	DBH, CFSA, DCPS, DHS, CBO/FRO	PG 180

Prenatal to age five		
28. Include Infant and Early Childhood Mental Health (IECMH)-specific MCO objectives that are measurable and supported with adequate financial incentives.	DHCF, DBH	PG 180
29. Ensure coverage and adequate reimbursement rates for evidence-based dyadic and multigenerational models.	DHCF, DBH	PG 181
30. Ensure adequate financing for Perinatal Mood and Anxiety Disorder (PMAD) screening, prevention, and intervention across all settings and providers, regardless of the caregiver's health insurance status.	DHCF	PG 181
31. Develop and disseminate a billing crosswalk for Medicaid behavioral health professionals across provider settings (DC 0:5 to DSM-V and/or ICD-10), along with training on use of that crosswalk. Policy guidance or clarification should also be issued regarding multisession assessment.	DHCF, DBH	PG 181
32. Continue and expand early childhood mental health consultation programs with permanent and stable funding mechanisms to support needed services in child care centers and Pre-K–3/4 classrooms.	DBH, DHCF, OSSE, DCPS	PG 182
Children who speak languages other than English		
33. DBH should make its website more accessible to limited or non-English-proficient (LEP/NEP) individuals.	DBH, OHR, DC Office of Disability Rights, D.C. Office for Deaf, Deafblind and Hard of Hearing	PG 182
34. Expand the bilingual/multilingual behavioral health workforce.	OHR, DBH, DHCF, MCOs, Community Based Agencies	PG 182
35. Contract providers who can provide or translate behavioral health services for children in American Sign Language (ASL).	DBH, DHCF	PG 183
36. Improve data transparency about the language accessibility of services for LEP/NEP individuals.	DHCF, DBH, OHR	PG 184
37. Managed care plans should ensure they have an adequate network of multilingual, child-serving providers and should have policies/guidelines for single-case agreements for LEP/NEP beneficiaries that require behavioral health services outside the MCOs standard network.	MCOs, DHCF, DBH	PG 184
38. Work with the DC Office of Human Rights to have DBH information included as part of the public awareness campaign for language services.	OHR, DHCF, DBH, DC Health, OSSE, DCPS	PG 185
39. Create more bridge service opportunities like DC Health-supported Help Me Grow DC and DC MAP Partnership	DC Health, Help Me Grow, DC MAP, DBH	PG 185

1. INTRODUCTION

The public behavioral health[i] system in the District of Columbia (DC) provides critical services to many children[ii] and families. While governmental and nongovernmental stakeholders have prioritized various improvements to the system in recent years, some children and families continue to have unmet behavioral health needs reflecting extant opportunities for system strengthening.

The goal of this report is to identify recommendations for transforming DC's public behavioral health system for children into a system that provides appropriate, equitable, and high-quality behavioral health services throughout the continuum of care for children in DC. The report's specific aims are to:

- identify components of our vision for the behavioral health system for children, including best practices and exemplar systems and programs in other states;
- describe the current public behavioral health system for children in DC in terms of leadership and governance, service delivery, workforce, financing, information and communication, and technology (this description will largely draw on our previously published paper[1] and fill in necessary gaps);
- analyze gaps between DC's current behavioral health system for children and a model behavioral health system that can meet the behavioral health needs of DC's children; and
- develop prioritized recommendations to strengthen DC's current public behavioral health system for children.

Section 1.2 outlines the systematic process used to develop the recommendations in this report. The recommendations outlined in this report will be strategically valuable for a variety of stakeholders, including executive and legislative policymakers who intersect with behavioral health care needs of children and families. The information contained in this report is also intended to support the work of behavioral health leaders and advocates in the District's communities.

This report is released by Children's Law Center, Children's National Hospital, the District of Columbia Behavioral Health Association, Health Alliance Network, Early Childhood Innovation Network, MedStar Georgetown University Hospital Division of Child and Adolescent Psychiatry, Parent Watch, and Total Family Care Coalition. It is the fifth paper in a series of papers that were previously released by the Children's Law Center, Children's National Hospital, the District of Columbia Behavioral Health Association, Early Childhood Innovation Network, and MedStar Georgetown University Hospital Division of Child and Adolescent Psychiatry. This report utilizes information and expands on concepts that were presented in the previous publications. The first paper in the series, Behavioral Health in the District of Columbia for Children, Youth, and Their Families: Understanding the Current System, provided a robust background of the current local public behavioral health system landscape. The second document, Principles and Values to Guide Child and Adolescent Public Behavioral Health Care System Transformation in the District of Columbia, outlined a set of guiding principles to inform future improvements to DC's public behavioral health system as it aims to deliver effective, accessible, and acceptable services and supports for children and families. The third paper, Addressing Children's Behavioral Health Needs Through Changes to DC's Medicaid Program, concentrated

[i] *We use the term "behavioral health" to refer to emotional and mental health as well as substance use and addiction. That term encompasses a continuum of promotion, prevention, early intervention, treatment, and recovery support services. We also acknowledge that learning, intellectual, or developmental disabilities may impact individuals' abilities to function at school, at home, and in the community, and those complex issues often drive families to seek behavioral health assessment and ongoing treatment.*

[ii] *For the purposes of this report, unless otherwise specified, "children" refer to persons under age twenty-one.*

on the transition to a fully managed care environment for Medicaid recipients in DC and continued our focus on uplifting children's behavioral health. Finally the fourth paper, Advancing Children's Behavioral Health During a Time of Transition in DC's Medicaid Program, offered a set of preliminary recommendations that were particularly relevant during the District's ongoing transition to a fully managed Medicaid program.

This report first discusses the landscape surrounding the behavioral health system for children in DC, with each subsequent chapter then discussing one of six system elements. The six behavioral health system elements were adapted from the World Health Organization's health system building blocks:[2]

Leadership and Governance	Ensuring that strategic policy frameworks exist and are combined with effective oversight, coalition-building, regulation, attention to system design, and accountability
Service Delivery	The immediate output of the behavioral health system that encompasses a comprehensive range of services, including prevention, treatment, and recovery services
Finance	The mobilization, accumulation, and allocation of money to cover the behavioral health needs of the people, individually and collectively, in the system
Workforce	All people engaged in actions with the primary intent to enhance behavioral health
Information and communication	The collection, transference, and dissemination of different types of information, occurring at different levels, to meet a wide variety of behavioral health objectives
Technology	The application of organized knowledge and skills in the form of devices, medicines, procedures, and systems developed to solve a behavioral health problem and improve the quality of lives

Each chapter that is dedicated to one of the above health system elements contains four subsections: (1) our vision for what that element should look like in an improved system, (2) the current situation in DC, (3) a gap analysis, and (4) recommendations for improving that element within the system. A final chapter is dedicated to specific special populations (i.e., children with or at risk for autism spectrum disorder, in foster care, experiencing homelessness, identifying as LGBTQIA+, in the juvenile justice system, who are not proficient in English, as well as transition-age youth and children under age five).

1.1 Guiding Values

While one of our previous publications outlines a comprehensive set of values and principles needed to improve DC's behavioral health system, it is worth reiterating in this document that the values of **family-centered care**, **cultural humility**, **racial equity**, and **trauma-informed care** must underpin the behavioral health system for children in DC. Family-centered care recognizes the significant role that families play in making decisions for children and, thus, necessitates active participation between families and professionals in the planning, delivery, and evaluation of health care.[3] Considering the diversity of the population of DC, it is critical that behavioral health practitioners demonstrate cultural humility, which involves practicing a curious and other-oriented interpersonal approach

with the intention of honoring others' beliefs, customs, and values.[4] Further, given the significant disparities among racial and ethnic groups in the District arising from decades of systemic racism, the behavioral health system must support equitable access to the full continuum of services to ensure all children's optimal behavioral health. Finally, adverse childhood experiences and adverse community environments are common occurrences for many children growing up in the District, so trauma-informed care must be interwoven throughout the behavioral health system. That requires care systems to recognize and validate the effects of traumatic events experienced by children to provide appropriate interventions.[5]

1.2 Our Approach

Data Sources

A combination of quantitative and qualitative data from peer-reviewed journal articles, grey literature (including whitepapers, government reports, and grant reports), government websites, and stakeholder interviews were utilized throughout this report's development.

The following provides more information on various instances of stakeholder consultations in developing this report:

- **Consultations with thirty-seven individuals representing managed care organizations, behavioral health service providers, professional associations, and advocacy organizations**
  Four stakeholder engagement sessions were held from August 2019 to March 2020 to gather information to guide the development of this report. Representatives from various organizations involved in service delivery or advocacy in DC attended each session. At the sessions, representatives were asked to provide their views on high-priority gaps in the behavioral health system for children in DC and recommendations for improving the system. Information gathered from those stakeholder consultations were used to inform areas of focus and initial recommendations for this report.

- **Focus groups or interviews with nineteen parents/caregivers and sixteen youth**
  Three focus groups for parents/caregivers, three focus groups for youth ages eighteen to twenty-three years old, and two individual interviews with minors were held during March and April 2021. Focus groups and interviews were organized and led by Children's Law Center, Total Family Care Coalition, and Parent Watch. Each focus group was seventy-five minutes, while each individual interview was thirty minutes. All participants had Medicaid insurance, except for one individual who was uninsured. At each focus group and interview, parents/caregivers or youth were asked about their views on the behavioral health issues of children in DC as well as the behavioral health services. Those focus groups and interviews will be referred to as "family engagement" when any findings from the focus groups/interviews are discussed throughout the report.

Methodology

The following describes the process used to develop this report:

1. . Developing a vision for the District's behavioral health system for children

To develop an appropriate vision for DC's behavioral health system for children, we developed a vision for each of the six health system elements, using secondary research and stakeholder consultations. A literature review of both grey and peer-reviewed literature was conducted to identify national and/or international standards, best practices, exemplar systems, and/or evidence-based programs in other states. Exemplary programs/systems were analyzed to identify transferable components for a well-functioning behavioral health system for children in DC. The best practices or exemplar programs/systems that aligned most closely with the identified local needs were included in the vision for the system. Last, the vision for each element of the system was reviewed and adapted, as necessary, to ensure it aligned with our guiding values of family-centered care, cultural humility, racial equity, and trauma-informed care.

Recognizing the limited resources available to any system, the vision subsections of each chapter are not meant to provide a comprehensive picture of an ideal system for DC, but instead they provide an overview of realistic goals for the system that the District should be working toward. Further, given the dynamic nature of the behavioral health system and its context, that vision for the system requires a regular review and updating to maintain its relevance.

2. Defining the District's current behavioral health system for children

The public behavioral health system for children in DC was first defined in terms of the six health system elements described above. That mapping of the District's behavioral health system relied on our previous publication, Behavioral Health in the District of Columbia for Children, Youth, and Their Families: Understanding the Current System. Information gaps were filled using other existing publicly available information (including District agencies' performance oversight reports, government agencies' websites, government contracts, and grant applications). Information was also gathered through stakeholder consultations.

3. Conducting a gap analysis

Elements of the current system were compared to the matching elements of the proposed model system to discern gaps between the existing and desired states. The identification of gaps was also supported by information from stakeholder engagement sessions. Using comparisons between the current system and our envisioned system, as well as information from stakeholders, a list of gaps for each behavioral health system element was prepared. Recognizing the limitations of this process, the list of gaps does not comprehensively outline all gaps in the behavioral health system for children in DC. Further, those gaps are not presented in any particular order in each chapter.

4. Formulating recommendations to address the gaps

Recommendations were developed to address each identified gap, with a few exceptions. Recommendations were formulated using findings from previous research on national/international standards, best practices, exemplar systems, and/or evidence-based programs in other states. Through internal consultations and external stakeholder engagement, initial recommendations were then refined based on considerations of the effectiveness of the recommendations, applicability of recommendations to the District's context, and perceived acceptability of the recommendation.

For each recommendation, "implementing bodies" and "timeline to implementation" were added using our team's best estimation. Further research and stakeholder engagement on the development of each recommendation will allow the implementing bodies and timelines to be more accurately identified. Currently identified implementing bodies and implementation timeline are included to provide readers with a better understanding of how we envision recommendations being implemented. Additionally, each timeline to implementation is based on the following term definitions:

- Short term—less than one year
- Medium term—within two years
- Long term—greater than two years

While we recognize that some proposed recommendations will be easier to implement, the recommendations in each chapter have not been ranked in terms of priority; therefore, they are not presented in any particular order.

1.3 Limitations

The scope of this analysis (which focuses on the public behavioral health system and individuals under age twenty-one) prevents the proposed recommendations from being fully comprehensive solutions toward ensuring optimal behavioral health for all children of DC. However, the recommendations are practicable solutions for improving integral components of the behavioral health system.

Addressing the behavioral health needs of children in DC requires strengthening both the public and private behavioral health systems. However, the public and private health systems in DC largely operate through distinct mechanisms, and recommendations for improving each system are likely to differ substantially. Thus, the scope of this report was limited to the public behavioral health system. The public system was prioritized because it serves children and families who are not only likely to have higher behavioral health needs (as their economic and social conditions serve as a risk factor) but also less resources to access the necessary continuum of services.

Additionally, the behavioral health of children in DC is linked to the entire behavioral health system for individuals who are both under and over age twenty-one. That is particularly evident because a caregiver's behavioral health can greatly affect their children's behavioral health. Therefore, a behavioral health system cannot fully meet the needs of children without also addressing their caregiver's behavioral health. Further, older children may be required to migrate to the adult behavioral health services, and seamless continuation of care will be necessary for ensuring optimal behavioral health. Despite those considerations, this report focuses on DC's behavioral health system serving children under age twenty-one to ensure a manageable scope for analysis. However, it should be recognized that the resulting recommendations may have the potential to also improve the broader behavioral health system that serves all ages.

2. LANDSCAPE

This section aims to establish a broad understanding of the contextual factors that affect the behavioral health of children and families in DC. It will describe key demographics of the overall population that the behavioral health system seeks to serve as well as discuss some of the social factors influencing the behavioral health of children and families. Finally, this section will provide an overview of the behavioral health needs of DC's children and families.

Ongoing Behavioral Health Reform

The behavioral health system for children and families and its surrounding landscape are not only complex but rapidly evolving in the District. In 2019, DC's Department of Health Care Finance (DHCF) announced plans to move toward a fully managed Medicaid program over the next five years. That shift will involve transitioning individuals currently in Medicaid's Fee-for-Service (FFS) program to the Medicaid managed care program. Also, at the beginning of 2020, the DC Section 1115 Medicaid Behavioral Health Transformation Demonstration became effective, which allows the District's Medicaid program to cover more behavioral health services. A key element of the ongoing behavioral health reform is the addition of behavioral health services into the District's managed care contracts beginning October 1, 2023.[6] This "carve-in" effort will serve to improve care coordination and foster whole-person care for DC Medicaid beneficiaries.[6]

The COVID-19 Pandemic

More recently, the health landscape has dramatically changed because of the COVID-19 pandemic. The public health measures connected to the pandemic have resulted in remote schooling for the majority of public schools, increased availability and use of telehealth, and employment changes/losses. Those ongoing changes have the potential to impact children's access to behavioral health services and overall behavioral health.

A national survey found that 14% of parents reported worsening behavioral health for their children, while 27% of parents reported worsening mental health for themselves between March 2020 to June 2020.[7] Even more concerning, the proportion of children's mental-health-related emergency department visits among all pediatric emergency department visits increased and remained elevated between April 2020 and October 2020 compared to the same time frame in 2019.[8] At the District-level, families at Children's National Hospital, in an ongoing community mental health needs assessment survey, have reported alarming new onset of behavioral and emotional health concerns since March 2020 (98% of respondents), with 64% of respondents observing signs and symptoms of anxiety in their children, 60% reporting onset of irritability, and 52% voicing concerns about their children's social health.[iii] Families that responded to the survey also indicated interest in individual- or family-based responses for support, brief one- to two-session approaches that target stress management and coping during the pandemic, and interventions delivered via telehealth.

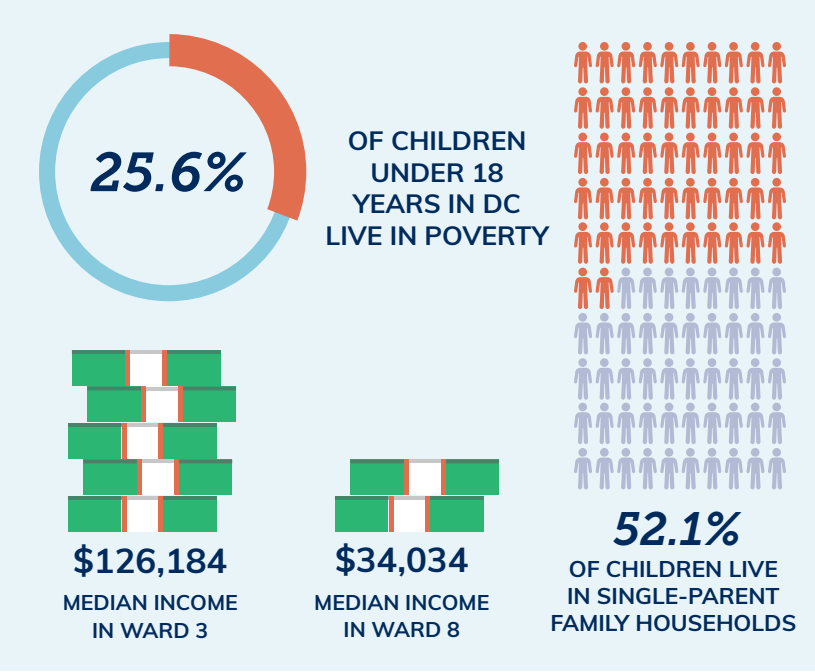
> ***In our family engagement focus groups, one youth shared:***
>
> ***"After-school programs or rec centers are places that have been shut down for the pandemic and ... it's kind of hard, because sometimes a rec center or, you know, a youth center or whatever is like all that a youth might have as a safe space."***

[iii] *Data shared from an ongoing community mental health needs assessment survey via email correspondence with Dr. Mackey from Children's National Hospital (August 2020). Reported results based on 52 respondents.*

Our family engagement focus groups also support those findings, with many youth speaking about the impact of the COVID-19 pandemic on their mental health. Many community- and school-based resources offering behavioral health support were not available in person to children through much of 2020, creating a gap in needed services.

2.1 Key Demographics of Children & Families in DC

According to the US Census Bureau 2019 estimates, DC has a population of 705,749 individuals, with children under eighteen years of age comprising 18.1% (or 127,901 individuals) of the population. The majority of the District's population is either Black/African American (45.4%) or White (42.4%), and 11.3% of the population identifies as Hispanic or Latino. It is noteworthy that 14% of DC's population was foreign-born (including over 6,000 individuals under eighteen years of age) in 2018, with El Salvador and Ethiopia being the top countries of origin for immigrants.[9] DC's adult population has a relatively high educational attainment, with 91.9% of the population over twenty-four years old having graduated high school, and almost 60% having a bachelor's degree or higher. Households have fairly high access to the internet, with 87.3% of households having a broadband internet subscription. While the District has a high median household income of $92,266, poverty affects 25.6% of individuals under eighteen years old in DC,[10] over twice the national poverty rate of 10.5%.[11] In terms of household structure, 52.1% of children live in single-parent family households out of all children living in family households.[12] It is also notable that approximately 10,816 grandparents live with their grandchildren under eighteen years, of which 24.8% (or 2,678 grandparents) were responsible for those children. The District has also noted a recent decline in the number of children in foster care, ending the 2019 fiscal year with 796 children in foster care.[13]



It should be acknowledged that these general District statistics conceal many disparities that are pervasive across the subregions of DC. There are distinguishable trends occurring in the District based on ward. According to five-year (2014–2018) US Census Bureau estimates, the youth population (under eighteen years old) varies dramatically among the eight wards, ranging from 6.2% of the population in Ward 2 to 29.7% of the population in Ward 8.[14] Racial and ethnic composition also varies across wards, with over 90% of Wards 7 and 8 being Black and over 70% of Wards 2 and 3 being White. There is a huge disparity in income and poverty across wards. Median household income ranges from $126,184 in Ward 3 to $34,034 in Ward 8 and similarly, the percentage of youth (under eighteen years old) in poverty ranges from 2.5% in Ward 3 to 46.1% in Ward 8.

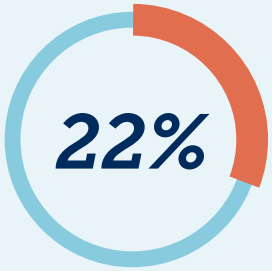
2.2 Behavioral Health of Children In DC

There is no District-specific routine surveillance system that collects and disseminates data on behavioral health issues in children. However, there are several national data collection and sharing mechanisms that can be used to gain rough estimates of some of the behavioral health needs of children in DC. Those mechanisms include the *Youth Risk Behavior Survey* (YRBS), the *State of Mental Health in America*, and the *National Survey of Children's Health*. The data of each report has limitations based on their research methodologies and therefore should be interpreted

with caution. For example, the YBRS sample was restricted to students in public and public charter schools and thus does not capture critical populations such as children in private schools or out-of-school children (including those in the juvenile justice system or homeschooled).

Prevalence of Behavioral Health Issues in Children in DC

The DC Health Matters Collaborative—a coalition of DC hospitals, community health centers, and associations—has repeatedly identified mental health as a priority need in the 2013, 2016, and 2019 Community Health Needs Assessment, reflecting that behavioral health persists as a major concern from a community perspective.[15] **Approximately 22% of children (ages three to seventeen years) in DC, which represents over 20,000 individuals, have a mental, emotional, developmental, or behavioral problem.**[16] Forty-seven percent of DC's children (less than eighteen years) have had adverse childhood experiences (ACEs),[17] which are risk factors for developing behavioral health issues. ACEs include experiencing racism, being exposed to violence, and having family members with severe mental disorders or substance use disorders.[18] The majority of individuals experiencing ACEs were Black, non-Hispanic children.[18] Family engagement focus group discussions also pointed to a high prevalence of adverse and traumatic experiences among participants. Trauma was often cited as a major behavioral health concern for DC children by both youth and parent participants, and, as one parent stated, "a lot of them [children] have been through traumatic situations or hard times, and a lot of times, the mental aspect isn't dealt with."



Approximately 22% of children (ages three to seventeen years) in DC, which represents over 20,000 individuals, have a mental, emotional, developmental, or behavioral problem.

Depressive symptoms appear to be prevalent among children in the District. Over 10,000 high school students (33%) reported feeling sad or hopeless almost every day for at least two weeks in the past year.[19] Based on the State Of Mental Health In America Report, approximately 3,000 youth (ages twelve to seventeen) have had at least one major depressive episode in the past year in DC, with 2,000 youth having a severe major depressive episode. Over one in three youth with past-year depression did not receive the mental health services that they needed.[20] While youth who participated in our family engagement focus groups infrequently referred directly to specific diagnoses when describing mental health concerns, symptoms associated with depression—particularly with regard to emotional experience—were frequently described, including hopelessness, anger, loneliness, and shame.

An alarming number of children in the District are also experiencing **suicidal ideation and/or are attempting suicide**, with noticeably higher rates in children who identify as lesbian, gay, and bisexual (LGB). The 2019 DC YRBS found that approximately 29% of middle school students and 19% of high school students seriously considered attempting suicide. Further, 14% of middle school students and 15% of high school students attempted suicide in the past year, cumulatively representing over 19,000 children. In the middle and high school populations, LGB students were more than two times as likely to have seriously thought about, planned to, or attempted to kill themselves.

Substance use among children in DC also appears to be problematic. Approximately 5.42% of youth (or 2,000 individuals between the ages twelve and seventeen) had a substance use disorder in the past year in DC, which is notably higher than the national average of 3.83%.[21] According to the 2019 DC YRBS, an estimated 9% of middle school students and 29% of high school students reported use of marijuana in the past thirty days. Relatedly, in our family engagement efforts, many youth and parents identified marijuana as the drug most frequently used among youth in DC. Some research has linked heavy marijuana use in adolescence to altered brain development, impaired cognition, and poor academic performance.[22] Additionally, 20% of high school students had at least one drink of alcohol in the past thirty days, and 13% of them reported current use of illegal drugs. LGB youth were overrepresented in the

percentage of students who reported substance use in both middle and high school. Notably, in our family engagement efforts, several youth identified substance use as a means of coping with psychological issues.

The prevalence of **disabilities and disability-associated disorders** in children in the District is particularly difficult to discern given the variance in definitions and sample populations. According to the US Census Bureau, 4.2% of the civilian noninstitutionalized population under eighteen years (or 5,421 individuals) have a disability (which was defined as a serious difficulty with four basic areas of functioning—hearing, vision, cognition, and ambulation). However, that is incongruent with the US Department of Education's estimate that over 12,000 students ages six through twenty-one in DC were served under the Individuals with Disabilities Education Act in 2018 (the qualifications for which include having a physical or mental disability that significantly limits at least one of the following: caring for oneself, manual tasks, sight, hearing, speech, breathing, learning, or work).[23] The *2018 National Survey of Children's Health* estimates that almost 3,000 children, ages three through seventeen, are diagnosed with an autism spectrum disorder in the District. Additionally, approximately 9,500 children, ages 3 through 17, are diagnosed with attention deficit disorder/attention deficit hyperactivity disorder (ADD/ADHD) in DC. The survey also estimated that 4,000 of the children with ADD/ADHD diagnoses did not receive treatment in the past year in DC, reflecting a great degree of unmet need for behavioral health services.

2.3 Social Determinants of Behavioral Health for Children in DC

The Centers for Disease Control and Prevention (CDC) defines the social determinants of health (SDOH) as "conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of life-risks and outcomes." The *2018 Health Equity Report* for DC has identified that, besides clinical care, there are other key drivers of health in the District (such as education, income and employment, community safety, and housing).[24] Research has applied the SDOH definition specifically to behavioral health, noting that social and environmental factors affect individuals' risk for mental health and substance use disorders, their access to behavioral health services, and their behavioral health outcomes.[25] Those determinants of behavioral health can be classified as risk factors or protective factors. For this report, risk factors refer to unfavorable social, environmental, and economic circumstances that are positively associated with behavioral health problems and/or increase the likelihood of negative behavioral health outcomes. Exposures to such risk factors can begin prior to birth and amass throughout the individual's lifespan.[26] On the other hand, protective factors for behavioral health refer to aspects of children's social environment, including their family, peer, school, and neighborhood contexts that are associated with the extent of their developmental resilience. In DC, some protective social determinants of children's behavioral health include elements of their school environment and family support. In contrast, some risk factors include housing situations, neighborhoods, and experiences with racism. Furthermore, children's behavioral health can be affected by their parent/caregiver's employment status, income, and health.

Protective Factors

- The presence of **behavioral health services in the public-school setting** in DC represents a protective factor for many children's behavioral health. Considering the significant amount of time that children spend in school, a school's environment can greatly influence children's attitudes, behaviors, and health outcomes.[27] The majority of children in DC attend public schools, with only approximately 15% of students attending a private school between 2013 and 2017.[28] Among students attending public schools in DC, there is almost equal enrollment in DC Public Schools (54%) and DC public charter schools (46%).[29] In the DC public school system, many children have access to behavioral health services through the Department of Behavioral Health's School Behavioral Health Program, which offers prevention, early intervention, and clinical services to students and their families.[30] Such services can directly improve students' behavioral health but also indirectly elevate school connectedness. A great proportion of DC students appear to feel supported by adults in school, with approximately 70% of students in public middle and high schools reporting that there is at least one teacher or other adult in school whom they can talk to if they have a problem.[19]

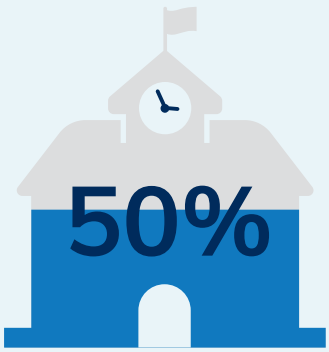
- A **positive family climate** also serves as a protective factor for children's behavioral health.[31] Data from the *2018 National Survey of Children's Health* reflects that many parents in DC have strong relationships with their children. Similar to the national average, 65% of children (ages six to seventeen) share ideas or talk very well with their parents. Additionally, given the strong association between frequent family dinners and better child mental health,[32] it is noteworthy that almost three of every four children (ages zero to seventeen) in DC have families that eat meals together at least four days per week. DC also ranked higher than the national average for the proportion of children (ages zero to five) whose parents or family members read, sing, or tell stories to them every day, which are early family routines that support healthy child development (including socioemotional development).[33]

Risk Factors

- Despite the positive attribute of schools, school environments have also been shown to be a source of risk factors for behavioral health issues in children through exposure to violence and bullying. The *2019 District of Columbia YRBS* found that 32.0% of middle school students and 12.7% of high school students were bullied on school property in the past year, which cumulatively represented over 20,000 students in the District.[19] Bullying was also highlighted by our family engagement focus group participants, who frequently cited peer pressure as a factor associated with behavioral health challenges, especially with regard to pressuring children to engage in dangerous substance use behavior. That high rate of bullying can have detrimental short- and long-term impacts on children's mental health, because research has shown strong associations between bullying and mental health problems such as depression, anxiety, and suicidal ideation.[34] Relatedly, within the last decade, DC Council passed the Youth Bullying Prevention Act of 2012 to address bullying at the District level, which requires all youth-serving district agencies (including schools) to adopt anti-bullying policies and implement reporting and investigation procedures.[35]

- **Housing** has also been linked to children's psychosocial well-being.[36] DC has a lack of affordable housing, with over half of renters paying more than 30% of their income on housing.[37] Parental stress over housing insecurity and/or a lack of finances to pay for other basic necessities (such as food or medical care) can contribute to children's poor mental health. The high cost of housing has contributed to homelessness increasing by 34% in the District between 2009 and 2016. In 2017, 1,166 homeless families (of which children comprised nearly 60%) were in DC.[24] Children without stable housing can have traumatic experiences, linked to high rates of behavioral problems, delayed development, as well as attachment and mood disorders.[38]

- Children's exposure to **violence** in their neighborhoods in DC is also concerning. The rate of mortality due to homicide in DC is three times the national average, suggesting poor community safety in some neighborhoods.[24] It is noteworthy that approximately 11% of the homicide victims in DC in 2017 were below eighteen years old.[39] Further evidence of children's high risk of exposure to violence was found by the 2019 DC YRBS, which noted that almost 50% of middle school students have seen or heard people where they live be violent or abusive in the past year. Additionally, District residents are experiencing increased rates of community violence, with homicides due to gun violence increasing 19% from 2019 to 2020.[40] Our family engagement participants also reported that violence was a contributing factor to behavioral health issues among children in DC, and a number of youth mentioned that the issue was concentrated in Southeast DC. Research has shown that exposure to community violence can have poor mental health outcomes for children, especially related to development of post-traumatic stress disorder.[41]



of middle school students have seen or heard people where they live be violent or abusive in the past year.

- **Racism** is another social determinant of behavioral health that contributes to many health inequities. Children can experience the outputs of racism through where they live, where they receive education, and their economic situation.[42] Many studies have demonstrated relationships between perceived racism and children's behavioral health.[43] One review found that research has repeatedly linked self-reported discrimination in adolescents and pre-adolescents with low self-esteem, as well as symptoms of depression and anxiety.[43] Racism has been documented in the District, with a 2018 survey finding that Black residents tend to experience less satisfaction and more fear in their daily lives compared to White residents.[44] While research specifically examining the impact of this racism on children in DC is limited, one recent study found that Black adolescents in DC reported an average of over five experiences of racial discrimination per day and that those experiences predicted short-term increases in depressive symptoms.[45]

- **Parental income and employment status** are also important social determinants of behavioral health for children. Those factors impact children's behavioral health through multiple mechanisms. For example, parents who are employed may have access to private health insurance coverage, which allows them to use a different network of behavioral health providers for their children. Similar to employment, household income affects **insurance coverage**, because it determines whether children qualify for public health insurance. In DC, health insurance coverage for children (eighteen years and below) was primarily through employers (44% or 57,300 children) and Medicaid (42% or 55,000 children), with only 8.4% (or 11,000 children) having nongroup insurance coverage.[46] However, despite many children having insurance coverage, the *National Survey of Children's Health* estimated that almost 30% of children in the District were not adequately or continuously insured,[16] which likely translates to a high number of children not being able to access necessary behavioral health services.

  Another mechanism through which income affects children's behavioral health can be linked to poverty rates, which are strikingly high in DC. Over one in every four children below eighteen years in the District are in poverty, which is a known risk factor for many mental, emotional, and behavioral disorders of children.[47] Parental income levels can also impact children's behavioral health through its mediating effect on **parental behavioral health**. Especially for low-income families, poor adult mental health has been shown to impair parenting and affect child development.[48]

- **Behavioral-health-related stigma (whether self-directed, peer, or societal)** is a barrier to seeking help and accessing care,[49] which can lead to isolation and escalation of behavioral health problems among youth. Stigma was frequently cited in our family engagement focus groups as one of the main barriers to youth accessing behavioral health services. Notably, participants who identified as people of color mentioned that stigma regarding behavioral health was highly prevalent in their cultural communities and presented a challenge to those seeking treatment for a mental health or substance use concern. In the same vein, a number of youth expressed that they felt their communities did not prioritize mental health and were not supportive of those struggling with behavioral health concerns.

In our family engagement focus groups, one youth shared:

"When you live like in a low-income neighborhood, I feel like, you know, half the time, most of the time, you're worrying about survival and stuff like that so you're not really like worrying about all, 'oh let me do some self-care and how am I feeling,' you know."

Against the backdrop of ongoing behavioral health reforms, children continue to be exposed to behavioral health risk factors. The complex landscape of children's behavioral health in the District has been considered in the development of all recommendations.

3. LEADERSHIP AND GOVERNANCE

For this report, leadership and governance in the behavioral health system refers to "ensuring that strategic policy frameworks exist and are combined with effective oversight, coalition building, regulation, attention to system design and accountability."[50]

3.1 Vision for the System

Recalling Section 2.3, the determinants of behavioral health for children in DC include factors such as housing, community violence, and parental income, which lie beyond the sphere of the traditional health sector.[51] Addressing behavioral health issues must involve addressing these broad determinants of behavioral health, and therefore, this requires established mechanisms for cross-disciplinary and cross-sectoral collaboration inclusive of nongovernment actors. Governance and leadership of a well-functioning behavioral health system (which encompasses effective oversight, policymaking, system design, and accountability) should be shared by both government and nongovernment actors, with transparent communication and engagement from the community. The following describes our vision for the governance and leadership of the behavioral health system for children from the perspective of both government bodies and the community.

How Government Bodies Should Lead & Govern the Behavioral Health System for Children

Apply a Collaborative Governance Framework

While government bodies traditionally take a leadership role in setting the policy agenda, all participants in collaborative governance influence decision-making and share responsibility for achieving outcomes.[52] The collaborative governance framework is deliberately designed to promote decision-making that is based on consensus, which is distinct from simple coordination across sectors.[53] *Figure B.1* in Appendix B presents the elements of a collaborative governance framework. Notably, a main challenge with this framework is the need to overcome existing power and information asymmetries among organizations in the behavioral health system for children. However, when this framework is implemented within systems of care, research has noted many positive outcomes, such as improved relationships between families and service providers and increased relevance of mental health services.[54] Additionally, intersectoral collaboration enables agencies to coordinate integrated services, avoid duplication of efforts, reduce service deficiencies, and spread cost and risk across several agencies.

Collaborative governance refers to an "arrangement where one or more public agencies directly engage non-state stakeholders in a collective decision-making process that is formal, consensus-oriented, and deliberative, and that aims to make or implement public policy or manage public programs or assets."

Source: Ansell C, Gash A. Collaborative governance in theory and practice. Journal of public administration research and theory. 2008 Oct 1;18(4):543-71.

A Local Example of Collaborative Governance: DC's Interagency Council on Homelessness (ICH)

The ICH was established by the Homeless Service Reform Act for the purpose of facilitating interagency, cabinet-level leadership in planning, policymaking, program development, provider monitoring, and budgeting for the Continuum of Care (CoC) of homeless services. ICH members include cabinet-level leaders, providers of homeless services, advocates, homeless and formerly homeless leaders. As of May 2021, the ICH has sixteen government representatives, eight CoC service providers, three advocates, four constituent representatives, four business representatives, one CoC representative, and three district council representatives. It is governed by bylaws to facilitate the performance of its duties as outlined in the Homeless Services Reform Act of 2005, DC Law 16-35, and the Homeless Services Reform Amendment Act of 2017, DC Law 22-65.

The city administrator serves as the ICH chairperson, while an executive committee (co-chaired by an appointed community representative and a representative of one of the ICH member agencies) acts as the ICH steering committee. The ICH is required to approve strategic plans, the annual winter plan, and formal performance reports. In terms of voting, if consensus cannot be achieved, a matter shall be deemed approved when a simple majority of the appointed representatives vote in the affirmative. The ICH has standing committees, which include Strategic Planning, Emergency Response and Shelter Operations, Housing Solutions, and Youth. Meetings are open to the public in accordance with the open-meeting provisions of the District of Columbia Home Rule Act, approved December 24, 1973 (87 Stat. 831; DC Official Code § 1-207.42).

The ICH (through its Youth Standing Committee) developed *Solid Foundations DC: Comprehensive Plan to End Youth Homelessness* in May 2017, which has successfully guided ICH's efforts toward improving support for children in DC experiencing or at risk of homelessness. Achievements include launching the District's first 24-hour youth drop-in center, developing prevention programming for young people seeking support and expanding bed capacity for young adults experiencing homelessness.

Sources: Coordinated Community Plan : District of Columbia; Interagency Council on Homelessness; 2020

Committed Efforts to Meaningfully Engage With Diverse Community Stakeholders

Diverse, inclusive collaborations with community stakeholders, especially families and youth, should be actively sought out.[54] With regards to managed care behavioral health integration, a Center of Health Care Strategies report states, "there is no such thing as too much stakeholder outreach, education, and communication."[55] Input of family members and youth can be obtained from multiple avenues, including focus groups, surveys, advisory councils/committees, and public awareness events that promote social connections.[56] Engagement strategies should account for historical and cultural inequities in representation. Behavioral health government bodies should investigate barriers to family and youth participation and actively identify and implement strategies to improve family and youth input in all their functions. For example, a recent study into building community partnerships for behavioral health equity noted that the "bureaucratic and restrictive climate of decision-making processes often alienated community members."[57] Considering that challenge, strategies to improve family and youth engagement should give familiies and youth the necessary tools to fully participate in the governance process.[54]

How the Community Should Be Involved in the Governance of the Behavioral Health System for Children

Institutionalized Collaboration

The community (inclusive of individual beneficiaries, advocates, and community-based organizations) committed to bringing the voice of lived experiences is a critical component of behavioral health system design and implementation.[58] It is important for their role in governance to be sustainable and clearly defined. Formalizing the roles of community partners through memorandums of understanding and/or similar approaches helps to institutionalize collaboration, such that it is sustained regardless of changes to government leadership.[54]

Shared Leadership for Community Members

Hogan et al (2020) note that community engagement is "not just a set of activities and methods confined to a particular project, policy, or process" but instead "a way of communication, decision-making, and governance that recognizes community members' power and includes them and other stakeholders in identifying problems and making decisions that promote equitable outcomes."[59] Authentically involving community residents with lived experience alongside health and social service organizations in the design of equitable policy and practice has emerged as a key tenet of effective system reform. Community members should be given shared leadership and be empowered to play defined roles in governing the behavioral health system. They should be considered partners in governing the system, instead of an external advisory group. Governance of the behavioral health system should have transparent decision-making processes, where community representatives are given decision-making abilities. This is necessary because when community engagement does not promote the ability to make and implement decisions, that creates frustration that undermines participation,[58] especially for groups who already experience inequities and whose voices need to be heard. Notably, accomplishing shared leadership with the community requires dedicated and persistent commitment from all stakeholders because it can be a challenging and resource intensive process.

Time-Bound Strategic Plan, Annual Work Plans, and Formal Quality Improvement Program

Formal governance structures and documents should guide changes in the behavioral health system over time. The DC government through appropriate interagency collaboration should create a time-bound strategic plan that outlines the long-term goals for children's behavioral health, with input from relevant stakeholders, including families, youth, service providers, and education agencies. In line with this strategic plan, the government should develop fiscal year (FY) work plans that identify goals, budget allocations, human resource requirements, and measures of success. The development of annual work plans allows for flexibility in the governance of the system. All plans should be published publicly to support transparency and promote accountability. In addition to plans, the government should have a formal quality improvement program for behavioral health services for children. This program should set District standards for the quality of services and regularly monitor behavioral health services. It should also include a standardized method for collecting feedback, with optional anonymity, about services and agencies from system users and service providers.

Developing comprehensive plans will be particularly important as DC transitions behavioral health services to managed care. There are many prior examples of managed care behavioral health integration that the District may look to as it plans its own efforts. Indeed, to effectively plan for system transformation, it is important to account for challenges commonly cited by states that have already achieved behavioral health integration, such as confusion and subsequent disruptions in care that occur as a result of the new relationships between managed care organizations (MCOs) and providers.[60,61]

Prioritize the Implementation of Evidence-Based, Evidence-Informed, and Emerging Best Practices Informed by Publicly Available Local Data to Facilitate Transparency and Build Trust

To make informed policy decisions, evaluate system functioning, and establish accountability, there should be routine data collection in the District on the behavioral health issues affecting children, as well as on behavioral health service delivery. Thus, government bodies should prioritize the establishment and implementation of a strong behavioral health surveillance system. There should be adequate government capacity for data collection, analysis, and dissemination to establish regular standardized reporting on behavioral health issues affecting children and the behavioral health services available to children to all relevant stakeholders.[62] Over time, these data become the evidence that informs benchmarks and standards for behavioral health services for children and guides clinical practices.

For evidence-based practices (EBPs) to be successfully implemented in behavioral health services, organizational structures and processes must sufficiently support EBP, and providers must perceive EBPs favorably and possess

the knowledge and skill to deliver them with fidelity.[63] Government leaders should communicate to providers and/or provider organizations how EBPs support organizational goals and needs and provide tangible rewards and positive reinforcement for implementing EBPs.[64] Additionally, EBPs must be acceptable to the community and intended beneficiaries of the service. There should also be policies and dedicated funding in place to allow for testing and scale-up of EBPs in the local context, as needed.[64]

3.2 Current System

This subsection will describe the current governmental role in policy creation, oversight, and regulation of the public behavioral health system for children, as well as the policies and legislation that establish authority, responsibility, and accountability mechanisms within the system. Further, this subsection will examine the roles of the community as critical monitors and drivers of change in DC's current behavioral health system.

Government Bodies

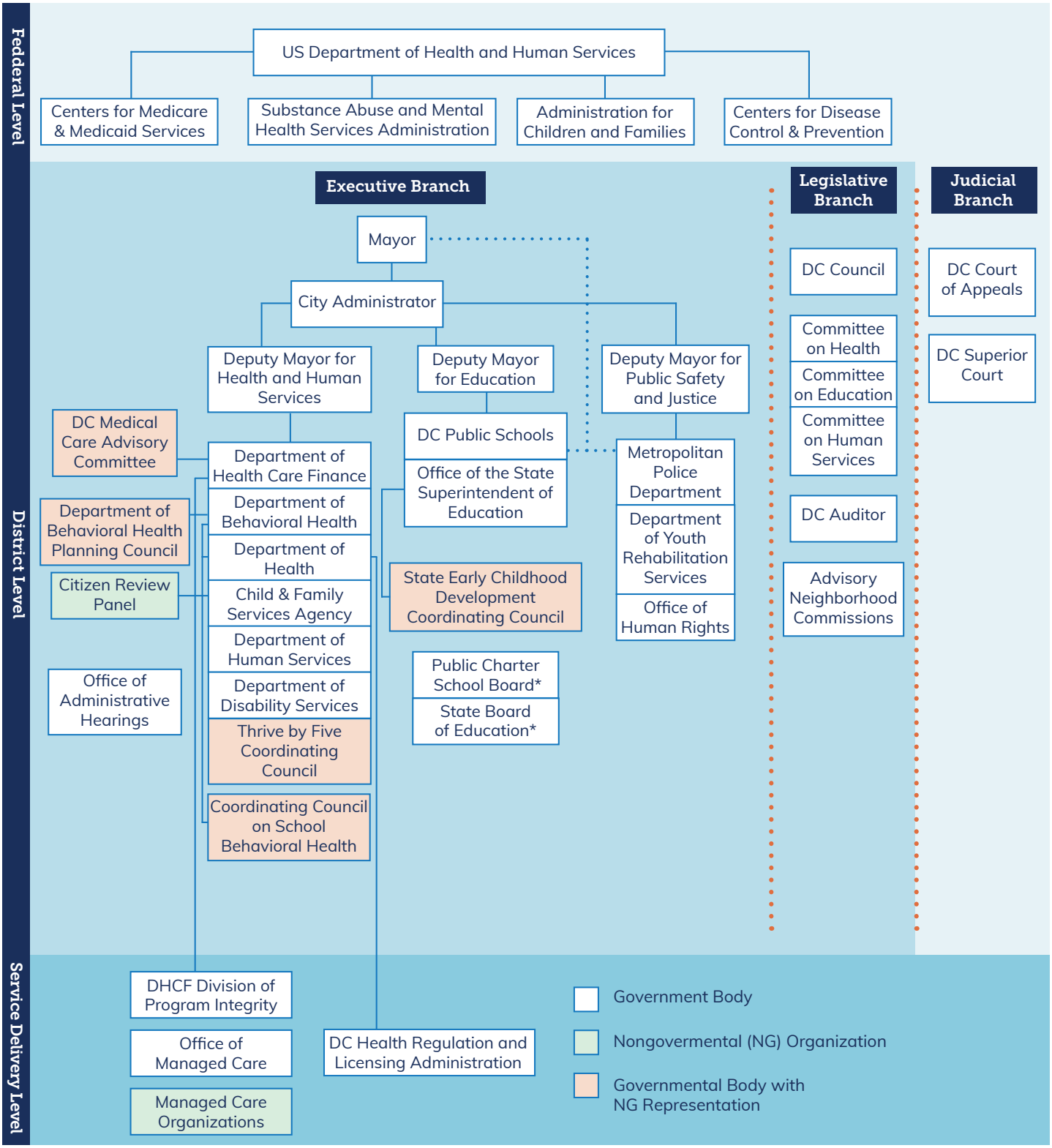
Organizations within the government (including some entities with defined nongovernmental representation) have legal authority to play discrete leadership and governance roles in DC's current behavioral health system for children. *Figure 3.A* highlights the plethora of governmental bodies/posts that perform these roles at the federal, District, and service delivery level and showcases some complexity in the organizational relationships between these bodies/posts. Considering that several aspects of the behavioral health system can fall under many governmental bodies' purview, it should be noted that *Figure 3.A* does not fully encapsulate all agencies involved in the leadership and governance of the behavioral health system but highlights the main agencies. *Table A.1* in Appendix A lists the functions of the main governmental entities shown in *Figure 3.A*, along with the laws and policies that outline these entities' authority and responsibilities.

Federal agencies under the US Department of Health and Human Services influence the local behavioral health system through legislation, regulations, policies, and guidance. In some cases, federal agencies provide a degree of direct oversight to state agencies, such as the monitoring of the DC Department of Health Care Finance's (DHCF) administration of the Medicaid program by the Centers for Medicare and Medicaid Services (CMS). For example, Section 1932 of the Social Security Act requires states to develop a quality strategy that includes access standards and quality evaluation procedures for MCOs contracted by state Medicaid programs, giving CMS oversight of those efforts and the authority to set foundational access standards.[65]

Figure 3.A highlights that two local governmental agencies are central to the public behavioral health system for children: the Department of Behavioral Health (DBH), which oversees the city's public mental health and substance use services, and DHCF, which administers the District's Medicaid plan.[66] The Department of Health (DC Health), specifically the Health Regulation & Licensing Administration, performs a regulatory role through the licensure of behavioral health practitioners and health care facilities. The Coordinating Council on School Behavioral Health represents an intergovernmental collaboration to guide the implementation of the expanded school-based behavioral health system.

Other agencies are also involved in the governance of the behavioral health system through their mandate to serve children who are negatively impacted by certain social determinants of behavioral health. For example, the Department of Human Services (DHS) is responsible for addressing youth homelessness, while the Child and Family Services Agency (CFSA) investigates child abuse or neglect and aims to ensure safe homes for children. In addition to creating laws that can shape the behavioral health system, the DC Council also provides performance and budget oversight to agencies (such as DBH, DC Health, DHCF, DHS, and CFSA) in the executive branch.

Figure 3.A. Government Bodies* Providing Oversight and Regulation to DC's Behavioral Health System for Children



*The Public Charter School Board and State Board of Education are independent organizations.

Adapted from: Government of the District of Columbia Organization Chart; Government of the District of Columbia, Mayor Muriel Bowser; 2019

Nongovernmental Influences: Advocates, Community Organizations, and Philanthropic Entities

While government agencies are formally tasked with most high-level leadership and governance roles in DC's public behavioral health system, it is noteworthy that individual advocates, community organizations, health care providers/organizations, as well as local and national philanthropic organizations and individuals are also key leaders of change in the system. Individual advocates often include caregivers and/or persons with lived experiences and community organizations such as professional associations, family-run organizations, advocacy organizations, and formal coalitions that have strong interests in children and/or behavioral health.

Such individuals and organizations have historically driven changes in the system through various mechanisms. For example, several organizations monitor the government's performance of their assigned functions in the public behavioral health system for children to identify areas of suboptimal practices. Many individuals and organizations also identify systemic problems through their direct work with children, families, and professionals who interact with the public behavioral health system. Once issues have been identified, community organizations can then engage in several processes (which can be aligned to each branch of government) for encouraging government accountability and driving changes in system design, oversight, and regulation. Organizations can engage with the executive branch of government directly by appealing to relevant Departments. For example, some organizations are members of government councils (such as the Coordinating Council on School Behavioral Health or DC Medical Care Advisory Committee) and use those councils as avenues to drive change. The community also can use the legislative branch of government to influence legal change and to urge accountability of departments by testifying to the DC Council. Last, community organizations can drive change through the judicial branch by filing cases (including class action lawsuits) at the courts. Based on the outcome of cases, courts may mandate government agencies to make reforms, which can spur legislative and other systemic changes.

Legislation, Plans, and Policies

While *Table A.1* in Appendix A lists some legislation and policy documents related to children's behavioral health, two particularly relevant plans will be highlighted here. DBH developed the Children's System of Care Plan in 2009, which was a three- to five-year plan to redesign the behavioral health system of care for children.[67] Included in the Children's Plan were aims to implement EBPs, expand community-based service capacity for youth and their families, reduce youth placement in residential inpatient treatment, increase availability of early childhood services, increase family involvement in the behavioral health system, and facilitate formal cross-agency decision-making to support the system of care.[67] In 2015, DBH published a performance report for the Children's System of Care Plan, which highlighted system changes, such as an increase in the number of available EBPs from one in 2009, to twelve in 2013.[67] More recently, DBH published a strategic plan in 2019 to improve behavioral health care for all residents (both children and adults). That plan delineates a number of initiatives, which the District plans to fulfill, categorized into five different overarching goals: (1) prevention and early intervention; (2) access to quality services; (3) recovery and resilience; (4) partnership, integration, and coordination; and (5) leadership, innovation, and accountability. Another relevant report is the 2019 Report and Recommendations of the Mayor's Commission on Healthcare Systems Transformation, which includes several recommendations on improving the District's behavioral health system.

3.3 Gap Analysis

A comparison of DC's current leadership and governance for the public behavioral health system for children to our vision highlights several key gaps that are discussed below.

1. Inadequate institutionalized collaborative governance involving the community

Figure 3.A also showcases that there are several formalized committees that have codified community representation. For example, the Department of Behavioral Health Planning Council requires that 51 percent of the membership with voting powers be consumers or their family members and their advocates. Similarly, the DC Medical Care Committee has fifteen voting members, with at least eight members required to be beneficiaries or beneficiary advocates. Committee bylaws that set the community membership as the majority are good first steps to ensuring nongovernmental voices are heard. However, additional mechanisms need to be established to ensure that community voices are not only heard but are incorporated in decision-making. The lack of compensation to community members for their time and expertise reflects and emphasizes power and resource differentials between government representatives and nongovernment representatives. These differentials can result in community members not being able to participate to their fullest ability. Additionally, these committees' outputs are sometimes used to advise decision-making, which can ultimately result in community members' efforts being dismissed and, thereby, create frustration that undermines participation.

2. Lack of publicly available updated plans

While an illustration of great strategy and initiative on the part of the District, there remain a number of gaps with regards to the plans indicated in Section 3.1 of the report. First, an updated Children's Plan has not been published in over a decade, which serves to reduce both transparency and opportunities for community engagement and collaboration.[68] In the same vein, there is currently no annual reporting of work plans in place, limiting the degree of transparency and accountability the District has to the public. Second, there are no recent published goals or action plans regarding behavioral health services specific to children. Given that children's behavioral health needs often require treatment that is unique from that of adults,[69] the lack of up-to-date strategies that highlight the need for services tailored to children and consider behavioral health advancements may prove detrimental to the District's youth.

3. Low governmental prioritization for data-driven decision-making and evidence-based practices

The lack of standardized data collection and reporting at the District level, along with insufficient data sharing both publicly and between entities suggest low governmental prioritization for data-driven decision-making and evidence-based practices. Further, regular data-driven performance reviews are associated with increases in data-driven decision-making within government agencies.[70] Data related to children's behavioral health in DC, including service utilization and outcomes data, while sometimes provided in agencies' annual performance oversight responses to the DC Council, is not reported by agencies in a user-friendly manner on a regular basis. Such lack of data reporting prevents the opportunity for both government and nongovernment organizations to use local evidence to enhance behavioral health decision-making.[70]

4. Fragmented leadership and governance

Figure 3.A highlights the great extent of fragmentation at the District level across DC's behavioral health system for children, with over five DC departments having some governance role in children's behavioral health. Based on current law, DBH could be identified as the organization primarily responsible for children's behavioral health because its defined purpose, according to DC Code § 7–1141.05, is to:

1. ensure the provision of high-quality behavioral health services by establishing District-wide behavioral health standards and policies;

2. foster and promote behavioral health education and disease prevention;
3. provide high-quality prevention, treatment, and recovery support services related to mental health disorders, addictions, and the abuse of alcohol, tobacco, and other drugs in the District;
4. develop and maintain an efficient and cost-effective behavioral health care financing system; and
5. implement, monitor, and evaluate the District's strategic behavioral health plan.

However, these roles have some overlap with other District agencies' responsibilities. For example, according to DC Code § 4–1303.01a., CFSA is responsible for "offering appropriate, adequate, and, when needed, highly specialized, diagnostic and treatment services and resources to children and families when there has been a supported finding of abuse or neglect," which overlaps with DBH's purposes (1) and (3) above. Another example is that one of DHCF's responsibilities, according to DC Code § 7–771.03., is to "develop a comprehensive, efficient, and cost-effective health-care system for the District's uninsured, under-insured, and low-income residents," which overlaps with DBH's purpose (4) above. These indistinct responsibilities create blurred lines of authority for children's behavioral health in DC, which leads to inefficiencies in the system. Further, with the District's planned shift of behavioral health services to MCOs, existing ambiguities about leadership and governance for children's behavioral health can worsen.

3.4 Recommendations

1. Review, strengthen, and—where possible—institutionalize collaboration with community through documentation and assessments.

Implementing Bodies: DBH, DHCF, CFSA, DC Health, DHS, MCOs
Timeline to Implementation: Short Term

As much as possible, decision-making about the behavioral health system for children should formally involve youth and family representatives. It is important to note that the community must be integrated into the decision-making process and not just be separate advisory or working groups. Extant collaboration agreements between governmental representatives and community representatives should be reviewed and updated to ensure that they include defined rules, partnership goals, and performance measurements. Existing collaborative groups should be formally, independently, and regularly evaluated to document how stakeholder involvement supports change within the behavioral health system, because that demonstrates that community voices are being heard and valued.

Youth and families should be consulted, with appropriate compensation, to comprehensively determine what they need to be able to fully participate in the behavioral health governance process. Notably, meaningful collaborations with community stakeholders require dedicated funding for stakeholder involvement. In addition to ensuring compensation, government agencies should offer education and training on relevant topics including behavioral health jargon and relevant legal issues to empower youth and families to fully participate in the governance process.[54] Tangible assistance such as stipends, transportation, childcare, and meals can also be used to help facilitate community participation.[54]

2. Prioritize and support the development of a sustainable system that routinely captures and analyzes data on prevalence, incidence, severity, risk factors, social determinants, functional outcomes, and access to care for behavioral health conditions.

Implementing Bodies: DBH, DHCF, CFSA, DC Health, DHS, MCOs
Timeline to Implementation: Short Term

Such a system is necessary to make informed policy decisions, evaluate system functioning, and increase accountability. Interagency collaboration to design and develop a behavioral health surveillance system should be prioritized. Leaders should identify a sustainable source of financing, support the required capacity building, and establish data-sharing agreements to support a behavioral health surveillance system. Recommendation #2 in Chapter 7 provides further details on this recommended behavioral health surveillance system.

3. Develop an updated strategic plan for children's behavioral health.

Implementing Bodies: DBH, DHCF, MCOs
Timeline to Implementation: Short Term

All relevant government agencies should collectively develop an updated strategic plan for children's behavioral health, in collaboration with nongovernmental stakeholders. With the upcoming carve-in of behavioral health services into managed care, it is an opportune moment to create a three-year strategic plan for system improvements that will benefit children's behavioral health.

4. Make all strategic plans, work plans, and performance reports publicly available.

Implementing Bodies: DBH, DHCF, MCOs
Timeline to Implementation: Short Term

All relevant plans and reports regarding children's behavioral health should be made publicly available in a timely manner, because that supports transparency and accountability, as well facilitates both federal and nongovernmental collaborations and investments. Published progress reports are associated with increases in data-driven decision-making.[70] It is important that publicly published information be accessible to those who speak other languages and those who are visually impaired.

5. Establish an Interagency Council on Behavioral Health that aligns with the Collaborative Governance Model.

Implementing Bodies: DC Council
Timeline to Implementation: Short Term

The establishment of an interagency council that is responsible for behavioral health will address the existing fragmentation within the system, in a manner aligned with a collaborative governance framework. The official bylaws of such a council should provide all relevant stakeholder representatives (including government and nongovernment representatives) with formalized mechanisms for discussion, collaboration, planning, and decision-making. This interagency council should have adequate representation of child-serving primary care providers, behavioral health providers, community-based and family-run organizations, parents/caregivers of children who receive services, and educators.

Interagency coordination governed by DC law increases accountability, promotes transparency, and enables systemic improvements. The united efforts of the government and the community facilitated through this council is critical to build a system that adequately meets the need for behavioral health services for District children, youth, and families. We acknowledge and support the establishment of this council as proposed in Bill 24-65, the Interagency Council on Behavioral Health Establishment Amendment Act of 2021, as well as the previous Bill 23-0178, Interagency Council on Behavioral Health Establishment Amendment Act of 2019. We also suggest that this interagency council's scope explicitly include children's behavioral health, with defined accompanying mechanisms (such as a standing committee) to focus on this population.

6. More clearly define the roles of DBH, DHCF, and other agencies in children's behavioral health, and update DC code and regulations, as needed, in light of the upcoming behavioral health reforms.

Implementing Bodies: DBH, DHCF, DC Health, CFSA, OSSE, DC Council

Timeline to Implementation: Medium Term

DBH, DHCF, and other relevant government agencies must collaboratively define their new roles in children's behavioral health, through consultation with appropriate stakeholders such as MCO representatives and service providers.

With the upcoming integration of behavioral health into DC's managed care program, we suggest DBH no longer play the role of service provider (perhaps with the exception of Saint Elizabeth's Hospital) or payer of claims billable services. In defining regulatory roles, it is important for provider organizations to be regulated by only one agency in order to minimize the duplication of regulatory burdens on provider organizations. We recommend that DBH regulate specialty mental health and substance use service provider organizations, as well as standalone low-barrier mental health and substance use service provider organizations. DC Health should continue to regulate primary care organizations and hospitals, but when DC Health regulates any organization providing behavioral health services, its regulatory board must include representatives with behavioral health expertise. All agencies regulating behavioral health services need to continue to undertake joint and complementary rule making when they regulate similar services provided by different types of entities regulated by different lead agencies, as exemplified during the implementation of the 1115 waiver. This streamlining and coordination of agencies' roles has the potential to optimize service delivery and care coordination for children.

Appropriate agencies must identify and update the relevant DC laws and regulations to reflect the new roles and requirements for the integration of behavioral health into DC's managed care program. For example, DBH's regulations are framed from the perspective of DBH as an integrated regulator and payor. Even if DBH continues to be a payor for some services, these regulations need to be reframed for a fully managed care environment with MCOs playing a greater role in care coordination and linkages. It is essential that all relevant DC laws and regulations support smooth transitions between forms of care and providers for children, without interruptions of care or confusion over billing.

4. FINANCING

For this report, health financing refers to the function of the behavioral health system "concerned with the mobilization, accumulation and allocation of money to cover the health needs of the people, individually and collectively, in the health system."[2] With reference to that definition, collective financing will be examined through the government's budget dedicated to the public behavioral health system, while individual financing will be examined through the public insurance programs for children in DC.

4.1 Vision for the System

Government Budget for the Public Behavioral Health System for Children

The District's budget for the public behavioral health system for children should be **sufficient to meet children's evolving behavioral health needs**. There must be adequate financing to support the full continuum of behavioral health care for children of all ages. Additionally, **funding sources should be sustainable** to maintain appropriate, high-quality behavioral health care for all. Considering the dynamic nature of population health, the budget should be informed by routinely collected data on the behavioral health needs of children in DC. Because the behavioral health of children falls under several government agencies' purview, there must be **formal interagency agreements** outlining assigned financing responsibilities for behavioral health services for children. All relevant government agencies should review behavioral health financing strategies regularly to ensure that the financing strategies align with, support, and prioritize the principles of family-centered care, cultural humility, racial equity, and trauma-informed care. Further, government plans for financing behavioral health services for children should support the Institute for Healthcare Improvement's Triple Aim (i.e., simultaneously improving the health of the population, enhancing the experience and outcomes of the patient, and reducing per-capita cost of care for the benefit of communities).[71]

A Fully Integrated Program with Value-Based Purchasing Strategies

Previous research has linked pediatric integration models to improved behavioral health outcomes in children.[72] A fully managed care program can be seen as a further step towards integrated care. Thus, in a fully managed care program, all **MCOs should be contracted to deliver both physical and behavioral health services** and not subcontract out behavioral health services, because this facilitates the integration of these services at the payment level and possibly the service delivery level.

As noted in a 2014 Commonwealth Fund report,[73] a carve-in purchasing model does not ensure integrated delivery of care because MCOs may be allowed to subcontract behavioral health payment to external organizations. This subcontracting may dilute integration benefits, especially if there are not strong contract provisions and oversight. Contrastingly, those who support subcontracting argue that MCOs lack the expertise to manage behavioral health care, especially for people with serious mental illness and substance use disorders (SUDs). States such as New York[74] and Tennessee[75] have led successful carve-in efforts that allow for subcontracting, although under stipulations such as careful monitoring of subcontractor performance[76] and requirements for subcontractors to operate within MCO

offices to facilitate coordinated management.[73] In Kansas, another example of a state that allowed subcontracts, subsequent review determined that the state was "not sufficiently involved in monitoring MCOs and sharing results with providers" during its transition to a carve-in system and has reported a substantial number of challenges from the process.[77] *Table C.1* in Appendix C highlights features of models in selected states, along with outcomes. Those examples serve to highlight the importance of oversight and accountability when allowing MCOs to subcontract behavioral health management to an outside entity. The National Health Law Program notes that there is no emerging behavioral health integration model across states, with states adopting a variety of models ranging from fully integrated managed care to hybrid integration models.[78] A recent study found that the shift to managed care at the national level led to a modest increase in Early and Periodic Screening, Diagnostic and Treatment (EPSDT) participation for children in Medicaid.[79]

Overall research has found mixed results on the impacts of managed care on quality, access, and costs of health services.[80] That may be because MCOs could be incentivized to limit payments to providers through minimizing service utilization and/or provider reimbursement rates to maximize their profits.[81] That can negatively impact provider networks (and, therefore, access to care), as well as quality of care. To guard against this, in our envisioned system, the government would **require and enforce MCOs' reporting on standard quality of care measures**, including targeted, validated[82] measures specific to behavioral health services for children and behavioral health outcomes. Another countermeasure is **mandated value-based payment approaches that are tied to quality outcomes, including behavioral health outcomes**. Below highlights some common value-based purchasing (VBP) strategies.

Common Value-Based Purchasing Strategies

- **Pay for performance: Providers are financially rewarded for meeting or improving their performance on pre-established quality measures.**
- **Bundled payments: Payments are based on expected costs for a clinically defined episode or bundle of related health care services.**
- **Episodes of care: Provider is held accountable for the costs and quality of a defined and discrete set of services for a defined period of time.**
- **Case rate: Fixed per-member, per-month rate for every actual user.***
- **Shared savings: VBP payment model that pays organizations using a fee-for-service (FFS) model but rewards organizations if spending is below the target at the end-of-year.**
- **Shared risk: VBP payment model in tandem with shared savings that penalizes organizations spending more than the target.**
- **Capitation: Fixed per-member, per-month rate for every eligible user.***

Source: Value-based Payment Arrangements in Children's Behavioral Health: A Provider Profile Report, National Council for Behavioral Health, 2018

***According to The Journal of Urgent Care Medicine, the main difference between capitation rate and case rate is that providers receive a flat monthly fee that covers all services with capitation, while they receive a flat fee per visit with case rate.**

Billing & Reimbursement

Public health insurance programs in the District, whether administered through FFS or MCOs, must offer **competitive provider reimbursements** to encourage behavioral health providers to participate in public health insurance plans. Practitioners delivering behavioral health care to children and preventive services should be **compensated at a level that is commensurate with the time and effort expended.**[83] A recent report from the National Bureau of Economic Research demonstrates that more competitive Medicaid reimbursement rates are tied to better access to care and outcomes for children.[84] Research showed that for every $10 increase in Medicaid reimbursement per visit, parents were 0.5 percentage points more likely to report no difficulty finding a provider for their Medicaid-insured children.[84] Additionally, the same $10 increase in payment per visit reduced reported school absences among primary school-aged Medicaid recipients by 14 percent.

Provider **reimbursements rates should be updated regularly** to remain competitive in evolving markets. DBH and DHCF, in collaboration with providers and beneficiaries, should also evaluate all newly added billing codes to ensure codes are appropriate for the service required. Additionally, billing processes should be easy to navigate and reimbursements should be timely enough to avoid disruptions to providers' businesses. There should be an **established mechanism for consulting providers on all major billing and reimbursement decisions** (whether operational or strategic).

Additionally, MCOs' coverage limits should be based on national standards of care, which take into account the full continuum of behavioral health care services when defining medical necessity.[85] The criteria for medical necessity should be made transparent to the public, be consistent across MCOs, and be formed by an independent party.

Network Adequacy

MCOs should have **adequate behavioral health provider networks for children.** It is critical for DHCF to not only routinely monitor but also enforce network adequacy. Meaningful measures of behavioral health network adequacy standards should go beyond the federally mandated standards (which include travel time and distance standards)[86] and should have strong correlations with access to and quality of care.[87] The development of new and/or updated local network adequacy standards should involve stakeholder consultation (inclusive of providers and beneficiaries) and consider specific settings, community needs, and resource constraints. All **network adequacy standards should be tied to accountability mechanisms** that are regularly and transparently enforced.

Investment in Addressing Social Determinants of Health

There should be increased investments from government agencies, MCOs, and provider organizations to address the social determinants of health (SDOH) that impact behavioral health in children in DC, including maximized opportunities, where appropriate, under Medicaid and Children's Health Insurance Program (CHIP) to address SDOH. In our family engagement forums, both parents/caregivers and youth from the District identified several socioeconomic factors—including poverty, community violence, and a lack of support from the community and family—that negatively impact children's behavioral health.

Research has found that investment in programs addressing such SDOH in children has yielded positive outcomes for children.[88] Therefore, strategies to improve children's behavioral health must include strategies to address these external factors affecting their behavioral health.

In our family engagement efforts, youth were asked to discuss the main mental health challenges currently facing youth in DC, and they shared:

"It's just, like, our environment. Like, we try so hard to not be a product of our environment, but even though we try so hard, we are still being judged."

"A lot of youth are really stressed with like their environment."

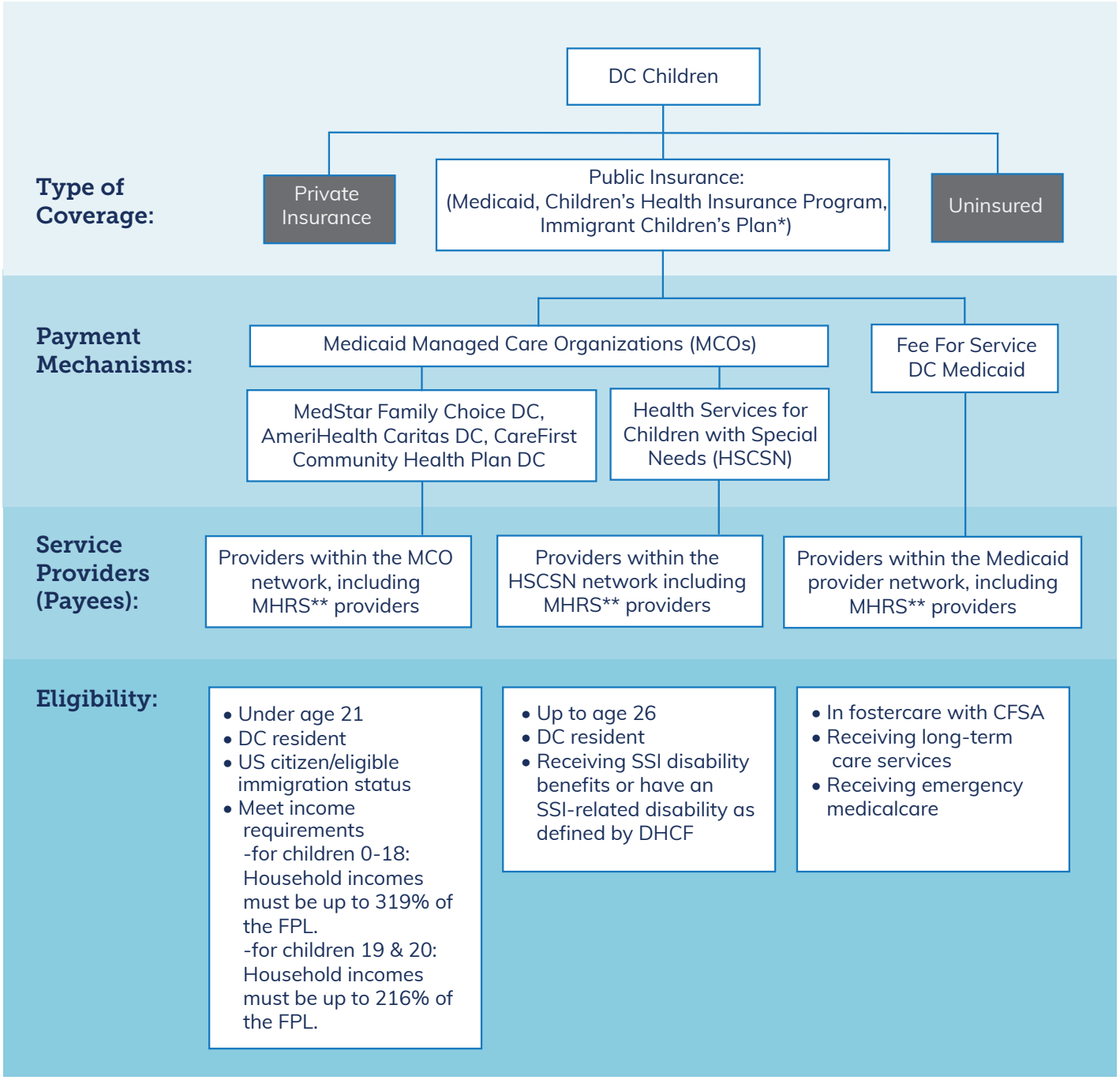
4.2 Current System

This section will examine collective financing of DC's behavioral health system for children through the government's budget dedicated to the current public behavioral health system. In contrast, individual financing will be examined through the existing public insurance programs for children in DC.

Insurance Programs

Figure 4.A highlights the different publicly funded health insurance options for children in DC, which are all administered by DHCF.

Figure 4.A. Public Health Insurance Programs in DC for Children



Adapted from: Behavioral Health for Children, Youth and Families in the District of Columbia: A Review of Prevalence, Service Utilization, Barriers, and Recommendations, Georgetown University National Technical Assistance, and Center for Children's Mental Health, May 2014.

*** Through the Immigrant Children's Program (a 100% locally funded program), children under age 21 who are not eligible for Medicaid and have income at or below 200% of the FPL are assigned to a managed care organization. See "Immigrant Children's Program," Department of Health Care Finance. Services covered under the Immigrant Children's Program are identical to the services covered under Medicaid for children under age 21 (MCO contract). Additionally, DC Health Alliance is another public health insurance program. It was not included because it serves individuals over age 21 and does not cover behavioral health and substance abuse services. See "Health Care Alliance," Department of Health Care Finance. Note that the CHIP is not a separate program in DC, but instead its funds are used to expand the Medicaid program.**

****MHRS- Mental Health Rehabilitation Services**

As reflected in *Figure 4.A*, DHCF finances services through contracts with four MCOs and directly through individual providers on an FFS basis. In September 2019, DHCF announced plans to move toward a fully managed care Medicaid program over the next five years.[89] That shift, which involves transitioning individuals currently in Medicaid's FFS program to the Medicaid managed care program, began in October 2020.

DHCF pays fixed capitated rates to the MCOs to finance the delivery of services to MCO-enrolled beneficiaries within the managed care network. In 2019, DC spent approximately $1 billion on MCO services, with 84 percent ($881 million) of that amount funding the full risk-based contracts signed by AmeriHealth Caritas DC Inc., Amerigroup DC, and CareFirst BlueCross BlueShield Community Health Plan DC (formerly known as Trusted Health Plan) and approximately 16 percent ($174 million) funding the risk-sharing contract with HSCSN.[90] For FY 2021, DHCF awarded three new managed care contracts (cumulatively comprising a not-to-exceed amount of approximately $1.49 billion)[91] to AmeriHealth Caritas, MedStar Family Choice, and CareFirst BlueCross BlueShield.[92] For those MCO plans in FY 2021, *Table 4.A* provides estimates of the monthly "actuarially sound rates" for children, and *Table 4.B* outlines the behavioral health services that MCOs are required to cover for children. Note that for children diagnosed with severe emotional disturbances and adolescents with substance use disorders who need more intensive in-home or community-based services, the responsibility shifts from the MCO to Mental Health Rehabilitation Services (MHRS) that DBH provides. *Table B.1* in Appendix B provides an overview of MHRS. All youth enrolled in Medicaid, whether their care is financed through an MCO or FFS arrangement, are eligible to receive MHRS through the DBH provider network. MHRS delivered through non-MCO arrangements are paid on an FFS basis, even when delivered to MCO-enrolled Medicaid beneficiaries. Note that the District's behavioral health system is undergoing reform, with the aim of adding certain behavioral health services (the list of services to be added are not yet publicly available) into the District's managed care contracts beginning October 1, 2023.[6]

Table 4.A. Enrollment Estimates for Children Proposed for the Base Year in the 2020 MCO Contracts

Rate Cohort	Actuarially Sound Rates	Estimated Total Monthly Enrollees per Rate Cohort*	Total Estimated Monthly Price per Rate Cohort
Children Age <1	$584.69	4,576	$2,675,541.44
Children Ages 1- 18	$240.87	72,499	$17,462,834.13

***Included Medicaid and ICP estimates**
Adapted from: MCO MedStar Family Choice Contract, CW83148, Base Period October 1, 2020, to September 30, 2021

Table 4.B. MCO Coverage Requirements for Behavioral Health Services for Children

Behavioral Health Service	MCO's Coverage Requirements
DBH-provided services: community-based interventions, multi-systemic therapy (MST), assertive community treatment (ACT), community support recovery support services	Care coordination, case management, and transportation for enrollees receiving services through DBH
Physician and mid-level visits including: diagnostic and assessment services, individual counseling, group counseling, family counseling, federally qualified health center services, medication/somatic treatment	Services furnished by the MCO's network of mental health care providers
Crisis services	Mobile crisis/emergency services, excluding beneficiaries actively receiving services in a DBH certified entity; the MCO is responsible for care coordination, case management, and transportation (when applicable) for enrollees who are enrolled in a DBH certified entity.

Behavioral Health Service	MCO's Coverage Requirements
Inpatient hospitalization and emergency department services	Inpatient hospitalization and emergency department services
Case management services	Case management services, as described in 42 C.F.R. § 440.169, for individuals identified by DBH as diagnosed with a serious mental illness (SMI) or other chronic behavioral health disorder.
Inpatient psychiatric facility services	Inpatient psychiatric facility services for individuals under age 21 as described in 42 C.F.R. § 440.160
Patient psychiatric residential treatment facility (PPRTF)	PPRTF services for enrollees less than 22 years of age
Access to mental health services	Education regarding how to access mental health services provided by the MCO, as well as the DBH
Pediatric mental health services	All mental health services for children that are included in an Individualized Education Program or Individualized Family Service Plan during holidays, school vacations, or sick days from school
Inpatient detoxification	Inpatient detoxification
Outpatient alcohol and drug abuse treatment	Clinic and other licensed practitioner services; for outpatient rehabilitation services, the MCO is responsible for referrals to DBH.
Behavioral health service to students in school settings*	Services are covered if the following are met: The provider has a sliding fee schedule for billing for children and youth without an IEP; the provider is credentialed as a network provider by the MCO; the provider has an office in the school and provides services in that office; and the provider bills the MCO for the services using the codes provided by DHCF.

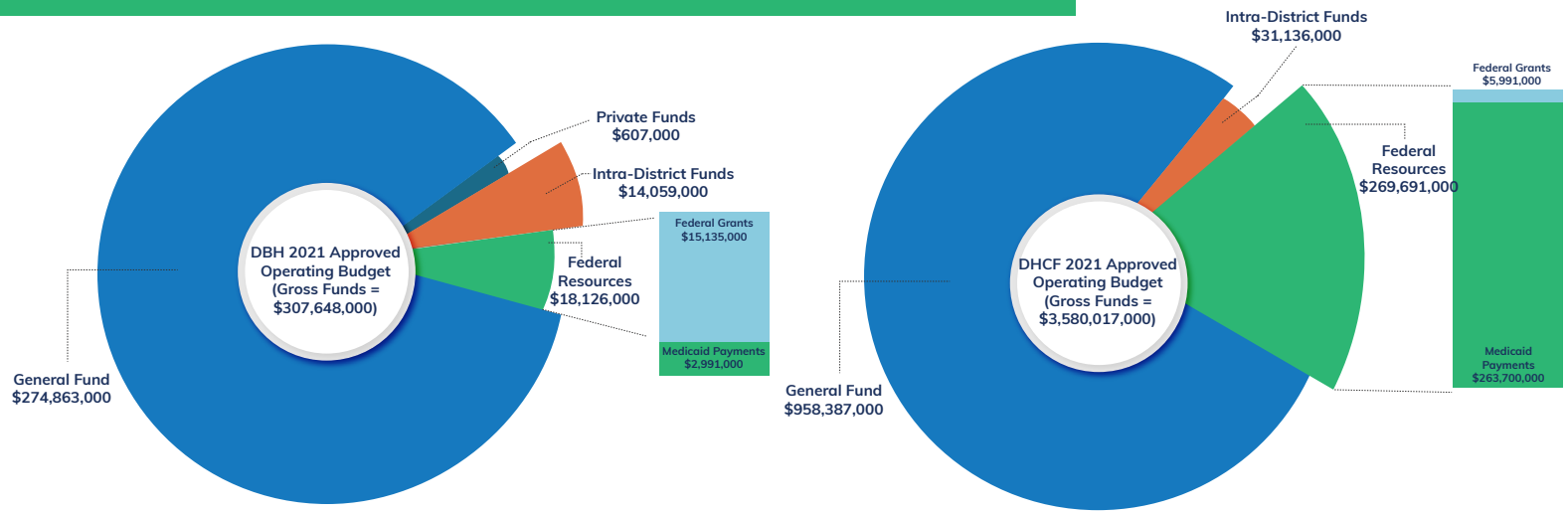
Adapted from: MCO MedStar Family Choice Contract, CW83148, Base Period October 1, 2020, to September 30, 2021. Table B: Medicaid Behavioral Health Services, rows 1–6, 8–14.

***A DBH grant has been awarded to supplement community-based organizations to engage in practices that support effective delivery of school-based mental health services but are not reimbursable (e.g., participating in team meetings, consultation with teachers, parent/family engagement, prevention activities, etc.).**

Government Budget for the Public Behavioral Health System for Children

It is difficult to accurately assess the current government budget allocation for DC's public behavioral health system for children because costs that are specific to children and/or behavioral health services are not always delineated in budget items (and therefore represent an unknown subset of several budget line items, such as "clinical health services" in CFSA's budget). Given that, the overall budget for the two main agencies involved in the public behavioral health system (DBH and DHCF) are presented in *Figure 4.B*.

Figure 4.B. 2021 Approved Operating Budgets[93] for DBH & DHCF



Note: The general fund includes local funds, dedicated taxes, and special purpose revenue funds. Private funds include private grant funds and private donations. Intra-district funds represent payments received for services from other District agencies. Federal grants are grants the District receives from federal agencies, including block grants, formula grants, certain entitlements, and competitive grants. Based on data from Government of the District of Columbia. FY 2021 Approved Budget and Financial Plan Volume 4 Agency Budget Chapters - Part III.

Figure 4.B highlights differences in quantity and type of federal funding between DBH and DHCF. Notably, local dollars (which refer to District funds used to cover services not reimbursable by Medicaid) comprise approximately 83 percent of DBH's budget compared to approximately 56 percent of DHCF's budget. DBH's federal budget is primarily grant funding, including the Community Mental Health Services Block Grant and the Substance Abuse Prevention and Treatment Block Grant from the Substance Abuse and Mental Health Services Administration (SAMHSA).[94] Those Block Grants are given for a two-year period and fund DBH programs and community-based organizations (CBOs). *Table 4.C* provides more information on some federal grants awarded to DBH that support behavioral health services for children in the District. For DHCF, the District's Medicaid administrator, a more significant portion of their budget comes from federal resources because Medicaid is a joint federal-state program. DHCF receives a federal payment or "match" for Medicaid based on the amount spent on services and the Federal Medical Assistance Percentage[iv] (FMAP) rate, which is set at 70 percent in the District. In DC, CHIP[v] is administered as part of the Medicaid expansion, instead of as a separate program.[95] The federal government reimburses CHIP spending at a higher matching rate than Medicaid's (known as the enhanced federal medical assistance percentage or E-FMAP). For FY 2020, the federal government covered around 94 percent of CHIP costs (an increase from the planned 90 percent due to emergency legislation), but that dropped to 79 percent in FY 2021, where it will remain.[96] DC Medicaid had an annual budget of approximately $3 billion dollars in 2019 (of which $55.3 million was CHIP spending), with 94 percent of that amount spent on services rendered by medical service providers.[95]

Table 4.C. Selected Federal Grants Awarded to DBH that Support Behavioral Health Services for Children in DC

Grant Number/Title	Grant Purpose	Funding Source	FY2020 Expenditure
6H79SM061903/Positive Transitions Youth – Young Adult/(81PTYA)	Design and implement a youth-focused system of care with Core Service Agencies providing transition-age youth-specific care planning, wraparound, evidence-based practices, and recovery supports.	SAMHSA	$46,757.59

[iv] *The Federal Medical Assistance Percentage (FMAP) is computed from a formula that takes into account the average per-capita income for each state relative to the national average. The FMAP rate for DC has been set in statute at 70 percent since 1998 for the purposes of Title XIX and XXI of the Social Security Act, but for other purposes, the FMAP rate for DC is 50 percent, unless otherwise specified by law. The Families First Coronavirus Response Act of 2020 (P.L. 116-127) provides a temporary 6.2 percentage point FMAP increase during a public health emergency for each calendar quarter occurring during the period beginning on the first day of the public health emergency period, as defined in Section 1135(g)(1)(B) of the Social Security Act (the Act), and ending on the last day of the calendar quarter in which the last day of such emergency period occurs*

[v] *CHIP is a joint federal and state program that provides health coverage to uninsured children in families with incomes too high to qualify for Medicaid but too low to afford private coverage.*

Grant Number/Title	Grant Purpose	Funding Source	FY2020 Expenditure
3B09SM010008/State Mental Health Block Grant/(02MHBG)	Funding is used to develop and support community mental health services such as peer services, continued support for clubhouse infrastructure[vi], DBH strategic planning and results-based accountability efforts.	SAMHSA	$548,001.00
5H79SM063426/District of Columbia Social, Emotional and Early Development (DC SEED) Project (91SEED)*	Implement a four-year system of care[vii] to address the highly specific, largely unmet needs of infants and young children (birth–6) residing in DC who are at high imminent risk for and diagnosed with serious emotional disturbance (SED).	SAMHSA	$1,074,332.11
1H79TI081212-01/District of Columbia Changing and Improving Treatment for our Youth (91CITY)	Enhance DBH services for youth (ages 12–18) and transition-age youth (ages 18–25) to provide a comprehensive, family-centered, trauma-informed, evidence-based, coordinated system of care from early intervention through recovery. Provide tobacco use counseling and interventions as a standard of practice. Increase access for youth/transition-age youth and their families to co-occurring substance use disorder/mental health services. Develop and implement education and messaging on making healthy choices regarding substance use and emotional wellness.	SAMHSA	$235,867.99
1H79SM081976-01/ OurTime: Exploration (91EXPL)	Focus on Wards 1 and 6 to increase the self-efficacy and meaningful participation in transition plans of young adults ages 16–25 who have mental health and/or co-occurring substance use disorders. Improve and expand treatment recovery and support services and strengthen evidenced-based practices that address all life domains.	SAMHSA	$156,547.00
5H79SM081976-02/ OurTime: Exploration (01EXPL)	Focus on Wards 1 and 6 to increase the self-efficacy and meaningful participation in transition plans of young adults ages 16–25 who have mental health and/or co-occurring substance use disorders. Improve and expand treatment recovery and support services and strengthen evidenced-based practices that address all life domains.	SAMHSA	$154,568.75

Adapted from Department of Behavioral Health FY20-21 Performance Oversight; Response to Question 12

***DC SEED Project Grant ended in March 2021**

Table 4.D highlights DBH's mental health services for children that were funded solely by local dollars over the previous five fiscal years. Additionally, according to DBH, $188.6 million (of which 6 percent or $11.5 million were local funds) was spent on claims-based mental health services for adults and children in FY 2020, reflecting a 30 percent increase in spending on mental health services from FY 2019 to FY 2020.[97] On the other hand, $26.4 million (of which 47 percent or $12.3 million were local funds) was spent on claims-based substance use services for adults and children in FY 2020, reflecting a slight decline from the previous year.

[vi] *Here the term "Clubhouse" refers to rehabilitative services providing an enriched, structured environment for individuals whose lives have been impacted by mental illness as reported by Clubhouse International.*

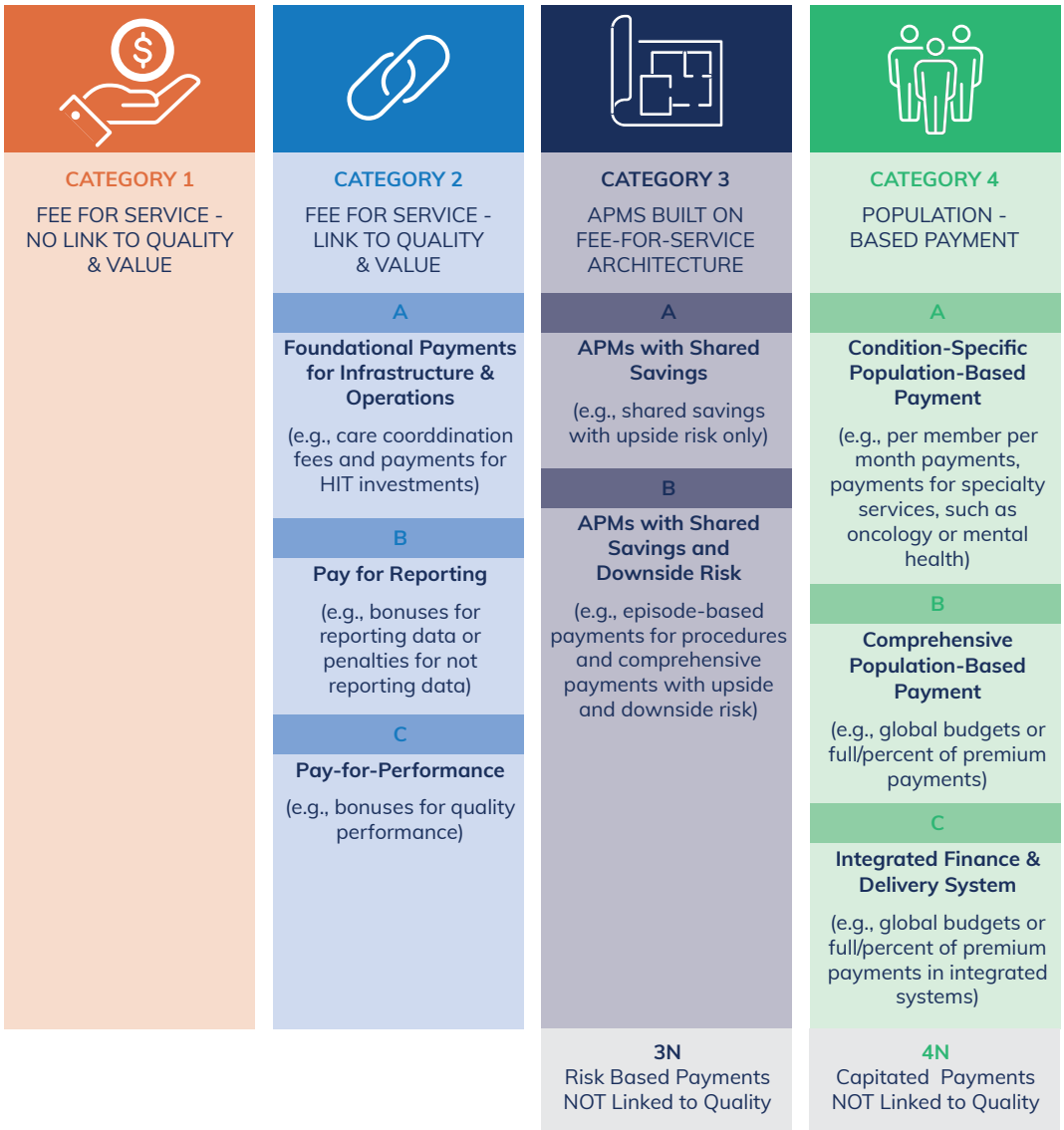
[vii] *"System of care" refers to "a broad, flexible array of services and supports for a defined population(s) that is organized into a coordinated network, integrates service planning and service coordination and management across multiple levels, is culturally and linguistically competent, builds meaningful partnerships with families and youth at service delivery, management, and policy levels, and has supportive management and policy infrastructure" as reported by the National Technical Assistance and Evaluation Center for Systems of Care.*

Value-Based Purchasing

DHCF implemented an MCO pay-for-performance (P4P) program in 2017, which included a provision that withholds the 2 percent profit margin for each MCO that is factored into the base per-member, per-month—or capitated—payment rate.[98] The withheld capitated payment amount, or withhold, can be earned back contingent upon performance in three outcomes-based measures: (1) Thirty-day hospital readmissions for all causes, (2) potentially preventable admissions, and (3) low acuity nonemergent (LANE) emergency department (ED) visits (the provision of ED services for nonemergency or low-severity health concerns).[98,99] Each of the three outcomes is weighted at about one-third the value of the withhold and can be earned back in full for a 10 percent reduction in the measure rate from baseline (defined as April 2015 through March 31, 2016).[100] For a 7.5 percent reduction in the measure rate from baseline, half of the weighted value of the withhold can be earned back. For a 5 percent reduction in a measure rate from baseline, an MCO can earn back one-fourth of the weighted value of the withhold.

Under the new MCO contracts, MCOs are required to incorporate value-based purchasing initiatives (which may include any combination of the payment model categories defined by the LAN-APM framework as shown in *Figure 4C*) with providers in its network, with a set target for the total medical expenditures required to be linked to VBP strategies.[91]

Figure 4.C. Health Care Payment Learning & Action Network Alternative Payment Model (LAN-APM) Framework



Source: "Figure 1: The Updated APM Framework," Alternative Payment Model: APM Framework, Health Care Payment Learning & Action Network and The MITRE Corporation, 2017

Additional clarification about use of the HCP-LAN framework may be needed, because regulators, payors, and providers may have different beliefs about what APM type/level matches a particular payment model. DHCF also aims to incorporate SDOH in its VBP initiatives and has sought community feedback regarding methods through which to accomplish this goal.[101]

Billing & Reimbursement

Under DC Medicaid FFS, DHCF pays providers directly per unit of services provided. For Medicaid managed care, each MCO is responsible for paying a provider network that offers traditional behavioral health outpatient services (e.g., diagnostic assessment, psychotherapy, and psychiatric evaluation and medication management services). If the MCO's network cannot provide a specialty service, the MCO is required to pay for the cost of out-of-network services. The MCO is required to coordinate with out-of-network providers with respect to authorization and payment in those instances. DBH providers are reimbursed on an FFS basis by Medicaid for MHRS and by DBH for locally funded services, including any children's SUD services paid on an FFS basis. In FY 2020, DBH transitioned billing for MHRS and SUD services to DHCF to enable the individual provider agencies to bill Medicaid directly.

Table 4.D. Children's Mental Health Services which are Currently Funded by Local Dollars*

Children's Services Funded with Local Dollars	FY15	FY16	FY17	FY18	FY19
High Fidelity Wraparound	$2,240,912	$3,258,388	$887,916	$616,851	$563,865
Court-Ordered Evaluations	$1,046,544	$1,105,250	$999,667	$893,149	$552,130
School Mental Health Program	$4,915,201	$5,600,889	$6,177,765	$5,314,292	$8,629,644
Primary Project	$367,213	$387,332	$371,618	$409,316	$439,320
Healthy Futures	$601,002	$619,590	$638,753	$658,508	$678,874

Source: Department of Behavioral Health FY19-20 Performance Oversight Questions, Response to Question 35, 2020.

The FFS reimbursement rates for behavioral health services are posted on DHCF's website.[102] It is noteworthy that except for behavioral health services provided by hospitals[viii], there is no mandatory process for calculation of rates for behavioral health services, and DHCF typically hires a third party to set rates. DBH provider reimbursement rates are not inflation indexed.

For children and families, the following MHRS services are eligible for Medicaid reimbursement when provided by certified MHRS providers to eligible consumers: community support, diagnostic assessment, mental health therapy (formerly, counseling), medication/somatic treatment, assertive community treatment (ACT), community based intervention (CBI), crisis emergency, child parent psychotherapy for family violence, intensive day treatment services, rehabilitation day services, and trauma-focused cognitive-behavioral therapy. Additionally, according to 22 DCMR Chapter A73, DBH-certified mental health peer specialists, who are employed by DBH-certified community mental health agencies, are authorized to provide Medicaid-reimbursable MHRS to consumers when working under the supervision of a qualified practitioner. These certified peer specialists can also provide other mental health services and support that can be reimbursed through local funds as per the MHRS provider's Human Care Agreement.[103]

Through a recently approved demonstration program ("Behavioral Health Transformation" section 1115(a) Medicaid demonstration), the District received authority to provide new behavioral health services reimbursed by the Medicaid program between January 1, 2020, and December 31, 2024. Authorized services that will directly benefit children include new reimbursement methodologies for youth mobile crisis intervention and specific trauma-targeted services.

[viii] *MCOs reimburse District hospitals, as described in Section C.5.29.7.1, per the DHCF FFS rate methodologies determined by DRG base rates, DC Medicaid FFS case weights, and outlier methodologies. The results of the annual rate analysis will be reviewed as a part of annual rate development and will be addressed in the final capitation rates per consideration of final hospital reimbursement requirements. MCOs reimburse District hospitals, as described in C.5.29.7.1, for outpatient services no less than 130 precent of DC Medicaid FFS fee schedule.*

Additionally, under the demonstration program, specific professionally licensed individuals are now eligible to enroll in the DC Medicaid program, including psychologists, licensed independent social workers, licensed professional counselors, and licensed marriage and family therapists. For those providers, Medicaid reimbursement will be available for psychological testing, assessment, diagnostic, and screening services when provided to an eligible beneficiary, with some exceptions.[ix] For eligible Medicaid beneficiaries diagnosed with an SED, SMI, or SUD, Medicaid reimbursement will also be available for counseling, psychotherapy, treatment planning, and care coordination.[102]

Some behavioral health services for children are not Medicaid-reimbursable and are paid for using DBH local funds, including services and supports provided by Child Choice Providers[x] (FLEXN codes), as well as some continuity of care treatment planning and discharge treatment planning for consumers in a hospital or other institutional setting.

Certain services also require medical necessity review and authorization typically from DBH prior to their delivery, including ACT, CBI intensive day treatment service, and residential crisis stabilization. Per DBH Policy 300.1, Level of Care Utilization System (LOCUS) Evaluation, DBH requires that Core Service Agencies complete a Child and Adolescent Functional Assessments (CAFAS) evaluation for each child/youth consumer, which is used to assist in making level-of-care determinations for services requiring prior authorization or reauthorization. MCOs are required to develop medical necessity criteria, which for children ages birth through twenty years of age must reflect EPSDT guidelines.[91]

Claims for behavioral health services can be submitted to DHCF's contracted fiscal agent, Conduent, by paper or electronically using standardized forms. DC providers have the option of billing via web portal, electronic data interchange, or paper. As of 2012, the timely filing period for Medicaid claims is 365 days from date of service. Under the Prompt Payment Act, D.C. Code §31-3132, MCOs are required to pay or deny clean claims within 30 days to satisfy timely filing requirements. It should be noted that this timely filing requirement does not apply to claims that are initially denied, and some providers have previously expressed concern that MCOs were unfairly denying a high rate of claims as a finance management strategy.[100] MCOs are required to pay or deny 90 percent of all clean claims within thirty days of receipt, consistent with § 1902(a)(37)(A) of the Act and D.C. Code § 31-3132. Further, in accordance with 42 C.F.R. §§ 447.45 and 447.46, MCOs must pay 99 percent of clean claims within ninety days of receipt. Behavioral health providers report experiencing periodic challenges with the reimbursement process, which can sometimes delay payments and disrupt business.

Network Adequacy & Timely Access to Care Standards

Under the new MCO contracts, MCO behavioral health services network must include: child psychiatrists, specialists in developmental/behavioral health medicine, child psychologists, social workers (including those specializing in treatment of mental health and substance use disorder), inpatient psychiatric units for children, residential treatment facilities, partial hospitalization and intensive outpatient programs, and coordination and case management service providers. Additionally, the MCO network must include certified early intervention providers for health-related IDEA services to children under age three, as well as providers qualified to perform evaluations for IDEA eligibility and provide health-related IDEA services for children three years of age and older (unless and until DC Public School (DCPS) provides those services).

MCOs are subject to ensuring access to behavioral health services in accordance with the 42 CFR § 438.68 (network adequacy standards) and § 438.206 (availability of services), as well as the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 (ensures that behavioral health coverage is on equal footing with medical and surgical coverage) and the District of Columbia Behavioral Health Parity Act of 2018.[91] Current DC Medicaid MCO contracts specify mileage and time provider access standards as within five miles of an enrollee's residence or no more than thirty minutes travel time.[91]

[ix] *See Section 9.1 for more information.*

[x] *Child Choice Provider is an MHRS Core Service Agency with demonstrated ability to provide quality, evidence-based, innovative services and interventions to meet the most complex and changing needs of children, youth, and their families in the District, particularly those who have histories of abuse or neglect. Organizations that have contracts with DBH as Child Choice Providers are eligible to bill DBH using FLEXN codes up to the monthly ceiling provided in their contracts. See Notice of Proposed Rulemaking, Department of Mental Health, 2010.*

MCOs Accessibility Requirements Based on Contract

Table 4.E outlines timely access standards for contracted MCOs. DC's Managed Care contracts specify that an enrollee must wait less than forty-five minutes once at the appointment to get services.[91] Phone-based assessment for crisis care must be available within fifteen minutes of request, and medically necessary treatment provided by a qualified mental health professional alongside access to an on-call psychiatrist must be within ninety minutes of assessment completion.[91]

DHCF requires MCOs to establish standards regarding the delay time between enrollee request for an appointment and the date of appointment as well as the in-office wait times for appointments within ninety days of their contract award.[91] MCOs must monitor provider performance in meeting those standards as well as provider requirements set by DHCF and take corrective action, such as through fines, remedial action, and sanctions to address noncompliance.[91]

If they choose, MCOs may set standards for its providers that are more stringent than DHCF requirements.[104] For example, while not required to do so, AmeriHealth Caritas makes public its access to behavioral health care standards, which states that nonemergency urgent psychiatric or mental health care, a level of care not defined by DHCF standards, must be administered by its providers within the same day as enrollee requests.[104]

Table 4.E. Timely Access Standards in MCO Contracts

Provider Type	Appointment Type	Timely Access Standards
Primary Care	New Enrollee Appointment	45 days from enrollment or 30 days from request, whichever is sooner
	Routine Appointment	30 days from request
	Non-Urgent Referrals	30 days from request
	Diagnosis and Treatment of Health Condition (not urgent)	30 days from request
Specialists	Non-Urgent Referral	30 days from request
Pediatrics (EPSDT)	New Enrollee Appointment	60 days from enrollment or sooner to comply with periodicity schedule
	EPSDT Examination	30 days from request
	IDEA Part C Multidisciplinary Evaluation	30 days from referral
	IDEA Part C Treatment	25 days from signed Individualized Family Service Plan (IFSP)
Mental Health	Mental Health Outpatient	-Within 7 days of discharge from a psychiatric residential treatment facility (PRTF) -Within 30 days of discharge from an acute care admission
	Treatment of Psychiatric Crises	Available 24 hours a day, 7 days a week, including holidays.
	Phone-Based Assessment for Crisis Care	Within 15 minutes of request
	Medically Necessary Treatment Provided by a Qualified Mental Health Professional Alongside Access to an On-Call Psychiatrist	Within 90 minutes of assessment completion

Adapted from 2019–2023 DC Medicaid Managed Care Quality Strategy, Table 3.

CSA Accessibility Requirements Based on DC Code & DBH Policies

The DBH standards require DBH-certified behavioral health providers who serve youth to schedule outpatient care for 70 percent of youth who receive acute care within seven days and 80 percent within thirty days.[105] CSA requirements outlined by the DC government include provision of routine appointments to consumers within seven days of original request and same-day interventions, including those involving face-to-face contact, for urgent needs.[106] They also include operation of an on-call system available twenty-four hours a day, seven days a week to respond to all consumer situations, whether emergency or routine (referred to as the "CSA On-Call System").[106] The CSA On-Call System must adhere to the following: (1) provide access to a licensed and qualified behavioral health provider to resolve problems telephonically, (2) provide timely access to a licensed and qualified behavioral health provider for crisis support services including face-to-face interventions, and (3) linkage to crisis support services, such as crisis stabilization services and next-business-day appointments for urgent care.[106]

4.3 Gap Analysis

A comparison of DC's current financing for the public behavioral health system for children to our vision highlights several key gaps that are discussed below.

1. Subcontracting of behavioral health services by managed care organizations does not support integrated service delivery

The upcoming carve-in of behavioral health services into managed care better supports integrated delivery of care, but it does not guarantee it, because under DC code, MCOs are currently allowed to subcontract the management of behavioral health services to another corporate entity.[xi] The benefits of an integrated delivery system may not be fully realized under this model, particularly if behavioral health services are subcontracted to an unrelated corporate entity. While some advantages to subcontracting exist—namely providing support to MCOs with little behavioral health experience and forging partnerships between MCOs and behavioral health organizations (BHOs) when subcontracting with BHOs[107]—there is some evidence that subcontracting adds administrative burden for providers and can drive down usage of behavioral health services when incentives for subcontractors to cut costs exist.[108]

2. Existing financing infrastructure does not fully support integrated and coordinated care at provider organizations

While there are several programs and models implemented to provide integrated and coordinated care in DC, the existing payment and reimbursement structures do not fully support integrated and coordinated care across provider types. The two DC Health Homes models (Health Homes I and My Health GPS, which are discussed further in Chapter 5) have been helpful in the provision of more integrated and coordinated care, but they have not bridged the gaps between primary care, mental health services, and SUD services. Current eligibility restrictions of the DC Health Homes models exclude many children who could benefit from integrated care.

Further, under the current care coordination financing structures, the vast majority of decentralized (occurring outside of MCOs) care coordination is not eligible for Medicaid reimbursement and is paid for through departmental or philanthropic funds, which are often time-limited and not sufficient to cover the full cost of services rendered. Provider organizations have established and trusting relationships with the beneficiaries they serve, and thus it is important for care coordination to be available in those settings.

[xi] *According to DC Code § 31–3110, "Each health maintenance organization may provide the treatment required by §§ 31-3103 and 31-3104 directly by its staff or by referring its members to a hospital or other treatment facility that provides those services under a contract or agreement with the health maintenance organization. Nothing in this chapter shall require the alteration of any terms and conditions of the health maintenance organization membership contract relating to prior approval by the health maintenance organization for treatment provided to its members by other treatment facilities."*

3. Inadequate structure and support to facilitate adoption of VBP methodologies by all child and adolescent behavioral health providers

As noted in the Report and *Recommendations of the Mayor's Commission on Healthcare Systems Transformation*,[109] VBP is substantially underdeveloped in the District. Beyond limited pay-for-performance measures, uptake of VBP remains small, and that is particularly true for behavioral health services. One challenge to VBP implementation is the lack of concordance on VBP terminology among District providers, MCOs, and government, which perhaps reflects divergences in their understanding of VBP methodologies. That contributes not only to inadequate and/or inappropriate VBP implementation but also presents a barrier to productive discussions on the topic. Additionally, MCOs may not track or measure performance in the same way, and providers often do not have the necessary technological tools to track and measure performance. Addressing those challenges to performance measurement will be critical to the success of VBP approaches.

4. VBP arrangements can disincentivize adequate care for children with complex needs

Reducing payments based on ED readmissions through the P4P initiative creates a strong incentive for MCOs or providers to avoid admitting patients who have characteristics that put them at risk for readmission.[110] Importantly, one such factor is lack of access to quality primary care, and another is socioeconomic need.[110,111] As a study conducted in DC by Mathison and colleagues (2013) has highlighted, while medical need prompting ED use may be low acuity or nonurgent, social needs may be urgent and unavoidable.[111] Thus, by creating incentives to reduce LANE ED visits, there is a risk that MCOs or providers will be disincentivized from treating children with greater social needs who already lack access to care.

5. Network adequacy standards are not being met

Networks are already inadequate, and that may continue to be a challenge without strong oversight and enforcement. In particular, there is a scarcity of behavioral health care providers that are able to provide services for children and youth in DC, particularly for very young children (under five years), families whose first language is not English, and children with Autism Spectrum Disorder or developmental delays, which are among the special populations that must be given extra attention. Currently, there is an insufficient number of child-serving behavioral health providers or providers with training in specific evidence-based treatments (e.g., applied behavior analysis therapy, parent-child interaction therapy, child-parent psychotherapy, dialectical behavior therapy, etc.). That limits the availability of treatment options available to families that are within their plan networks, which results in long wait times for appointments and unmet behavioral health needs.

According to MCO contracts, "failure to maintain a Provider Network that ensures Enrollees have access to covered Mental Health services, as described in section C.5.29.8, may result in DHCF requiring the Contractor to develop and implement a corrective action plan (CAP) to remedy the failure." However, the public is not aware of any enforcement measures (such as penalties) of network adequacy standards for having an inadequate network of behavioral providers, despite recent external reviews[112] documenting network inadequacies. Additionally, current MCO contracts that require MCOs to adhere to the federal laws (§ 438.68, § 438.206, and the MHPAEA) lack sufficient clarity and direction to effectively incentivize payers to improve behavioral health care access. Limited focus on time-and-distance standards, without complementary focus on time to intake, time to therapy, and time to psychiatry, allows payors to say they have adequate networks even when services remain severely inaccessible.

6. Outdated provider reimbursement rates and no established rate-setting process for behavioral health providers

Except for behavioral health services provided by hospitals and Federally Qualified Health Centers (FQHCs), there is no mandatory process for calculating rates for behavioral health services. DHCF typically hires a third party to set rates. Current reimbursement rates for DBH-certified providers were set based on a 2016 cost study and were not inflation indexed. According to the Blue Ridge Academic Group, reimbursement for behavioral health services nationally has been significantly lower than reimbursement for physical health services. One study

found that behavioral health professionals are reimbursed at FFS rates that are 20 percent below the rate for primary care physicians when the time required to evaluate behavioral health is often longer than a basic primary care visit. In addition, reimbursement is often more limited for preventative services and/or behavioral health rehabilitation services.[113]

7. Restrictions and challenges related to the billing and reimbursement processes

As described in Section 4.2, certain services require medical necessity review and authorization typically from DBH or MCOs prior to their delivery. Further, according to the DHCF Behavioral Health Billing Manual Version 1.05,[102] certain same-day service combinations cannot be billed, and same-day prior authorization service combinations will not be authorized due to limitations. Some of those same-day billing restrictions can impede providers from either providing needed services to children in a timely manner or from being reimbursed if they do provide them.

Providers report experiencing periodic challenges with the reimbursement process, which can sometimes delay payments and disrupt business. In 2019, the overall claims denial rate for District MCOs was 8.3 percent.[100] Behavioral health providers report that excessive administrative time is used addressing prior authorizations put in place by public insurers and appealing denials in care. Challenges with navigating the complex and inconsistent reimbursement process can result in providers opting not to accept public health insurance and thereby reduce accessibility to care.

8. MCOs lack uniform credentialing requirements

Each MCO has its own credentialing requirements for behavioral health providers. That results in behavioral health providers participating in duplicative credentialing activities, which increases administrative costs but has no benefit to enrollees.[114]

9. Insufficient data to inform financial decision-making

While some behavioral health data on children is captured through service utilization statistics and the biannual YRBS, there is no routinely collected, publicly available data on the behavioral health needs of all children in DC. Further, government spending on behavioral health services for children is not reported distinctly, and reported spending is not currently disaggregated by demographics (such as age, sex, race, ethnicity, and ward). That limits the government's ability to analyze and adjust financing to promote behavioral health equity.[xii]

10. Heavy reliance on grants limits financial sustainability

Figure 4.B in Section 4.2 demonstrates that federal grants comprise a large amount of funding for behavioral health services in DC. While a grant is a good funding source for testing or piloting a new financial model or program, it is time-bound and presents a challenge for sustainability of models and programs that work well. For example, DC SEED was funded through a SAMHSA System of Care grant, which ended in March 2021. The grant was used to cover participating providers' salaries. As the grant ends and the providing organization transitions to provide DC SEED services through FFS Medicaid, it now has to consider maintaining the workforce.

11. Inadequate investment in social determinants of behavioral health

Through our family engagement efforts, parents and youth identified poverty, violence, poor community support, and a lack of safe spaces as factors negatively impacting children's behavioral health. The persistence of those factors in DC indicates that there is insufficient investment in solutions to address these determinants and protect children's behavioral health in the long-term.

[xii] *According to SAMHSA, behavioral health equity is "the right to access quality health care for all populations regardless of the individual's race, ethnicity, gender, socioeconomic status, sexual orientation, or geographical location. This includes access to prevention, treatment, and recovery services for mental and substance use disorders."*

12. No sustainable financing structure for school-based behavioral health

School-based behavioral health expansion is currently funded through DBH-issued annual grants. Those grants are not always allocated prior to the start of the school year, despite the need for lead time to hire and train program staff. The short-term and misaligned timing of those grants undermines schools' and providers' ability to deliver services to students in a timely manner and makes it difficult for schools and providers to do the planning and coordination work over the summer that is necessary for the program to be a success. Further, there is no process in place to assess the adequacy of the grant amount. For example, staffing and supervision costs, inflationary cost pressures, and refined billing expectations should be considered to ensure funding levels are adequate to meet the cost of delivering services.

13. Current levels of funding do not support adequate clinical and nonclinical staff for school-based behavioral health

As of the 2021–2022 school year, DBH will have funded at least one full-time clinician in every DC public school, but in some schools more than one clinician will be needed to meet the behavioral health needs of the school community. Further, for behavioral health clinicians to successfully reach students and families in need of their services, school staff must provide communication, coordination, and support to the clinician. Effective partnership between DBH and Office of the State Superintendent of Education (OSSE)/DCPS (education agencies) and between individual schools and their providers is the cornerstone of this program's success. Currently, all participating schools identify an existing staff member to serve as the school behavioral health coordinator, but that position is not supported with any funding, which often limits the capacity of this staff person to provide the support needed.

4.4 Recommendations

Given the overlaps between financing and service delivery of the behavioral health system, we recommend that the recommendations in Section 4.4 and Section 5.4 be considered together.

1. Plan to move MCOs toward a fully integrated corporate model that does not allow MCOs to subcontract behavioral health services.

Implementing Bodies: DHCF, DBH
Timeline to Implementation: Long Term

To fully realize the benefits of integration, DC should plan to move toward a fully carved-in model where subcontracting is not allowed. We recommend that the ability to subcontract persists during the initial carve-in of behavioral health services, which is planned for FY 2023, to ease the transition and plan for the necessary knowledge transfer. However, in subsequent terms, DC should move toward not allowing subcontracting of behavioral health services and implement an active plan for knowledge transfer from behavioral health subcontractors to the MCOs.

2. Avail primary care with payment and reimbursement infrastructure to optimize integrated care.

Implementing Bodies: DHCF, DBH
Timeline to Implementation: Medium to Long Term

Child, adolescent, and family mental health care require team-based care approaches. Those types of care must also support promotion and prevention in addition to treatment (when clinically appropriate in primary care) and timely referral mechanisms when a higher level of care is necessary. We recommend the District enable the following:

- **Psychiatric Collaborative Care Management (CoCM) through CPT Codes 99492–99494.** The CoCM model is an evidence-based framework that integrates a behavioral health care manager and psychiatric consultant into the primary care team with the goal of building primary care provider (PCP) capacity to manage patients' behavioral health conditions. Research demonstrates the model is effective with publicly insured and minority populations and can reduce health disparities. PCCM has dedicated CPT codes used to bill for services on a monthly basis; those codes include 99492 (rate code 5246), 99493 (rate code 5247), and 99494. Of note, billing codes for FQHCs are a different set of codes, which are currently not on the District's Medicaid fee schedule but are used in other states. We also recommend the adoption of these FQHC CoCM codes. Research on the implementation of this model shows that at least fifteen states currently allow for Medicaid reimbursement, including Missouri, New York, Oregon, and Washington.[115]

- **Coverage of discrete Z-codes to promote mental health and prevent mental health disorders.** Health care providers often see children who do not meet the full criteria for a mental health diagnosis but who are experiencing conditions and family circumstances that place them at high risk for developing significant mental health disorders. Families and their health care providers should not have to wait until a child has a full-blown psychiatric diagnosis before effective interventions can be delivered. Further, given the stigma still associated with mental health diagnoses, we should enable

providers with reimbursable codes and services that bolster the promotion and prevention end of the care continuum. To that end, Z-codes in the ICD-10-CM (also known as V codes in the *DSM-5*) are included to account for "other conditions that may be a focus of clinical attention," such as problems related to upbringing, social environment, housing and economics, negative life events in childhood, and education and literacy.[116] While those codes can be billed by providers currently, bills submitted with only Z-codes for a diagnosis (i.e., no other primary mental health disorder or medical condition) are unlikely to be reimbursed. Coverage of Z-codes under Medicaid would allow for children to receive needed care to address significant concerns regardless of whether the child has another mental health concern or condition. California and Oregon are examples of states that incorporate coverage of Z-codes via Medicaid.

- **Continue adequate funding of DC mental health access in pediatrics (DC MAP).**
  DC MAP is a rapidly growing, evidence-based consultation model that supports integrated mental health in primary care and is currently funded by the DC Department of Behavioral Health. The program successfully supports pediatricians in addressing the mental health needs of their patients through real-time access to child psychiatrists, psychologists, social workers, and care coordinators, which frees up DC's specialized mental health resources to serve youth who truly need a higher level of care.

- **Establish mechanisms to adequately reimburse decentralized care coordination services provided by clinical and nonclinical professionals in settings where families frequent and trust.**
  Effective care coordination, provided by individuals who are trusted by the community, is a bedrock of a high-functioning, integrated behavioral health care system. Peers should be recognized as qualified professionals for delivery of nonclinical care coordination services in settings such as pediatric practices, OBGYN, peer-operated centers, family-run organization, and other community settings and should be reimbursed accordingly. To facilitate adequate reimbursement for all care coordination services, it is important that same-day billing restrictions on service delivery and care coordination be eliminated.

  The District should consider adopting financing mechanisms that support the decentralization of care coordinators to environments that children and families frequent on a regular basis and trust (e.g., pediatric primary care, schools, or family-run organizations), rather than housing all care coordination services within managed-care plans. Decentralized care coordination allows for more flexibility in care coordination payment and reimbursement models that will ensure the sustainability and growth of care coordination that is already taking place and working well for families. The following are payment models for decentralized care coordination that we recommend be expanded:

  - **Health Homes:** Eligibility criteria for the two Health Home models in the District should be updated so that more children are eligible for services and care coordination. Currently, children need to have a minimum of three chronic conditions to be eligible for My Health GPS. We recommend relaxing the eligibility requirements to individuals with a minimum of two chronic conditions or individuals with one chronic condition who are at risk of another. Additionally, for both Health Home models (Health Homes I and My Health GPS), we recommend expanding the list of qualifying behavioral health conditions to include any mental health or substance use diagnosis. As permissible, it is also important that DHCF allows and expects MCOs to continue their care coordination services even if an individual is enrolled in a Health Home. For example, if a patient has to seek care outside a Health Home, the MCO care coordination team should be allowed to assist families with that. Those changes allow families to access care coordination services in a timely manner from organizations where they have established trusting relationships.

  - **HealthySteps:** This is an evidence-based national pediatric primary care program that provides infants and toddlers with social-emotional and development support by integrating child development specialists into primary care and strengthening family engagement.[117] HealthySteps is currently

implemented at multiple sites in DC. The model includes "care coordination and systems navigation" as one of its core components, in which a trained member of the community is able to build ongoing relationships with families and connect them to community resources.[118] Given that risk-based MCOs often do not have the care coordination expertise and capacity needed to serve the birth to three population, we recommend reimbursing clinical and nonclinical care coordination services delivered through HealthySteps or otherwise ensuring that any local Medicaid financing of the HealthySteps model adequately compensates for the clinical and nonclinical care coordination components delivered by FQHC and non-FQHC pediatric primary care centers.

3. Advance value-based, alternative payment methodologies, and/or accountable care models specific to child and adolescent behavioral health.

Implementing Bodies: DHCF, DBH, MCOs, CSAs
Timeline to Implementation: Short to Medium Term

- **Establish a pathway for creation and payment of certified community behavioral health clinics (CCBHCs).** Those clinics are designed via federal legislation to provide a comprehensive range of mental health and SUD services to under-resourced individuals and receive an enhanced Medicaid reimbursement rate based on their anticipated costs of expanding services to meet the needs of complex populations. Recent data from states that have implemented CCBHCs demonstrate drastic reduction or elimination of waitlists for services within a few years of initiating their CCBHC work. Additionally, each state was able to leverage the model to reach under-resourced populations, with improvements in children's services frequently mentioned as a key advancement. The inclusion of CCBHCs in the District's behavioral health system is important because this model offers nationally standardized services with specific performance measures and expectations, as well as a payment framework outside of the Medicaid rehabilitation option that ensures financial sustainability while broadening the range of services available. As of July 2021, there are over 431 CCBHCs nationwide, and a growing number of states are moving toward implementing the CCBHC model independently via a state plan amendment or Medicaid waiver.[119] With current and emerging opportunities to adopt the CCBHC model statewide, it is critical for the District to establish a plan for organizations to be certified as CCBHCs by October 1, 2023.

- **Develop value-based and alternative payment models that prioritize children's social and emotional health. As** the District considers VBP models, we encourage a focus on advancing value-based or alternative payment models that incorporate a focus on child and family behavioral health, including early childhood social and emotional development. Those may take the form of bundled payments, episodes of care, or other models. Additionally, value-based or alternative payment models should be focused on equity through collaborative and team-based care, disaggregated race/ethnicity data, and incentivizing equitable care by tracking the quality of culturally responsive care a person receives.[120] In particular, we recommend the recent paper, Alternative Payment Models to Support Child Health & Development: How to Design and Implement New Models, as a starting point for design considerations. Additionally, some policy recommendations from *Behavioral Health Provider Participation in Medicaid Value-based Payment Models: An Environmental Scan and Policy Considerations*, which are highlighted below are worthy of consideration. DC should also utilize the major strategies outlined by the Center for Health Care Strategies to increase the number of providers paid under VBP arrangements through MCOs.[121] The first is mandating a standardized VBP model across MCOs. Others include requiring that MCOs make a given percentage of payments through approved VBP arrangements, mandating MCOs to take part in a multipayer VBP alignment initiative, and directing MCOs to initiate VBP pilot projects

that are subject to state approval. Innovation, testing, and stringent evaluation of payment models generates local evidence to inform decisions for financing DC's behavioral health system for children.

Extracted Policy Recommendations from Behavioral Health Provider Participation in Medicaid Value-based Payment Models: An Environmental Scan and Policy Considerations:

- Implement a robust stakeholder engagement process that includes meaningful participation from behavioral health providers and a broad range of state agencies.
- Leverage existing behavioral health system payment models and infrastructure to support VBP goals.
- Adapt VBP models to include policies that further incentivize adoption of VBP for behavioral health services.
- Include sufficient financial incentives and flexibility in VBP models to allow for behavioral health care delivery improvement.
- Implement state policies to track behavioral health VBP models and promote transparency about VBP adoption.
  - E.g., Since 2012, the Texas Health and Human Services Commission has published an annual summary of the VBP plans submitted by MCOs.
- Support alignment and development of meaningful behavioral health quality measures and data-sharing infrastructure to facilitate quality improvement.
  - E.g., Pennsylvania's VBP Steering Committee created a consensus document that identified a small number of standardized performance measures within four domains (outcomes, member experience, social determinants of health, and cost), which could be used within VBP models implemented by primary contractors and their associated behavioral health MCOs.

Source: Behavioral Health Provider Participation in Medicaid Value-Based Payment Models: An Environmental Scan and Policy Considerations, Center for Health Care Strategies Inc. and National Council for Behavioral Health, 2019

- **Implement VBP arrangements that adjust for social risk** when linking quality measures to payment incentives, using methods such as reporting quality-improvement data stratified by social risk level or adding bonuses for reducing disparity rates.[122]

- **Conduct operational readiness assessments** across government agencies, providers, and MCOs to prepare for behavioral health managed care carve-in,[123] specifically examining VBP readiness. That should include an assessment of whether provider organizations have the necessary technological tools to track and measure performance.

- **Provide education and technical assistance for MCOs, provider organizations, and the relevant staff at government agencies** on VBP strategies to ensure a common understanding, consistent use of terminology, and proper implementation. Technical assistance sessions should include the opportunity for feedback from MCOs and provider organizations to clarify strategies needed for payment.

4. Strengthen reporting of access to care standards in MCOs.

Implementing Bodies: DHCF, DBH, MCOs
Timeline to Implementation: Medium Term

Establish additional access-to-care standards specific to behavioral health, including specific metrics for children, and require MCOs to publicly report on those standards on a regular basis. Currently, MCOs must meet the minimum time and distance standards for primary care, specialty care, mental health, and hospital providers of five miles or thirty minutes from the beneficiary's residence. Standards should include time to treatment and

time to follow-up visits (i.e., wait time between appointments, such as time from initial appointment to second appointment) and as recommended by National Association of Community Health Centers,[124] the number of Medicaid patients (overall capacity and new patient capacity) that participating providers are willing to accept. Regular public reporting on such new standards by MCOs may be useful for beneficiaries to find care more easily and more quickly. Standards should be informed by consultations with beneficiaries and providers.

5. Implement transparent strategies to enforce network adequacy.

Implementing Bodies: DHCF

Timeline to Implementation: Medium to Long Term

DHCF should ensure public transparency about MCOs network adequacy standards and compliance measures, as well as publish regular reports on network adequacy. Demonstrated enforcement of network adequacy standards can encourage all MCOs to ensure compliance. Some strategies to consider for enforcing network adequacy include:

- Monetary penalties for failure to meet network adequacy standards.
- A backstop dispute resolution process, whereby independent medical experts (which can be the same experts who review MCOs' medical necessity decisions) determine when patients need to go out of network to receive necessary medical care.[125] That external review should be focused on whether an MCO's available network resources are adequate for a patient's particular needs, rather than on whether the MCO is in technical compliance with regulatory requirements. Such a process can be triggered by a patient's inability to secure a timely appointment or referral.

6. Require universal contracting for critical providers to ensure initial network adequacy immediately following the carve-in of behavioral health services into managed care programs.

Implementing Bodies: DHCF, DBH, MCOs

Timeline to Implementation: Short Term

DHCF and DBH should first require universal contracting for critical providers to ensure network adequacy. That means that any provider who is licensed, credentialed, and willing to accept the plan's contract terms would initially be offered a contract. DBH-certified providers, in addition to other types of providers (i.e., Adolescent Community Reinforcement Approach [ACRA] providers, Adolescent Substance Abuse Treatment [ASTEP] providers, Federally Qualified Health Centers [FQHCs], Psychiatric Residential Treatment Facilities [PRTFs], and hospitals) are included as critical providers. MCOs should be required to offer at least an initial contract to all other child-serving providers to ensure there is an adequate network for children immediately following the carve-in of behavioral health services into managed care programs.

7. Update provider reimbursement rates that are adjusted for inflation, and establish a transparent rate-setting process.

Implementing Bodies: DBH, DHCF
Timeline to Implementation: Short to Medium Term

A critical feature of an effective, integrated system is ensuring behavioral health reimbursement rates are sufficient and on par with reimbursement for physical health conditions. Additionally, it is imperative that reimbursement be adequate for assessment and diagnosis (including medically necessary psychological and neuropsychological testing). We recognize that DC is undergoing a behavioral health reimbursement rate study, which is intended to improve reimbursement rates and rate-setting methodologies. It is important that this rate study prioritizes reimbursement of children's behavioral health services. Additionally, newly established rates must be inflation-indexed, and a formal mechanism for regularly examining and updating rates, rate structures, and rate-setting methods should be established. As a matter of parity, behavioral health services should be adjusted or rebased as frequently as comparable medical and surgical services.

8. Require MCOs to use standardized and simplified authorization, billing and credentialing processes and protocols.

Implementing Bodies: DHCF, MCOs
Timeline to Implementation: Short to Medium Term

Standardized processes ease administrative burden for providers and improve data consistency for district-level analyses. The development of those standardized processes and protocols should involve all relevant stakeholders, and the implementation should involve training providers.

- At a minimum, authorization and utilization management should conform to evidence-based, publicly available, nationally accepted standards of care developed by clinical provider associations or societies. All codes eligible for billing under DC Medicaid FFS should be available for billing by any provider paneled with any MCO.
- Which organization types are eligible for facility credentialing, group credentialing, or individual credentialing should be consistent across all MCOs, and credentialing should use a standardized electronic process or clearing house accessible to all MCOs and all providers and provider organizations.

9. Eliminate same-day billing restrictions that hinder children's access to behavioral health services.

Implementing Bodies: DHCF, DBH
Timeline to Implementation: Short to Medium Term

DHCF and MCOs should review same-day billing restrictions and seek input from families to identify restrictions that are hindering access to care. For example, same-day billing restrictions for IEP and non-IEP behavioral health services can prevent a child on an IEP from accessing non-IEP behavioral health services if the need

arises at school. Further, billing restrictions should be updated to ensure that when children see both a medical and behavioral health provider at the same location on the same day (e.g., seeing both an endocrinologist and psychiatrist on the same day), payment is rendered to both providers. That would substantially reduce the burden on parents in having to make multiple visits, reduce children's time out of school, and advance the District's goals of successfully integrating physical and behavioral health care.[126]

10. Ensure proper clinical expertise in medical necessity determinations.

Implementing Bodies: DHCF, DBH, MCOs
Timeline to Implementation: Short Term

DHCF and DBH should ensure that individuals with the proper clinical, developmental, and treatment expertise are involved in the decision-making regarding medical necessity determinations, prior authorization decisions, denials, grievances, and appeals regarding care for children. For example, autism spectrum disorder treatment plans should be determined by specialists within the area of expertise for which they are recommending services (e.g., speech language therapists should determine the number of speech therapy hours recommended) and in ambulatory (medical or mental health) care settings. Additionally, medical necessity determinations must align with publicly available, evidence-based standards, independent from business considerations and consistent with generally accepted standards of care. According to current MCO contracts, any decision to deny a service authorization request must be made by a health care professional who has appropriate clinical experience in treating the enrollee's condition or disease. However, that should be amended such that the credential of any clinician denying care should be at least equal to the credential of the recommending clinician and based on relevant clinical experience. Relatedly, in line with the Mental Health Parity and Addiction Equity Act of 2008, DHCF and DBH must ensure prior authorization requirements for behavioral health services are comparable to or less restrictive than those for physical health services.

11. Assess all available public and private funding streams, including Medicaid, that can support plans to address the social determinants of children's behavioral health in DC.

Implementing Bodies: DHCF, DBH, DC Health, CFSA, DHS
Timeline to Implementation: Medium Term

Government agencies involved in children's behavioral health (including, but not limited to, DBH, DHCF, DC Health, and CFSA) should assess all available public and private funding streams, including Medicaid, to cover assistance with unmet social needs such as housing, nutrition, employment, education, and transportation when developing a strategy for addressing beneficiaries' SDOH. That assessment can be done annually as part of each agencies' budget planning. DC's efforts to address children's behavioral health must prioritize the social determinants of behavioral health. This may include supporting the development of safe spaces, convenient and efficient transportation, safe neighborhoods, strong social connections, and quality education for children in DC. DHCF should particularly examine how federal funding may be able to support this, such as outlined in the recent "Opportunities in Medicaid and CHIP to Address Social Determinants of Health" letter (SHO# 21-001) from CMS.[127]

One relevant project that can benefit from continued funding is the Community Resource Information Exchange (CoRIE) project, which is developing data infrastructure to support coordinated screening and referrals across a range of health, human, and social services in DC. Expanded investments in the CoRIE project will support data analytics to improve health equity; clinical-community linkages; and the integration of community social support, government, and health care. Considering those potential benefits, DHCF should prioritize funding the full implementation and evaluation of this project.

12. Adequately fund the School-Based Behavioral Health Expansion Program.

Implementing Bodies: DBH, OSSE/DCPS
Timeline to Implementation: Short to Medium Term

The goal of the School-Based Behavioral Health Expansion Program is to fully integrate behavioral health resources into school communities. Students, teachers, school leaders, and families should be able to access all three tiers of behavioral health supports at school. Connection to additional behavioral health supports or other kinds of support services outside of the school setting should be seamless. To do that, the school-based behavioral health expansion program must be adequately resourced:

- **Sustainable funding:** Funding for this program should be converted to multiyear contracts with option years to allow schools and providers some stability and capacity to make long-term plans regarding behavioral health resources and support for school communities. That would enable schools and providers to do the planning and coordination work, including the hiring and training of clinicians, over the summer that is necessary for the program to be a success.

- **Sufficient clinical staff in all schools:** As of the 2021–2022 school year, DBH will have funded at least one full-time clinician in every DC public school, traditional and charter. The next phase of expansion must focus on developing an accurate understanding of the behavioral health needs of each school community—teachers, parents, school leaders, and students—and identifying schools that need additional clinicians to meet those needs.

- **Right-sizing grant or contract funding amounts: DBH** set the current per-school grant amount (approximately $70,000) based on estimates developed in 2019. For school year 2021–2022, the DC Council provided a one-time grant enhancement of $8,000 per school to cover additional costs to providers during the ongoing pandemic and transition to in-person learning. As the program enters its fourth year of implementation in FY2022, DBH should work with providers to collect actual cost and billing data from the last few years to assess the true cost of this program. Right-sizing the per-school grant amount is essential to the long-term financial sustainability of this program.

- **School capacity to support behavioral health:** OSSE and DCPS should provide dedicated funding to cover the cost of the additional staff capacity needed to effectively provide program communication and coordination, as well as support to the clinician. That could include funding for the school behavioral health coordinator position, which is critical to supporting the clinician's work. Further, some schools may require additional nonclinical support staff to provide expanded Tier 1 and Tier 2 services and enable deeper and more direct engagement with families.

- **Provider capacity-building:** Over the past two years, DBH has made significant investments in its community of practice (CoP), a collaborative learning environment designed to support the implementation of school-based behavioral health.[128] The CoP brings providers, school staff, and school

leaders together to share best practices, participate in trainings and other learning activities, and take part in specialized practice groups that deepen participants' understanding of what timely access to high-quality support looks like in certain areas of behavioral health. Continued investment in the CoP is essential to building provider capacity and maintaining consistent quality of services across the program.

- **Evaluation:** DBH is also investing in a thorough, multiyear evaluation of the school-based behavioral health expansion program to gain early on-the-ground insight into how the program is working. The evaluation will focus on processes and outcomes at both the system-level and the school-level and ultimately result in a series of reports that describe how the expansion is being implemented over time, the outcomes associated with implementation, and actionable recommendations. That information will then be used to guide policy decisions regarding how to strengthen and improve the program. Continued investment into the evaluation piece will be critical for the program's long-term success.

13. Adequately invest in technologies that can support and optimize the work of behavioral health service provider organizations, MCOs, and government agencies involved in children's behavioral health.

Implementing Bodies: DHCF, DBH

Timeline to Implementation: Short to Long Term

Various technologies can be leveraged to improve behavioral health services in DC. For example, the use of interoperable electronic health records (EHRs) to facilitate better care coordination or the use of the District Health Information Exchange system to do population-level data analysis. Specific recommendations around appropriately leveraging the use of technology to benefit the behavioral health of children in the District are included in Chapter 8. However, in general, implementation of those recommendations would require long-term fiscal planning that anticipates the costs of acquiring and/or developing appropriate technologies, providing financial incentives to promote uptake, and providing the necessary technical support for initial and continued implementation.

5. SERVICE DELIVERY

Service delivery or provision is an immediate output of the health system that encompasses a comprehensive range of accessible, high-quality health services with continuity of care. Behavioral health services can be categorized along the continuum of care, ranging from prevention services that target individuals before they develop a behavioral health issue to treatment services for individuals with a diagnosed behavioral health disorder.

5.1 Vision for the System

The behavioral health system for children should deliver high-quality mental health and substance use services along the full continuum of care that meets the evolving needs of children in DC. Service networks should be actively coordinated with accountability and efficiency. All behavioral health services should be based on evidence-based practices and informed by local data on children's behavioral health (including the social determinants of behavioral health). Further, these services should be aligned with the tenets of family-driven, family-centered, youth-guided, and trauma-informed care. Additionally, services must be delivered with cultural attunement and in a manner that promotes racial equity.

Table 5.A. Components of Principles that should Guide Behavioral Health Service Delivery for Children

Principles that Should Guide Service Delivery					
Family-Driven	**Family-Centered**	**Youth-Guided**	**Cultural Attunement**	**Trauma-Informed**	**Racial Equity**
• **Families have a primary decision-making role in the care of their own children** as well as the policies and procedures governing care for all children in DC.	• An approach to the planning, delivery, and evaluation of health care that is **grounded in mutually beneficial partnerships among health care providers, patients, and families** (Ahmann & Johnson, 2000).	• Young people have the right to be **empowered, educated, and given a decision-making role** in their own care and in the establishment of policies and procedures governing all youth in DC (Youth MOVE National and SAMHSA).	• Five components: "recognizing the pain of the oppression, involving in actions of humility, serving with high regard, involving commonality, and keeping a 'not knowing position'" (Hoskin, 1999, p. 77).	• "A program, organization, or system that is trauma-informed **realizes** the widespread impact of trauma and understands potential paths for **recovery; recognizes** the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and **responds** by	• The elimination of racial disparities such that **race no longer predicts opportunities, outcomes, or the distribution of resources** for residents of the District, particularly for persons of color and Black residents (Council Office of Racial Equity)

Family-Driven	Family-Centered	Youth-Guided	Cultural Attunement	Trauma-Informed	Racial Equity
• Includes: choosing services, setting goals, designing and implementing programs, monitoring outcomes, participating in funding decisions, and determining effectiveness of all efforts to promote the behavioral health of children (Osher, Osher, & Blau, 2006).	• Parents identify **communication, responsiveness, honesty, and emotional support** as being important to the delivery of child- and family-centered care.	• This includes giving young people a **sustainable voice and then listening to that voice.**	• The **synchronization of treatment with the cultural and the social context of the clients** (Falicov, 2009).	fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization." (SAMHSA) • A trauma-informed approach is **inclusive of trauma-specific interventions**, whether assessment, treatment, or recovery supports, **yet it also incorporates key trauma principles into the organizational culture** (SAMHSA).	

A Full Continuum of Care of Behavioral Health Services

Mental Health America states that children and families should have **access to a full continuum of mental health supports, which includes promotion of mental health, prevention of mental illnesses and substance use, early identification, treatment, recovery and rehabilitation services, and long-term supports**, as needed.[128] *Figure* 5.A in *Section* 5.2 describes the full continuum of care. A full continuum of care must be delivered across sectors and settings, including government, schools, CBOs, and health care facilities as well as nontraditional locations (e.g., faith-based institutions, grocery stores, barbershops, rec centers, etc.). The delivery of services should be integrated in nonstigmatizing locations, where children and families are most likely to engage, even if that requires innovative practice and policy changes. Based on the description of a full continuum of care, our vision for the District's child and youth public behavioral health system includes greater access to behavioral health promotion and prevention services, as well as intermediate levels of care services.

Prevention and Promotion

Prevention services are a fundamental part of promoting healthy development in children and youth and are critical in the prevention of mental health disorders in adulthood. Prevention is defined as "Interventions that occur before the onset of a problem, as well as interventions that prevent relapse, disability, and the consequences of severe mental illness or substance abuse."[130] Promotion is defined as "Efforts designed to enhance an individual's social competence, self-esteem, and sense of well-being."[131] According to SAMHSA, prevention and promotion of mental health takes a public health approach to addressing mental health in which the child's physical, psychosocial, cultural, and social environments are considered, including the child's individual, family, school, and neighborhood

context.[131] That requires developing interventions and services that focus on identifying and addressing risk factors early on while building on protective factors that lean on the strengths and resources that occur naturally in the child's environment to promote resiliency during childhood and adolescence. For example, implementing a parenting/caregiver education program to strengthen the parent-child relationship through building parenting strategies and skills, which can have a positive outcome for the child's developmental trajectory. Prevention programs can be categorized using a tiered model in which a program is universal (applicable to the general population), selective (applicable to a specific group based on biological or social risk factors), and/or indicated (applicable to individuals who are at highest risk, some symptoms of mental health problems that are not yet severe).[131] Some programs may address all three levels of prevention.

The Good Behavior Game: An Evidenced-based, Universal Prevention Program for Children and Youth

The Good Behavior Game is a universal classroom-based prevention intervention program focused on behavior management.[132] It has four core elements: four classroom rules for students to follow; team membership, in which students play the game in teams to build relationships with peers; behavior monitoring by the teacher as well as students monitoring their own and their peers' behaviors; and positive reinforcement. The game is played during independent and group work time, three times a week for 10 minutes ramping up intensity to 30–40 minutes daily. The program's short-term goals include reducing aggressive and disruptive behaviors in the classroom. Longer-term goals focus on reducing likelihood of substance use; providing referrals for academic or behavioral services; and lowering the rates of suicidal ideation, depression, and incarceration. There is a strong evidence base to support the effectiveness of the Good Behavior Program, including being rated as effective by the Office of Juvenile Justice and Delinquency Prevention.[133] It was originally implemented in 41 classrooms across 19 elementary schools in a randomized trial in Baltimore, Maryland, that showed positive outcomes. The program also shows a 25% rate of return on investment and a cost savings of $31.19 for every dollar spent.[133]

There are a number of evidence-based and promising practice promotion, prevention, and early intervention programs across the age continuum. Examples include HealthySteps, Attachment and Biobehavioral Catch-up (ABC), Circle of Security Parenting, Reconnecting Youth, Triple P Positive Parenting, Strengthening Families Coping Resources, Centering Pregnancy, and First Episode Psychosis Programs.[134] Several of those programs are applicable to the prenatal to age five population and are discussed in the Chapter 9. Prevention and early identification services also include leveraging the Early and Periodic Screening, Diagnosis, and Treatment benefit to promote increased behavioral health screening and timely referrals to appropriate treatment.

Substance Use Services

Access to a full continuum of care for children and youth must also include appropriate access to substance use prevention, screening, assessment, referral, and treatment services in integrated and easily accessible locations, such as primary care and schools. The full continuum of substance use services is critical because substance use problems that develop and remain untreated in adolescence can lead to negative health outcomes that persist into adulthood.[135]

Substance Use Prevention

Substance use prevention programs for children can be implemented across a variety of settings and can target specific or combined drug use. One review found that school-based drug-specific prevention programs were effective, with interventions based on a combination of social competence and social influence approaches having protective effects against drugs and cannabis use.[136] The review also highlighted supporting evidence for mass media campaigns and family-based interventions, but the authors noted mixed findings for the effectiveness of internet-based interventions, policy initiatives, and incentives.[136]

Substance Use Treatment

There have been multiple guides and principles outlined on how to treat adolescents with SUD or who misuse substances, such as the TIP 32: Treatment of Adolescents with Substance Use Disorders: Treatment Improvement Protocol (TIP) Series 32, the State Adolescent Substance Use Disorder Treatment and Recovery Practice Guide,

and Identifying Mental Health and Substance Use Problems of Children and Adolescents: A Guide for Child-Serving Organizations. The figure below outlines the principles of Adolescent Substance Use Disorder Treatment from the National Institute on Drug Abuse (NIDA).

NIDA Principles of Adolescent Substance Use Disorder Treatment
1. Adolescent substance use needs to be identified and addressed as soon as possible.
2. Adolescents can benefit from a drug abuse intervention even if they are not addicted to a drug.
3. Routine annual medical visits are an opportunity to ask adolescents about drug use.
4. Legal interventions and sanctions or family pressure may play an important role in getting adolescents to enter, stay in, and complete treatment.
5. Substance use disorder treatment should be tailored to the unique needs of the adolescent.
6. Treatment should address the needs of the whole person, rather than just focusing on the individual's drug use.
7. Behavioral therapies are effective in addressing adolescent drug use.
8. Families and the community are important aspects of treatment.
9. Effectively treating substance use disorders in adolescents requires also identifying and treating any other mental health conditions they may have.
10. Sensitive issues such as violence and child abuse or risk of suicide should be identified and addressed.
11. It is important to monitor drug use during treatment.
12. Staying in treatment for an adequate period of time and continuity of care afterward are important.
13. Testing adolescents for sexually transmitted diseases is an important part of drug treatment.

Adapted from Principles of Adolescent Substance Use Disorder Treatment: A Research-Based Guide; National Institute on Drug Abuse; 2014

According to these principles and guides, youth should be able to access substance use treatment services through multiple entry points via a coordinated system of care, such that there is "no wrong door." That means that youth should be identified, screened, assessed, and referred through their primary care provider, school system, child welfare system, juvenile justice system, etc., which requires collaboration and coordination between all the systems. Screening and assessment tools should be culturally competent, evidence-based, and standardized throughout the systems. Referrals should be facilitated by those making the referral so that adolescents and caregivers receive help in navigating, accessing, and utilizing the appropriate services, as well as monitoring and follow-up after treatment. For example, a youth primary care team should screen all youth for substance use, administer assessments to those who screen positive, communicate with caregivers about concerns, provide brief interventions, refer to appropriate levels of treatment services if needed, and then coordinate with the youth's school system and caregivers to monitor and follow- up after treatment. That requires investments in training, education, and supportive/consultative services such as in the Massachusetts Child Psychiatry Access Project (discussed below). Adolescents should also be able to access treatment services directly through an adolescent focused outpatient treatment center. Further, in a coordinated system of care, mental health, and substance use services should be integrated or collocated together to decrease stigma and provide easier access for adolescents and their families.

An Example of Early Identification & Treatment of Substance Use: Expanding The Massachusetts Child Psychiatry Access Project (MCPAP)

MCPAP partnered with the Adolescent Substance Use and Addiction Program at Boston Children's Hospital (ASAP) to expand the consultation program to provide pediatric primary care providers with SUD treatment information.[137] That expansion allows for the early identification and intervention of adolescents with substance use needs within primary care. Consulting ASAP clinicians provide primary care providers with services such as such as brief intervention tools and behavioral contracting, medications to curb withdrawal and drug testing programs, and referrals to behavioral health services.[138] Since launching this partnership, substance-use-specific consultation requests have steadily increased from primary care providers, with the ultimate goal of building PCPs' competency and capacity over time to manage adolescent substance use needs in-house.[138]

An Example of a Substance Use Service Model: the Colorado SBIRT-SBHC Project

The SBIRT-SBHC (Screening, Brief Intervention, and Referral to Treatment for alcohol and substance use in School-Based Health Centers) Project is a five-year collaboration between the Colorado Department of Public Health and Environment and the Colorado Department of Human Services Office of Behavioral Health.[139] The project aims to establish SBIRT as a standard part of care within participating school-based health centers and provide substance use and mental health services to adolescents. Adolescent SBIRT is a research-based promising practice for prevention and early intervention of alcohol and substance use for youth, developed from the standard evidence-based SBIRT implemented with adults.[140] The first step is to screen individuals to determine where they are on the continuum of substance use (from abstinence to severe SUD), which then determines what level of brief intervention service the individual needs. Individuals who have used substances without an SUD diagnosis receive brief-interventions focused on making healthier choices. Individuals screened to have mild to moderate SUD receive brief motivational interventions to reduce use and risky behaviors. Individuals who have severe SUD receive brief motivational intervention with a focus on reducing use and referring to treatment. Medicaid-enrolled members 12 and older are eligible to receive services, which are billed as either full screening or full screening and brief intervention. Benefits of SBIRT include reducing health care costs and decreasing at-risk alcohol, marijuana, and other drug use. In addition to being implemented in SBHC, adolescent SBIRT can also be implemented in primary care and community health centers by certified providers

Integrated Care

The World Health Organization defines integrated care as "health services organized and managed so that people get the care they need, when they need it, in ways that are user-friendly, achieve the desired results and provide value for money."[141] Integrated care is associated with improved behavioral health outcomes. For example, a meta-analysis of 35 intervention-control comparisons revealed significantly better behavioral health outcomes for integrated care when compared to usual care.[141] Integrated behavioral health services also help to reduce stigma for individuals who may not have otherwise sought services in a behavioral health clinic.[143]

For children, care integration ensures access to behavioral health services in settings in which they frequent most, such as child care/early learning centers, K–12 schools, and pediatric primary care practices. Behavioral health capacity should exist in primary care settings to promote early identification and intervention for behavioral health issues in children. Children are more likely to go to their primary care provider due to scheduled well-child visits, and therefore a primary care provider is well positioned to detect the early onset of behavioral problems.[144] Child and adolescent mental health specialists should be integrated into primary care practices to provide the necessary knowledge, skills, and support to effectively support PCPs caring for youths with mental health disorders. There are a multitude of behavioral health integration frameworks that allow for a comprehensive, coordinated, and patient- and family-centered system of care.

Elements of Integrated Behavioral Health Care	Strategies For Greater, More Effective Integration of Care
• Care team expertise tailored to the patient population • Share clinical workflow • Systematic patient identification • Treatment monitoring • Leadership alignment • Operational reliability • Business model sustainability • Data collection and use • Patient experience **Source: A Framework for Measuring Integration of Behavioral Health and Primary Care; Agency for Healthcare Research and Quality**	• Cross-training of PCPs and behavioral health providers • Inclusion of family partner/navigator • Establishment of enhanced referral and care coordination systems • Use of standardized behavioral health and social and emotional development screening tools • Warm handoffs[xiii] • Wellness promotion and prevention as part of the well-child visit • Shared record keeping • Provision of parenting education and support groups • Embedding of mental health consultants in primary care settings **Source: The Integration of Behavioral Health into Pediatric Primary Care Settings; National Academy for State Health Policy; 2017**

One model of integrated care is the **Collaborative Care Model or the Psychiatric Collaborative Care Management (PCCM) model**, which was previously mentioned in *Section 4.4*. The PCCM model is an evidence-based framework that integrates a behavioral care manager (typically a social worker, counselor, nurse, or psychologist) and a psychiatric consultant (a trained medical professional who can prescribe a full range of medications) into the primary care team.[145] This model utilizes the following approach[146] to help support treatment of patients' behavioral health conditions within the primary care setting:

- Patient-Centered Team Care—primary care providers, behavioral health providers, and all other members of the patent's care team work together effectively using a shared care plan;
- Population-based Care—the care team's caseload is tracked within a patient registry where patient's progress is tracked;
- Measurement-based Treatment-to-Target—personal goals and clinical outcomes within a patient's care plan are routinely measured and adjusted using evidence-based tools;
- Evidence-base Target—treatment plans and therapies are supported by evidence-based research proving effectiveness;
- Accountable Care—Reimbursement is based on quality of care and clinical outcomes.

Over 70 randomized controlled trials conducted across diverse health care settings, with different financing mechanisms and varying patient populations, have established a robust evidence base for a collaborative care approach. Research has demonstrated that collaborative care programs are not only highly effective for patients from ethnic minority groups, but they also can reduce health disparities observed in such populations.[147] However, there is not much research published on implementation of the Psychiatric Collaborative Care model with children as of yet. While the model is not applicable to young children, it fills a gap in the continuum of care for treatment with older children, adolescents, and transition-aged youth who have diagnosed disorders, such as ADHD, anxiety, depression, etc.

[xiii] *According to the Agency for Healthcare Research and Quality, a warm handoff is "transfer of care between two members of the health care team, where the handoff occurs in front of the patient and family. This transparent handoff of care allows patients and families to hear what is said and engages patients and families in communication, giving them the opportunity to clarify or correct information or ask questions about their care."*

A State Example of the PCCM: The New York State Collaborative Care Medicaid Program

The New York State Collaborative Care Medicaid Program (NYS CCMP) offers Medicaid reimbursement to primary care practices that serve youth 12 years and older and that implement the evidence-based principles of the Collaborative Care model.[148] To be eligible for reimbursements, NYS CCMP requires that the collaborative care team include a behavioral health care manager, designated program lead, data manager, billing lead, and psychiatric consultant (MD/PNP). It also requires a registry to manage collaborative care caseload, a standardized depression screening process (PHQ-9), warm handoff to the behavioral health care manager, and the utilization of a treatment-to-target approach using the depression screener to monitor patient progress over time. In a preliminary evaluation of 32 primary care clinics implementing the model, research showed that clinics that increased investments in full-time staffing and greater lengths of time spent with care managers had better depression improvement rates in patients and were more likely to sustain the model.[149]

The **Certified Community Behavioral Health Clinic (CCBHC)** model is another model that embodies the vision for integrated care. According to the National Council for Mental Wellbeing,[150] a CCBHC is "a specially-designated clinic that receives flexible funding to expand the scope of mental health and substance use services available in their community." CCBHCs are responsible for directly providing (or contracting) nine types of services.[151]

1. crisis mental health services
2. screening, assessment, and diagnosis, including risk assessment
3. patient-centered treatment planning
4. outpatient mental health and substance use services
5. primary care screening and monitoring of key health indicators/health risk
6. targeted case management
7. psychiatric rehabilitation services
8. peer support and family supports
9. intensive, community-based mental health care for members of the armed forces and veterans

In return, CCBHCs receive an enhanced Medicaid reimbursement rate based on their anticipated costs of expanding services to meet the needs of these complex populations. CCBHCs were specifically designed to address financing shortfalls by paying clinics a Medicaid rate that is inclusive of their anticipated costs of expanding their service lines and serving new consumers, through a prospective payment system. Unlike CCBHCs, which have this enhanced funding formula, CSAs do not have the financial backing to provide the nine nationally standardized services with specific performance measures and expectations.

Data from states that have implemented CCBHCs demonstrate elimination of waitlists for services within a few years of initiating their CCBHC work and increased care coordination across sectors. Additionally, each state was able to leverage the model to reach under-resourced populations, with improvements in children's services frequently mentioned as a key advancement.[152] New York State reported during the Behavioral Health Commissioners Summit that the implementation of the CCBHC model allowed for an increase in the delivery of behavioral health services for children and adolescents, including home-based, school-based, and crisis services for youth. It reported that 24% of all individuals receiving services were under age 22. Nevada was another state that reported increased access to children's behavioral health services after implementing the CCBHC model, as well as medication-assisted treatment (MAT) services and primary care. Twenty-two percent of organizations participating in the CCBHC demonstration program in 2018 were able to add specialty outpatient child and youth mental health and SUD services; 15% were able to add community wraparound services for children and youth.[153]

The recent *CCBHC Impact Report by the National Council for Mental Wellbeing* highlights that 84% of CCBHCs either are providing direct services within schools or are planning to, 63% engage in suicide prevention for children and youth, 42% provide Mental Health First Aid (MHFA)[xiv] training to middle or high school teachers and staff, and 20% are providing MHFA training to students.[150] That demonstrates the increased relationship and partnerships between child-serving organizations and systems allowing for greater integration of services and increased support for families. Other benefits of the CCBHC model include expansion of the behavioral health workforce in the state and funding for more

[xiv] *According to the National Council for Mental Wellbeing, Mental Health First Aid is a training that gives a person the skills need to identify, understand, and respond to signs of mental illnesses and substance use disorders.*

nontraditional workforce (e.g., peer support) due to the allocation of funds to hire staff at a higher salary, thus helping to attract more providers to the state.[152] For example, New York reported being able to hire more child-serving providers.[152]

As mentioned above, implementation of CCBHC has also helped to improve care coordination. Some strategies used by programs participating in the demonstration program include adding additional provider types to care teams; increasing partnerships and contracting with CBOs, schools, juvenile justice bodies, police, and other external groups; expanding targeted care coordination strategies to different populations; and implementing improvements to EHRs and health information technology systems.[150] Those strategies have helped some CCBHCs to better integrate care plans, create linkages with external providers, and receive alerts about clients' care transitions.

Another example of an integrated behavioral health care model currently implemented throughout the country are **Child Psychiatry Access programs**. These collaborative programs require staffing of child psychiatrists to support pediatricians and other PCPs through telephone consultation services.[154] The child psychiatrists are able to provide education, referrals to community mental health services when needed, and other immediate assistance to pediatric PCPs. Each team in a Child Psychiatry Access program is staffed with two full-time child and adolescent psychiatrists, independently licensed behavioral health clinicians, resource and referral specialists, and program coordinators. These programs have increased children's access to and use of mental health services,[155] as well as decreased inappropriate and excessive prescription of psychiatric medication.[156] In addition to allowing for greater use of mental health services, this model provides opportunities for expansion. The expansion of the Massachusetts Child Psychiatry Access Project to support early identification and treatment of substance use in adolescents was provided above as an example.

Care Coordination

According to the Agency for Healthcare Research and Quality, "care coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care."[157] Care coordination across settings reduces fragmented care and leads to decreased health care costs and improvement in the patient/family experience of care.[158] Care coordinators have different titles and roles in a care team, such as case manager, patient navigator, peer support worker, community health worker, etc. Care coordination is a central tenant for ensuring successful integration of care for children and families across systems. Similarly, effective implementation of integrated care (such as the models mentioned above) enhances care coordination and communication for families. That is especially true for children with complex health care needs and multiple conditions who are often receiving care from and navigating multiple systems, such as the educational system; early intervention; child care; community-based services; advocacy organizations; payers; medical, social, and behavioral health systems; and in some instances, child welfare and juvenile justice systems. Effective care coordination requires a focus on care planning, as well as building collaboration, partnerships, and trusting relationships between all the providers working with the child and family (e.g., PCP, teacher, care coordinator, behavioral health clinician, social worker, etc.). Also, a patient-centered and culturally mindful care philosophy, which takes into account the individual perspectives and needs of the patient and their family, should be incorporated into the process of effective care coordination.

National Care Coordination Standards for Children and Youth with Special Health Care Needs (CYSHCN)

Developed by the National Academy for State Health Policy, the National Care Coordination Standards for Children and Youth with Special Health Care Needs (CYSHCN) outline guiding principles and core components of effective care coordination for children, youth, and their families. The foundational standards, which can be applicable to all children, include:

1. **Care coordination is based on the premise of health equity, that all children and families should have an equal opportunity to attain their full health potential, and no barriers should exist to prevent children and their families from achieving this potential.**
2. **Care coordination addresses the full range of social, behavioral, environmental, and health care needs of CYSHCN.**
3. **Families are co-creators of care coordination processes and are active, core partners in decision making as members of the care team. CYSHCN, families, and care coordinators work together to build trusting relationships.**

4. **Care coordination is evidence based where possible and evidence informed and/or based on promising practices where evidence-based approaches do not exist.**
5. **Care coordination is implemented and delivered in a culturally competent, linguistically appropriate, and accessible manner to best serve CYSHCN and their families.**
6. **Insurance coverage of care coordination for CYSHCN allows for it to be accessible, affordable, and comprehensive.**
7. **Performance of care coordination activities is assessed with outcome measures that evaluate areas including:**
   a. **process of care coordination (e.g., number of families with a shared plan of care);**
   b. **family experience with integration of care across medical, behavioral, social, and other sectors and systems;**
   c. **quality of life for CYSHCN and families; and**
   d. **reduction in duplicative and/or preventable health care utilization.**

Source: National Academy for State Health Policy; October 2020

Some existing models for delivering care coordination:

- **Health Homes**—an optional Medicaid State Plan benefit for states that integrates and coordinates all primary, behavioral health, acute, and long-term services and supports to treat persons with chronic conditions.[159]
- **High Fidelity Wraparound**—a collaborative, team-based, and structured approach to providing coordinated services and support to families. Families and youth drive the planning.
- **Nonclinical care coordination**—e.g., community health workers (CHWs) and peer support specialists
  - CHWs are trusted and trained individuals who serve as the bridge between health care systems and their communities.[160] There is strong evidence supporting the integration of CHWs into health care teams to provide services such as care coordination and system navigation, leading to improved health care outcomes and reduced costs.[161]
  - Peer support specialists are individuals with lived experience who provide nonclinical strength-based support, education, and connection to services and resources. One type of peer support services is peer recovery support delivered by peer recovery coaches. There is a growing body of evidence to support the effectiveness of peer recovery coaches in reducing substance use and improving outcomes.[162]
- **Help Me Grow**—a national model in which "an information and referral helpline provides parents, physicians, and providers with the knowledge and resources they need to make a difference in the lives of children."[163] There are four main components that make up this model: centralized access point, family and community outreach, child provider outreach, and data collection and analysis.[164]

Intermediate Levels of Care

Intermediate levels of care services or step-down care options refer to acute or intensive services provided in the community or outpatient settings that are critical to the continuum of services. These include:

- **Intensive Outpatient Programs (IOPs)**
  IOPs are several hours of structured programming a week, usually after school and short term.[165] This type of program serves as a transition for youth from residential or inpatient care, as well as serves to reduce the need for inpatient care by providing more intensive services for patients who are not responding to standard outpatient care.
- **Partial Hospitalization Programs (PHPs)**
  PHPs are full-day treatment programs, usually short term and more intensive than IOPs, in which adolescents experiencing acute psychiatric symptoms but not in need of 24-hour care receive group therapy, family therapy, individual counseling, and/or psychoeducational sessions.[166] Research on PHPs has shown they have been proven to prevent future hospitalizations and decrease the length of stay in the hospital.[166] A 2014 study with 35 adolescents demonstrated that the PHP was effective in improving psychological symptoms and resulted in positive self-perceptions of getting better.[167]

- **Youth Crisis Stabilization Units**
  These are bed units, often co-located in a hospital emergency department, in which children and youth who are experiencing acute concerns but do not rise to the level of needing residential treatment are admitted on average for three to five days and receive brief intensive mental health therapy (e.g., one-on-one therapy, family therapy, crisis intervention, psychiatric evaluation, and, if necessary, medication management).[168] They provide a safe, secure, and less-restrictive environment for short-term crisis evaluation and intervention, with the goal of working toward stabilization with both the individual and their family.

One strong clinical example in which these models are currently being implemented is NYC Health+Hospitals/Bellevue Hospital Center in New York. That hospital provides a full range of psychiatric assessment and treatment services across the care continuum. From most to least intensive/restrictive, services include:

1. a hospital-based inpatient psychiatric unit,
2. a hospital-based public school,
3. a hospital-based and exclusively Children's Comprehensive Psychiatric Emergency Program (CCPEP, more information highlighted below),
4. an in-home crisis stabilization program,
5. an outpatient bridging clinic for step-down care and crisis stabilization,
6. a mobile crisis stabilization program,
7. a partial hospitalization program, and
8. traditional outpatient services.

A Model for a Children's Comprehensive Psychiatric Emergency Program (CCPEP)

NYC Health + Hospitals/Bellevue's CCPEP is one of the few existing examples of an adaption of the CPEP model that is specialized to serve children ages zero to 18. It has three main components:

1. **Emergency Evaluation Area (available 24/7):** Children and their families are triaged by an experienced child psychiatric nurse and then seen by a child psychiatrist and a child psychiatric social worker for evaluation and diagnostic assessment.
2. **Pediatric Observation Unit (available 24/7):** Children who present with more severe and acute symptoms can be held overnight or for several days for treatment in the extended observation and brief stabilization six-bed unit. This is a high-quality alternative to triage in medical emergency rooms.
3. **Outpatient Acute Care Services:**
   a. *Interim Crisis Clinic Services:* serves children who do not require inpatient admission but present with issues that require immediate intervention with ongoing monitoring. Children who are evaluated in the CCPEP can be seen for up to five follow-up visits at the CCPEP. That serves as a bridge between emergency evaluation and outpatient follow-up care, particularly when there are long wait times to be seen by a psychiatrist at community outpatient clinics. These services can include medication prescription and monitoring, psychoeducation, brief psychotherapeutic interventions, and family interventions.

   b. *Home-Based Crisis Intervention Services:* These are short-term (six to 12 weeks) in-home and community services to prevent psychiatric hospitalization in at-risk youth.

   c. *Mobile Crisis Services:* This is a team of mental health clinicians who are available to evaluate patients in their homes and are authorized to request emergency medical services transport of those patients to the CCPEP if necessary. This service is utilized when high-risk patients do not attend scheduled follow-up appointments in the Interim Crisis Clinic. This ensures that patients do not fall through the cracks of the emergency management system.

While research on this CCPEP is limited, a study by Gerson et al (2017) examining one year of data found that while 86% of children presented in crisis (emergent or urgent severity of visit), 59% of the patients could be discharged after evaluation, and 13% of patients could be stabilized in the observation unit in under 72 hours.[169] The study inferred that brief stabilization with active treatment is an effective alternative to inpatient admission for some patients. Additionally, the authors suggested that the "availability of child psychiatrists in this program allowed greater ascertainment of suicide risk (and thus hospitalization to mitigate that risk) than occurs in emergency rooms without such staffing."

Source: Children of Bellevue Child & Adolescent Psychiatry, Children's Comprehensive Psychiatric Emergency Program (CCPEP).

Accessibility of Services

As mentioned previously, ensuring access to timely care includes reducing wait times and waitlists, ensuring a robust child-serving provider network and adequate workforce, and multiple pathways for families to enter into and receive care.

Wait Time Standards

Minimizing wait times for appointments is critical, because delays in behavioral health services are associated with prolonged distress, potential exacerbation of the existing problem, an elevated risk of poor outcomes, and a decreased likelihood that patients will keep their appointments.[170] Behavioral health care literature suggests that a new patient psychiatry appointment must be available within 24 hours of scheduling to avoid increased risk of no-shows.[171, 172] Further research suggests that the first therapeutic contact should be made on the same day as intake,[173] and patients should have access to an initial psychotherapy visit within four days to avoid an increase in the likelihood of no-shows.[174] However, evidence-based wait time standards have not been set.[175] Further, the evidence base does not support the broad use of a specific wait time standard for new mental health or primary care patients.[176]

Accessibility Monitoring

It is also advantageous to incorporate real-time monitoring of service availability indicators, such as wait times, into behavioral healthcare EHR systems to detect and resolve problems related to inaccessibility of services as quickly as possible.[177] For example, Seattle Children's hospital redesigned its EHR systems to incorporate real-time monitoring of wait times, which allowed for the rapid trialing of wait-time reduction techniques in both the emergency department and inpatient facility.[178]

Quality of Services

Behavioral health services for children should not only be accessible and comprehensive, but they must also be of high quality. Regularly measuring and reporting care quality informs quality improvement initiatives and makes financial incentives and penalties for performance possible.[179] Additionally, data collected on quality of care needs to include qualitative data and direct beneficiary feedback. As such, efforts to standardize behavioral health care quality measures are ongoing.[179]

Reporting on quality of services

A review of 510 commonly used behavioral health quality reporting systems by Patel and colleagues (2015) demonstrated that 72% were process measures, 21% were outcome measures, and 6% were structure measures.[180] Given that process variables do not necessarily translate to patient outcomes directly, the extent to which those data can be interpreted to improve patient outcomes is limited. Eighty-nine percent of those measures were obtained from administrative claims data, which are subject to variation based on billing codes used in individual settings.[180] The review also revealed that, among quality reporting programs selected, only 28 (5%) unique measures existed, although there was variation in the way that they were framed (for example, readmission within 14 verses 30 days).[180] As such, there is a substantial need for behavioral health quality measures that better translate across settings.[180]

CMS Medicaid/CHIP Child Core Set

The CMS Medicaid/CHIP Child Core Set provides an avenue through which states can measure and report the quality of care provided through Medicaid or CHIP-funded services.[181] Eighteen of the 25 measures in the core set are graded by the Oxford Centre for Evidence-Based Medicine (CEBM) criteria with either an "A" or "B."[181] Those measures are a good start to introducing standardized measures of quality of care to child health care settings.[181] Nevertheless, there is some room for improvement, especially given that there is a lack of behavioral health care quality indicators in the set.[181] Forty-nine states report at least half of those measures, demonstrating that data collected through the core set is becoming widely available.[182] States' utilization of the core set is promising and allows states to benchmark their quality indicators to those of aggregated national data.[181]

National Committee for Quality Assurance (NCQA)

NCQA offers the Distinction in Behavioral Health Integration recognition to primary care practices that meet 18 criteria, including incorporation of behavioral health providers on-site, information sharing with outside organizations for care coordination, use of evidence-based protocols related to behavioral health, and use of quality behavioral health measures to inform care.[183] PCPs who incorporate those measures into practice are likely to contribute to increased behavioral health care accessibility and seamless care transitions.[183] However, PCPs may be disincentivized to acquire and maintain that distinction by the $6,700 initial recognition fee and $2,010 annual reporting fee.[183]

5.2 Current System

The Continuum of Behavioral Health Services

Figure 5.A highlights the behavioral health services and programs available to children in DC with public insurance along the continuum of care. *Table D.1* in Appendix D provides a more comprehensive description of each of the programs in *Figure 5.A*, along with its target population, utilization data, and locations served. Many of the services/programs for children that are included in *Figure 5.A* are covered under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit, which ensures that children under age 21, enrolled in Medicaid, receive comprehensive and preventive health care services, including mental health, developmental, and specialty services.[184] These programs and services are furnished through several types of behavioral health service providers in DC, which are explained further below.

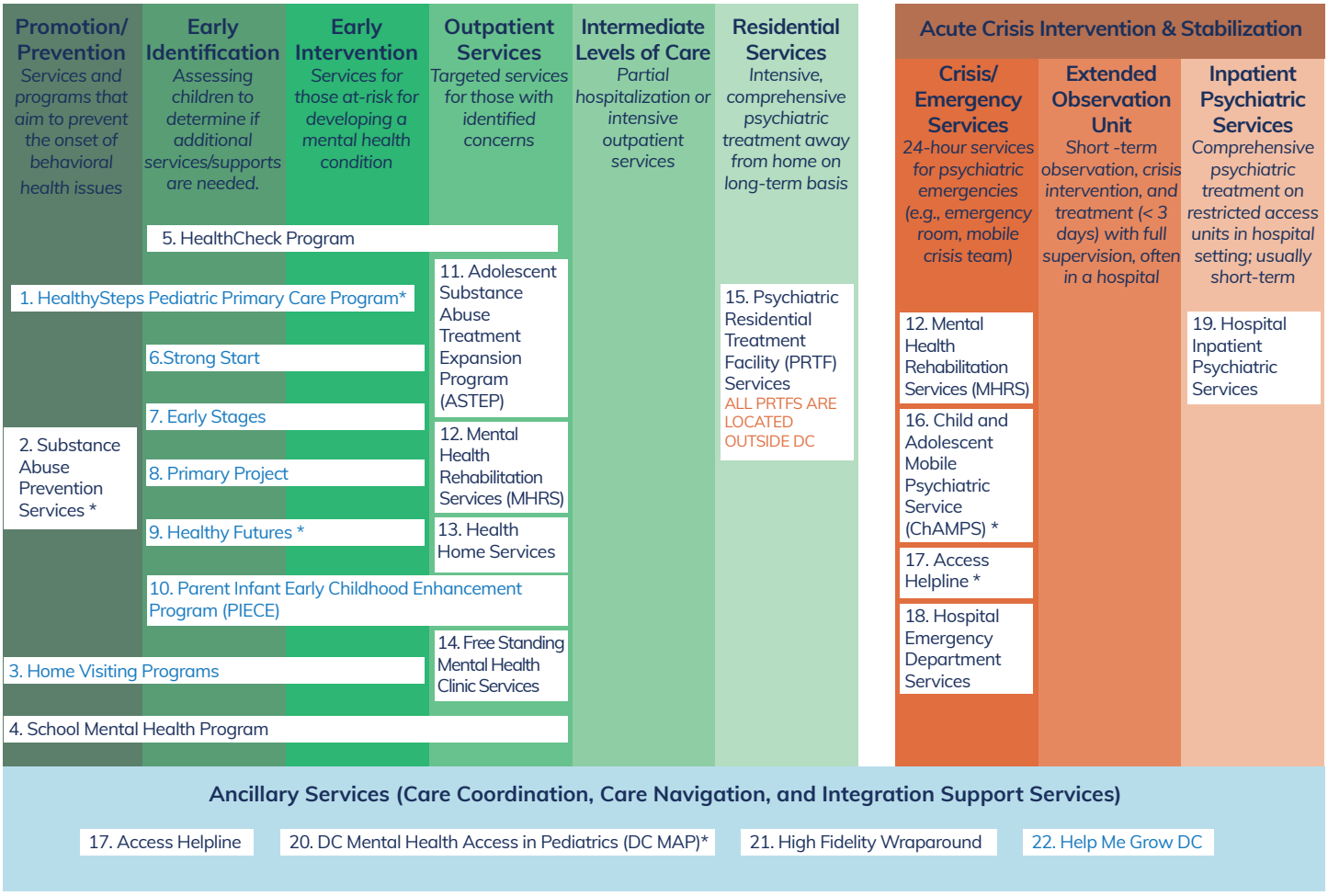
Selected Types of Behavioral Health Service Providers in DC

Service providers are classified according to their funding, services provided, and/or populations served. Provider types in DC include:

- **Pediatric Primary Care Clinics**—clinics that typically provide integrated primary care physical and behavioral health services, along with referrals for acute or sub-specialty services as needed. Some children first have behavioral health conditions identified in primary care settings. Some settings offer behavioral health services with an on-site clinician, and some have access to psychiatric consultation services including DC MAP.
- **Federally Qualified Health Centers (FQHCs)**—community-based health care providers that provide services typically offered in an outpatient clinic and qualify for specific reimbursement systems under Medicare and Medicaid. FQHCs include community health centers, migrant health centers, health care for the homeless, and health centers for residents of public housing.
- **Free-Standing Mental Health Clinics (FSMHCs)**—clinics that offer outpatient care for individuals with a mental illness who are Medicaid eligible. FSMHCs are subject to oversight from DHCF.
- **Health Homes**—specific provider organizations that coordinate care for eligible Medicaid beneficiaries who opt to enroll in a Health Home. Health Homes were implemented through the Affordable Care Act. To be eligible for one of the two types of Health Homes in DC, an individual must be enrolled in Medicaid and have specific health conditions (dependent on the eligibility requirements of the type of Health Home).
- **Core Service Agencies (CSAs)**—nonprofit and for-profit community-based providers that provide mental health and substance use disorder treatment services for DC residents under Mental Health Rehabilitation Services (MHRS). CSAs are subject to oversight from DBH. Child/youth MHRS include: diagnostic/assessment, medication/somatic treatment, counseling, community support, crisis/emergency and community-based intervention.
- **Psychiatric Residential Treatment Facilities (PRTFs)**—certified facilities that are not hospitals and provide inpatient psychiatric services to individuals under the age of 22. There are currently no PRTFs located in DC.

Note: Provider organizations can qualify to be both a CSA and a FSMHC.

Figure 5.A. DC Public Behavioral Health Services and Programs for Children Along the Continuum of BH Care



Note: Blue text refers to programs restricted to children who are at least below seven years old; *funded mainly through nonbillable services.

Program	Description	Service Location
1. HealthySteps Pediatric Primary Care Program	Primary care services (including social-emotional & behavioral screening and behavior consults) for children 0-3 based on the HealthySteps Model	HealthySteps Sites
2. Substance Abuse Prevention Services	Education on drugs and substance abuse	Prevention Centers
3. Home Visitation Programs	Services to help prevent child abuse/neglect, support positive parenting, improve child health, and promote child development and school readiness for parents and children 0-3	At Home
4. School Mental Health Program	Prevention, early intervention, and clinical services to middle and high school students and their families	Certain DC Public Schools and DC Public Charter Schools
5. HealthCheck Program	Early and periodic screening, diagnostic, and treatment services, including well-child visits at age-appropriate periodic intervals that include developmental/ behavioral assessments	Primary Care Providers (Who Serve FFS or MCO Beneficiaries)
6. Strong Start	Services for children under 3 who have or are at risk for developmental disabilities or delays	At Home or In the Community
7. Early Stages	Screening and early intervention for children 3-6 who have or are at risk for developmental disabilities or delays	Early Stages Centers (2 In DC)
8. Primary Project	Screening and early intervention services to children in PreK through third grade with mild school adjustment issues	Certain Public and Charter Schools and Child Development Centers
9. Healthy Futures	Consultation services to care providers and family members	Child Development Centers
10. Parent Infant Early Childhood Enhancement Program (PIECE)	Screening & therapy services to children ages 0-7	PIECE Site
11. Adolescent Substance Abuse Treatment Expansion Program (ASTEP)	Substance abuse assessment and treatment services using Adolescent Community Reinforcement Approach	Certified SUD Providers
12. Mental Health Rehabilitation Services (MHRS)	Services include diagnostic/assessment, medication treatment, counseling, crisis intervention, and community support for children with severe emotional disturbance diagnosis	CSA, Sub-Specialty and Specialty Providers
13. Health Homes Services	Interdisciplinary teams coordinate care across medical, behavioral, and social service systems for individuals with chronic medical conditions	Certified Health Homes
14. Free Standing Mental Health Clinic (FSMC) Services	Outpatient care for patients through a formally organized psychiatric clinic	Certified FSMHCs
15. Psychiatric Residential Treatment Facility (PRTF) Services	Inpatient care for patients under the age of 22 provided at certified facilities that are not hospitals	PRTFS (All Located Outside of DC)
16. Child and Adolescent Mobile Psychiatric Service (ChAMPS)	Mobile team provides crisis intervention for children 6-17	In the Community, at Schools, or at Home (Mobile Service)
17. Access Helpline	Call service that enrolls individuals in the DBH system of care & assists with consumer transfers between providers. Also, responds to crisis calls and dispatches crisis services if needed	Not Applicable
18. Hospital Emergency Departments (EDs)	Emergency diagnostic and treatment services for acutely ill children	DC Hospitals with EDs that Serve Children
19. Hospital Inpatient Psychiatric Services	Inpatient psychiatric programs for children of varying age groups	DC Hospitals with Inpatient Psychiatric Units for Children
20. DC Mental Health Access in Pediatrics (DC MAP)	Consultations (typically by phone) and trainings to pediatric primary care providers from mental health providers	Not Applicable
21. High Fidelity Wraparound	Care coordination service & collaborative team-based care planning process for children with complex needs	Not Applicable
22. Help Me Grow DC	Information & referral helpline that also provides personalized care coordination individual follow-up for children 0-5	Not Applicable

Note: Blue text refers to programs restricted to children who are at least below seven years old; *funded mainly through nonbillable services.

More information about service delivery can be found in our previous publication, *Behavioral Health in the District of Columbia for Children, Youth, and Their Families: Understanding the Current System*, but it should be noted that there have been several changes to the system since the previous publication. One major change has been the approval of the District of Columbia Section 1115 Medicaid Behavioral Health Transformation Demonstration, which became effective on January 1, 2020. Through that demonstration, DC's Medicaid program can temporarily cover more behavioral health services, including youth mobile crisis services and specific trauma-targeted services. Another major change is the shift of behavioral health services to covered benefits in the District's managed care contracts by October 1, 2023, with the goal of providing whole-person care and strengthening coordination.[6] On the path to this carve-in of behavioral health services, current efforts have been focused on conducting a behavioral health rate study and advancing a recently formed Behavioral Health Integration Stakeholder Advisory Group to support planning.

Evidence Based Practices

With reference to *Table 5.B*, DBH facilitates several evidence-based practices through certified providers. Notably, through the School Mental Health Program, some schools also offer evidence-based practices. While other providers in the District may also offer the services listed below, the following table represents publicly available data on evidence-based practices available through DBH clinics.

Table 5.B. Evidence-Based Practices Provided in the District for Children through DBH

Evidence-Based Practice	Number of Providers	Total Capacity	Total Enrollment*	Medicaid Reimbursable?
Child Parent Psychotherapy (CPP)	4	45	34	yes
Parent Child Interaction Therapy (PCIT)	4	65	32	yes
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)	5	89	37	yes
Functional Family Therapy (FFT)	2**	48**	37	yes
Multi-Systemic Therapy (MST)	2	24	15	yes
Trauma Systems Therapy (TST)	2	23	14	yes (but no specific code; uses Counselling code)
Transition Into Independence (TIP)	5	437	359	yes (but no specific code; uses Community Support code)
Adolescent Community Reinforcement Approach (ACRA)	3	140	18***	yes

***These numbers may not be fully representative of the typical program utilization due to the COVID-19 pandemic.**
****One FFT provider has informally notified DBH that it plans to close its FFT program so capacity will be reduced to 36.**
*****Two ACRA providers have indicated difficulty with referrals and retaining the youth once enrolled in their programs.**

Source: Department of Behavioral Health FY20-21 Performance Oversight Questions

Substance Use Services

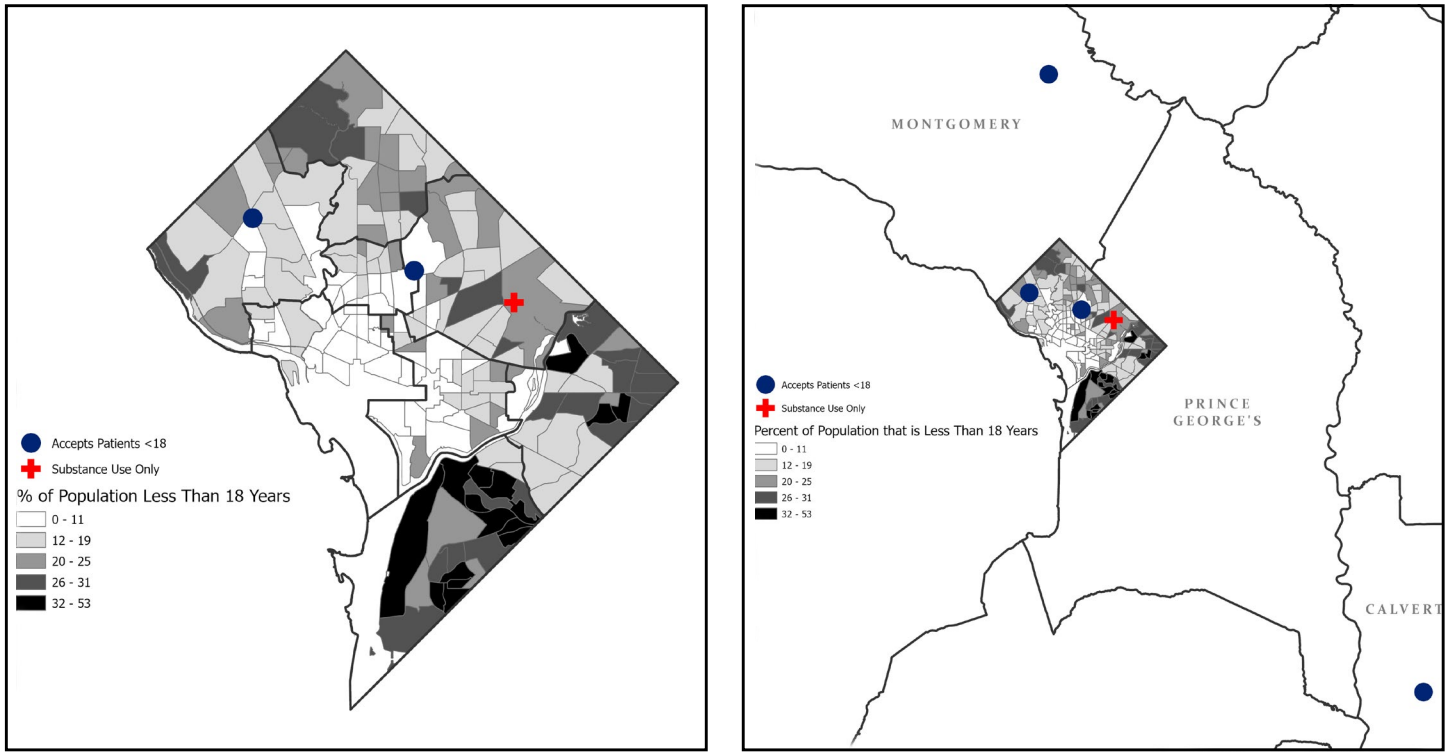
As shown in *Figure 5.A* and *Table 5.B*, DC has three ASTEP providers that administer ACRA to youth experiencing substance use issues. Additionally, DC has four Prevention Centers, which use education campaigns to prevent and delay the onset of alcohol, tobacco, and other drug use.[94]

Accessibility of Services

According to the DC Health Matters Collaborative's *2019 Community Needs Assessment*, some community stakeholders perceive a shortage of pediatric psychiatrists, child psychologists, drug and alcohol abuse counselors, and fully licensed therapists in the District, while others counter that there is not a provider shortage but an uneven provider distribution. The latter group of stakeholders noted that Wards 5, 6, 7, and 8 are most affected by the distribution disparity. Notably, Anacostia is the only HRSA-recognized High Needs Geographic Health Professional Shortage Area (which specifies geographic regions with a lower provider-per-capita ratio than needed) for mental health providers in DC.[185] *Figure 5.B* shows the distribution of behavioral health inpatient services that accept DC's public health insurance for children ages 18 and under, based on data from the Spring 2021 DC Child & Adolescent Mental Health Resource Guide.

The COVID-19 pandemic has driven recent increases in telehealth.[186] The rise in the number of providers who are offering behavioral health services for children remotely increases accessibility to services by removing transportation barriers. However, that improved accessibility is not true for the entire population, because families without reliable internet access and children with behavioral health conditions that preclude them from responding well to virtual services cannot enjoy this benefit. For example, The Wendt Center noted differences in the way children engage with behavioral health services through telehealth in comparison to in person treatment.[186] The availability of remote behavioral health services in DC is explored further in Chapter 8.

Figure 5.B. Maps* Showing the Location Inpatient Behavioral Services Available for Children (Ages 18 and Under) on DC's Public Health Insurance



***Maps developed based on data from DC Child & Adolescent Mental Health Resource Guide, Spring 2021**

Wait Times

Related to provider network adequacy issues, there are also long wait times for children to access behavioral health services. For fiscal year (FY) 2020, 26% of children newly enrolled in MHRS had to wait over 30 days from enrollment to their first appointment. Other wait times for selected services in FY 2020 and 2019 are shown in *Table 5.C.*

Table 5.C. Wait Times for Selected Services in FY 2019 and FY 2020

FY	Description of Service	Average Wait Time
2019	Number of days between when a family or child's enrollment takes place to a medication somatic service appointment with a psychiatrist	76 Days
2020	Number of days between when a family or child's enrollment takes place to intake appointment	24 Days
2020	Number of days between when a family or child's enrollment takes place to diagnostic assessment	22 Days
2020	Deployment time for ChAMPs	39 Minutes

Adapted from: Department of Behavioral Health FY19–20 Performance Oversight Questions; Department of Behavioral Health FY20–21 Performance Oversight Questions

Of note, DBH has reported that as of February in FY 2021, initial wait times between a family or child's enrollment to either intake appointment or diagnostic appointment has been less than 10 days, with providers citing the role of telehealth in increasing ease of scheduling and attending appointments.[187]

Integrated Care

In recent years, there have been a number of efforts to promote integrated care in the District, including DC MAP and the Integrated Care Technical Assistance (ICTA) program.

DC MAP is a telephonic Child Psychiatry Access Program aimed at improving mental health integration within pediatric primary care in Washington, DC.[188] This program is funded by DBH, and was previously administered by Children's National Hospital and MedStar Georgetown University Hospital. The program has a new vendor as of late 2021. The DC MAP program is modeled after a highly successful program started in Massachusetts (MCPAP) and joins other pediatric psychiatry access programs across the country that are part of the National Network of Child Psychiatry Access Programs. These programs offer pediatric PCPs increased access to child mental health experts and have led to significant improvements in providers feeling better able to address their patient's mental health issues.

DC MAP has four primary missions: 1) Increase collaboration between pediatric PCPs and child mental health specialist; 2) promote mental health within primary care; 3) improve the identification, evaluation, and treatment of child mental health problems; and 4) promote the rational utilization of scarce specialty mental health resources for the most complex and high-risk children. DC MAP offers a wide range of free services, including timely provider-to-provider phone consultation; community resource referrals; care coordination; free one-time face-to-face evaluations for families as needed with a DC MAP mental health clinician; and mental health education and training in primary care. Since launching in 2015, nearly 400 pediatric providers from over 50 practices in the DC area have utilized DC MAP services. As of June 2021, DC MAP received 4,890 consultation requests for 4,230 unique patients. With the transition to a new vendor, DC MAP services may experience changes. The DC Collaborative for Mental Health in Pediatric Primary Care project shall continue to serve as an oversight body in this work to monitor and provide feedback regarding DC MAP.[189] DBH needs to ensure this transition happens with fidelity and quality by providing assistance to the new vendor as well as any necessary oversight.

DC's ICTA program, managed by DHCF and DBH, assists DC Medicaid providers by using data to inform care for patient's medical, behavioral health, and social needs while supporting organization leadership in bringing VBP efforts to fruition.[190] Participation in the ICTA program can be accomplished through individual coaching, webinar sessions, learning collaboratives, and a virtual learning community available at https://www.integratedcaredc.com/.[190] Priority providers for the initiative include Health Homes, DBH, long term services and supports (LTSS), MAT, and free-standing mental health providers as well as FQHCs.[190]

Care Coordination

There are multiple avenues through which families and children on public health insurance receive care coordination. *Figure 5.A* and *Table D.1* in Appendix D highlight some care coordination services provided to special populations of children. Additionally, all Medicaid managed care plans offer some level of care coordination and case management services to enrollees.

High Fidelity Wraparound (HFW)

DBH also offers HFW services to youth at risk for or returning from an out-of-home residential treatment center and/or for youth who have experienced multiple psychiatric hospitalizations.[191] The HFW model provides care coordination and family support by creating individualized plans to help families develop goals, prioritize needs, and implement a transition plan. For FY 2019, HFW served 63 youth, and it has capacity to serve 94 youth.[191]

Natural Supports

Natural supports, which can be defined as "the personal associations and relationships developed in the community that enhance the quality and security of life for people,"[192] frequently play critical care coordination roles in DC. Natural supports may include family members, friends, sponsors, mentors, religious leaders, community members, and/or block captains. Natural supports are often involved in helping individuals initiate contact with the District's behavioral health system and are sometimes the first point of contact when someone experiences a crisis. Beyond that initial assistance, natural supports may also help individuals through treatment and recovery. Unlike formal programs and services, natural supports have personal, trusted relationships with those seeking care, as well as relevant intellectual skills and knowledge from lived experiences. Thus, they may be well-positioned to facilitate care connections and follow-ups. As a testament to their value, natural supports are recognized as one of the 10 core principles in all wraparound processes, which includes intense critical support and aftercare,[192] including DC's HFW.[193]

DC Health Homes

Health Home services include comprehensive care management, care coordination, health promotion, comprehensive transitional care/follow-up, patient and family support, and referral to community and social support services. DCHF provides two types of Health Homes:

- **My DC Health Home (Health Home I),** *implemented in January 2016, is a care coordination benefit for Medicaid beneficiaries with mental health care needs. It provides coordination of an individuals' health and social service needs, including primary and hospital health services, mental health care, substance use care, and long-term care services and supports. However, given that my Health Home has an age requirement of 18 minimum, it does not serve a significant number of children and youth. Providers in DC are CSAs or community-based mental health providers that implement care teams that include nurses and PCPs. Health Home providers must pass DBH's Health Home certification process. Current My DC Health Homes include: Anchor Mental Health, Community Connections, Family Matters, Hillcrest Children and Family Center, Mary's Center, MBI, McClendon Center, MedStar Washington Hospital Center/Behavioral Health Service, and Volunteers of America.*[194]

- **My Health GPS (Health Home II),** *implemented in July 2017, is a care coordination benefit for Medicaid beneficiaries (enrolled with an MCO or FFS) with multiple chronic conditions, in which an interdisciplinary team is embedded in the primary care setting to integrate and coordinate primary, acute, behavioral health, and long-term services and supports. Current MY Health GPS providers include: Bread for the City,*

Children's National Hospital, Community of Hope, Medical Home Development Group, Family and Medical Counseling Service, La Clinica del Pueblo, Mary's Center, Providence Health Services, Unity Health Care, and Whitman-Walker Clinic.[195]

Quality of Services

Currently, there is no one standard of measures or metrics for assessing and reporting on quality of care and services across the different agencies and providers of behavioral health services. Medicaid's website provides an overview of each state's rate on quality of care, including that DC.[196] In FY 2019, DC reported 18 of the 21 reported health quality measures in the CMS Medicaid/CHIP Child Core Set. *Table 5.D* includes the child quality behavioral health related measures for DC.

Table 5.D. Child Quality Behavioral Health-Related Measures for FY 2019

Measure	DC Rate	Median Rate	# of States Reporting	Notes
Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17—After 7 Days	29.9%	41.9%	44	Higher rates are better for this measure.
Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17—After 30 Days	52.3%	66.3%	44	Higher rates are better for this measure.
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication: Ages 6 to 12—with 1 Follow-up Visit during 30-day Initiation Phase	40.9%	48.6%	40	Higher rates are better for this measure.
Follow-Up Care for Children Prescribed ADHD Medication: Ages 6 to 12—with at least 2 Follow-up Visits in 9 months	50.0%	58.6%	40	Higher rates are better for this measure.
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics: Ages 1 to 17	39.9%	62.8%	29	Higher rates are better for this measure.
Use of Multiple Concurrent Antipsychotics in Children and Adolescents: Ages 1 to 17	1.2%	2.6%	42	Lower rates are better for this measure.

Source: Medicaid & CHIP in District of Columbia, Quality of Care in District of Columbia.

The DC DHCF 2019 Annual Technical Report (April 2020) provides an evaluation of the performance of the Medicaid MCOs[xv] to assess the quality, access, and timeliness of health care services beneficiaries in the DC Healthy Families program receive.[197] For the purpose of the report, we are reporting the behavioral health-related measures. The five behavioral health performance measures reported (not specific to children) are shown in *Table 5.E*. Overall, performance varied widely across MCOs, and no positive trends were identified. Additionally, all measures fell below the NCQA Quality Compass Medicaid Averages.

[xv] *Amerihealth Caritas DC, Trusted Health Plan, Amerigroup, and HSCSN*

Table 5.E. Behavioral Health MCO Performance Measure Results for Calendar Years 2016–2018

Performance Measure	Year	ACDC %	AGP %	HSCSN %	THP %
Antidepressant Medication Management—Effective Acute Phase Treatment	2016	47.19	-	17.14	53.89
	2017	52.92	-	29.55	54.92
	2018	45.23	41.63	16.67	48.46
Antidepressant Medication Management—Continuation Phase Treatment	2016	36.55	-	8.57	37.07
	2017	37.79	-	9.09	34.06
	2018	29.77	25.75	5.56	27.65
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	2016	36.50	-	NA	38.55
	2017	39.13	-	60.87	36.49
	2018	38.03	23.96	58.82	28.99
Follow-Up After Hospitalization for Mental Illness—Within 7 Days after Discharge	2016	49.91	-	28.10	67.51
	2017	30.73	-	19.01	33.13
	2018	39.14	9.06	26.67	24.10
Follow-Up After Hospitalization for Mental Illness—Within 30 days after Discharge	2016	62.43	-	49.59	74.11
	2017	50.17	-	39.67	46.99
	2018	58.99	18.13	50.00	36.14

ACDC = AmeriHealth Caritas District of Columbia; AGP = Amerigroup District of Columbia; HSCSN = Health Services for Children with Special Needs; THP = Trusted Health Plan; - = results are unavailable as AGP became operational October 1, 2017
Source: Medicaid Managed Care 2019 Annual Technical Report; Qualtrant; 2020

The report also includes data from the *Child CAHPS Survey* (surveys parents/guardians of child enrollees) on experience of care with all four MCOs. Those measures include composite scores on customer service, how well doctors communicate, shared decision-making, health promotion and education, coordination of care, as well as ratings of the health plan, all health care, personal doctor, and specialist seen most often. Overall, the data showed a positive trend in the Shared Decision Making Composite measure and a decline in performance for How Well Doctors Communicate Composite, Health Promotion and Education Composite, and Rating of All Health Care.

DHCF publishes an annual MCO report card that compares Medicaid MCOs in key performance areas such as "keeping kids healthy."[198] Similarly, DBH previously produced a Provider Scorecard that evaluates certified community-based mental health providers.[199] It gives providers a rating on quality and financial performance based on evaluation of quality of services and adherence to federal and District policy and regulations. In FY18, DBH indicated that it was replacing Scorecards with separate compliance indicators and Results Based Accountability indicators. DBH reported that it implemented in late FY 2019 an enhanced performance management system, in which metrics are displayed and monitored using an internal dashboard.[187]

With CMS approval, DHCF implemented the MCO pay-for-performance program in 2017, which is funded through a 2% withhold of each MCO's actuarially sound capitation payments. DHCF used data from the period April 1, 2015, through March 31, 2016, to set the initial baseline. Section 4.2 in Chapter 4 provides more details on the MCO pay-for-performance program.

5.3 Gap Analysis

A comparison of DC's current behavioral health service delivery for children on DC's public health insurance to our vision highlights several key gaps that are discussed below.

1. Gaps in the continuum of behavioral health services

Figure 5.A highlights that DC lacks access to a full continuum of psychiatric care services for children and youth. The following are missing services in the continuum of behavioral health services for children in DC with public insurance:

i. No intensive outpatient program;
ii. No partial hospitalization or day hospital;
iii. No crisis stabilization unit or extended observation unit specifically for children less than 18 years;
iv. No Bridging Clinic for youth who are being discharged from inpatient psychiatric units without established outpatient therapy and medication providers;
v. No therapeutic group home/community residence; and
vi. No local PRTFs.

The lack of intermediate levels of care treatment options means that youth may be served at a level of care that is insufficient for their needs, which leads to costly, avoidable inpatient psychiatric admissions, excessive numbers of patients boarding in the emergency department, patient/family dissatisfaction, and poor patient outcomes. There are also no PRTFs located in the District. Children and their families are inconvenienced by having to travel out of state to Maryland, Virginia, or often farther distances to seek needed services. The lack of a local facility for residential psychiatric treatment was also discussed in our family engagement forums. One parent/caregiver noted, "I know personally trying to navigate the system that as far as residential centers for children that are experiencing needs, to my knowledge, D.C. does not have a residential center … Sometimes if they (children) are lucky, they're going to Maryland. But they're going to Kansas. They're going to Michigan. They're going to Texas."

In addition to the missing services mentioned above, the District also lacks sufficient behavioral health services on the prevention and promotion side of the continuum, including programs that build protective factors to address suicide and suicidal ideation, substance use, problem behaviors, depression, etc. While the District does currently implement several evidence-based prevention and promotion services, such as HealthySteps and Substance Use Prevention Centers, many of those services, particularly for young children and their families, are grant funded and not sustainable. Further, prevention programs face many financial barriers such as lack of reimbursement mechanisms, particularly for community-based settings, and when components are Medicaid reimbursable, they tend to be at lower rates than treatment services.[200]

2. Challenges with substance use treatment options for children in the District

While ASTEP has increased accessibility for substance use treatment by giving adolescents and families the ability to go directly to any ASTEP location for a substance abuse assessment, barriers to substance use treatment for children persist.

The only SUD evidence-based treatment currently provided for youth (ages 12–21) is ACRA, an evidence-based behavioral health intervention geared toward reducing the use of alcohol and illicit drugs and increasing prosocial behaviors.[94] The District currently has three ASTEP locations (in Wards 1, 4, and 6) that provide ACRA, and enrollment is persistently lower than capacity. Current location options can cause barriers to access and utilization of services for youth in other wards, especially for families with limited transportation options.

An additional gap identified is the lack of youth engagement in continuing SUD treatment once started, especially for transition-age youth.[201] With reference to *Table 5.B*, ACRA providers have indicated that they experience difficulties with referrals and treatment continuation, which may explain the low enrollment in services despite the high number of children (5.42% of youth or 2000 individuals between ages of 12–17) estimated to have SUD in the District in the past year. Through our family engagement efforts, some youth cited ineffective behavioral health services as a main reason for treatment discontinuation, which suggests a need to explore the effectiveness of ACRA for children experiencing substance use issues in the District. Of note, ACRA is not a trauma-informed practice, which may limit its effectiveness for many children in DC whose substance use issues are linked to trauma.

Finally, the current process for entering into treatment is time consuming. Youth must be referred to treatment, which requires an intake coordinator to complete an assessment to determine appropriate level of care and treatment options. They utilize the GAIN-I Assessment, which typically takes about three to four hours. That causes a lag time of about two to three weeks before entering into treatment, because assessments are usually broken into two appointments (since youth may lose focus or cannot sit for the full four hours in one appointment or because of other time constraints/administrative burdens).

3. Fragmented behavioral health service delivery

Currently, behavioral health service delivery is highly fragmented, with children who experience more severe behavioral health issues needing to seek care from multiple treatment and supportive service provider organizations. That presents issues for integration of medical records, care coordination, closed-looped communication, and informed decision-making by providers, especially as families move back and forth along the continuum of services.

4. Existing care coordination services do not meet the needs of youth and families

Although many resources currently exist within DC to facilitate access to behavioral health care, as a result of service decentralization and fragmentation, lack of adequate reimbursement methodologies for both clinical and nonclinical providers, and inaccurate directories, current services do not meet the needs of youth and families. These resources vary widely in quality, reliability, eligibility, accessibility, and ease of use.[202] Moreover, these services are not all centralized and often do not communicate or connect with one another, which can lead to siloed service lines and fragmented experiences for families. Existing care coordination services through the HFW and Health Homes serve special populations of youth but are insufficient to meet the needs of all families in DC. Care coordination was identified as one of the top four needs for youth and families within the District, according to the 2019 DC Community Health Needs Assessment. That was supported in our family engagement forums, where a few parents expressed the need for better coordination along the continuum of services, with one parent highlighting the need for more support as a child transitions from inpatient or residential services to community-based services.

Further, care coordination services that do exist are impeded by inaccurate directories. Public lists of agencies that are in-network for beneficiaries and care coordinators can be difficult to find and access (especially when behavioral health benefits are subcontracted through a third-party provider), and lists often include inaccurate details and information. Additional gaps that exist within the current behavioral health system for care coordination include lack of Medicaid reimbursement or payment for both clinical and nonclinical care coordination. Currently, CHWs and/or peer support specialists are underutilized for care coordination in the child and family behavioral health system.

5. Lack of accessibility of behavioral health services

While *Figure 5.A* highlights that there are extant behavioral health services for children in DC across most of the continuum of care, challenges persist with accessing care. For example, the map in *Figure 5.C* highlights that

there are no inpatient behavioral health services for children under age 18 located east of the river for residents in Wards 7 and 8. While most behavioral health care appointments are eligible for managed care's nonemergency medical transport services (NEMT), not all families are familiar with those services or successful with attempts to use NEMT, and MCOs have placed limits on NEMT uses during COVID-19.

Challenges with transportation were also reflected in our family engagement forums, where a number of individuals expressed challenges with accessing services. Several parents/caregivers felt that accessing services is made more difficult by inadequate available transportation, noting that many of the services that their children need are far from their place of residence. As one parent/caregiver shared, "I have problems with getting quality services, unless I transport me and the kids way out of our community." One youth pointed out that safety concerns, particularly in Wards 7 and 8, can translate into transportation barriers, stating that "people don't even feel comfortable going to Anacostia station."

Additionally, schools are one of the main settings in which many children in DC can directly access behavioral health services or be referred to services. However, families are not always aware that those resources are available to them or of the process for seeking a referral for services. Anecdotally, school leaders or individual teachers sometimes put pressure to avoid scheduling treatment during the school day, which undermines the usefulness of school behavioral health services as place-based care.

6. Long wait times reported for behavioral health services

Despite national best practice recommendations for timely access to care, families often encounter long waitlists when attempting to connect with behavioral health services in the District. The waitlist can vary between a few weeks to a few months, with the wait time increasing when specialty services are required (e.g., medication management, substance use services, ABA therapy options, etc.). There are many factors that contribute to those extended waitlists, including but not limited to a lack of licensed or certified behavioral health professionals to meet the needs of the community (both therapist and psychiatrist), low reimbursement rates for behavioral health services, and network inadequacy.

Relatedly, there is a lack of reliable data available to track the timeliness of access to services due to lenient/nonstandardized data collection guidelines and decentralized data reporting. For example, the *District of Columbia Managed Care Program 2020 Annual Technical Report* only reported wait times for dental providers.[112] Additionally, the data that are available are often aggregated among many diagnoses, making it hard to track/oversee the types of services that are being provided and the length of time it takes for youth and families to connect to those services.

7. Lack of consumer satisfaction with local behavioral health services

There is some evidence that Medicaid beneficiaries are not satisfied with behavioral health services delivered through MCOs or DBH. Based on *NCQA Health Insurance Plan Ratings 2019–2020 Summary Report*, DC commercial health plans received higher quality and customer satisfaction ratings than DC Medicaid plans. Fourteen DC commercial health plans averaged a 3.4 quality rating and 2.9 customer satisfaction rating, while three Medicaid plans averaged a 2.8 quality rating and 2.3 customer satisfaction rating. Additionally, through our family engagement focus group analysis findings, some youth indicated that they felt the behavioral health services they received were not helpful or made them feel worse.

8. No single standard of measures or metrics for assessing and reporting on quality of care and services

This is true across the different agencies and providers of behavioral health services. There is also a need to develop meaningful qualitative data collection methods to track and assess consumers' perceptions of quality of care and quality of life based on the services they are receiving.

9. Lack of family-centered care

Given that family dynamics significantly impact children's behavioral health,[203] it is essential that behavioral health services for children are family-centered and incorporate the needs of families and caregivers. The following are some areas where the District lacks family-centered behavioral health care practices:

- A number of accounts report a high rate of unnecessary psychiatric institutionalization among DC youth,[204, 205] which may suggest that youth are not provided with enough treatment options that allow them to stay with family and other sources of social support. This also suggests that the criteria being used to determine medical necessity regarding sending children to PRTFs out of the state may not be responsive enough or that additional criteria are needed. Further, there are anecdotal reports that parents and other caregivers are not always engaged when their child is in residential treatment, and when the child returns to the community, the parents do not always know how to implement de-escalation tools the child learned in the facility. The education provided to parents/caregivers regarding their child's diagnosis, treatment options, and behavioral health plan are insufficient.
- There exists insufficient District guidance ensuring that family needs are measured and incorporated into child and youth behavioral health care plans.
- The District does not have an adequate reimbursement infrastructure to support dyadic or family therapy. For example, PCIT and CPP do not have their own specific billing code when billed through managed care. Behavioral health providers will usually bill these dyadic therapies using individual psychotherapy codes because the family psychotherapy reimbursement rate is lower.
- In the District, self-directed home and community based services (HCBS), which allow a patient to pay an aide of their choice, including family members,[206] are only available for adults.[207] Further, they are not available to individuals who qualify for HCBS services on the basis of behavioral health-related disabilities.[207] As a result, full-time family caregivers of children with advanced functional impairment related to behavioral disorders have limited opportunities to be compensated for the care they provide.

10. Insufficient cultural competency among providers to serve DC's diverse population of children

Through our youth engagement efforts, children and youth revealed that the lack of cultural competency among behavioral health providers was a deterrent to accessing or staying in services. Further, children and youth felt that sociocultural differences prevented providers from being able to understand them, and therefore, they felt uncomfortable sharing. The lack of people in the workforce who look like and come from similar communities as Medicaid beneficiaries reinforces challenges with cultural humility and cultural competence.

11. Trauma experienced by the District's children remains inadequately addressed

Many children in DC are exposed to high rates of trauma, including community violence as discussed in Chapter 2, and such trauma could have lasting negative behavioral health effects. While the District offers several trauma-specific EBPs for children and several provider organizations have adopted elements of trauma-informed care, trauma remains unaddressed for many children, including infants and toddlers. Through our family engagement efforts, children's trauma emerged as a major recurring theme discussed by parents/caregivers, with one parent stating, "a lot of them [children] have been through traumatic situations or hard times, and a lot of times, the mental aspect isn't dealt with."

Professionals in any setting where a child may need support after traumatic experiences (all health care settings, schools, child care centers, community centers, recreation centers, faith-based institutions, etc.) need appropriate training to deliver trauma responsive interventions in the frontlines.

12. Social determinants of health are inadequately addressed

Evidence indicates the social determinants of health as causal to the development of behavioral health disorders and an important target for health care providers. However, the support systems within DC's behavioral health care system that identify and address social determinants, such as community violence and poverty, remain inadequate. Our family engagement findings revealed that DC youth experience excessive police force, poor neighborhood conditions, including prevalence of violence within their communities. Poverty emerged as another significant barrier to receiving sufficient support and behavioral health care in our family engagement groups. As one youth expressed, for many experiencing poverty, basic survival needs receive a greater focus than overall well-being, which discourages them from seeking behavioral health care when needed.

5.4 Recommendations

Given the overlaps between financing and service delivery of the behavioral health system, we recommend that the recommendations in Section 4.4 and Section 5.4 be considered together.

1. Establish the full continuum of psychiatric care for children, including acute care, crisis stabilization, and intensive outpatient care in the District.

Implementing Bodies: DHCF, DBH, DC Health, CSAs, MCOs
Timeline to Implementation: Long Term

We recommend the District work toward establishing a full continuum of services for children less than 18 years in need of acute or crisis stabilization psychiatric care that is accessible by children who are uninsured or on public health insurance. Establishing the following services *specifically for children less than 18 years* would allow children to access services that better meet their needs:

I. Crisis stabilization unit, with an extended observation unit;
II. Bridging Clinic for youth who are being discharged from inpatient psychiatric units;
III. Therapeutic group home/community residence;
IV. Intensive outpatient programs;
V. Partial hospitalization or day hospital; and
VI. A local PRTF.

We recommend establishing a CCPEP modeled after New York City Health + Hospitals/Bellevue's CCPEP, because that would create services I. and II. Another approach to create a Bridging Clinic would be to expand DC MAP funding to include psychiatry access services for patients discharging from inpatient psychiatry units and the emergency department.

Establishing those new services must involve the creation of competitive reimbursement rates to support missing programs. Models for public-private partnerships should be explored as a means of delivering and financing those additional programs.

2. Improve services for youth at-risk for or diagnosed with substance use disorders (SUD).

Implementing Bodies: DHCF, DBH, MCOs, PCPs, ASTEP Providers
Timeline to Implementation: Long Term

The following are some strategies to consider for improving services for youth at-risk for or diagnosed with SUD:

- Place special emphasis on working with youth, families, and providers to explore solutions to improve screening, assessment, referral and treatment, and options for improved integration of SUD prevention and treatment services into easily accessible locations, such as primary care and schools. There is

also a need to work with youth, families, and providers on identifying and implementing innovative strategies to better engage youth to stay in treatment.

- Standardize screening tools for SUD (ensuring that the tools are culturally competent and evidence-based or at least evidence-informed) and implement them universally at PCPs, in the school system, in the child welfare system, and in the juvenile justice system.
- Substance use outpatient services should be integrated or collocated together with mental health services to decrease stigma and provide easier access for adolescents and their families.
- Explore the implementation of other adolescent substance use evidence-based treatments besides ACRA. A recent review by Fadus and colleagues (2019) noted that there is considerable evidence supporting numerous substance use treatment options for adolescents. EBPs, particularly those that are trauma-informed, should be piloted to determine if they work for DC's youth.

Table 5.F. Adolescent Substance Use Disorder Treatment Recommendations by Fadus et al (2019)

Well-Established Standalone Interventions	Family-based therapy, cognitive behavioral therapy, multicomponent psychosocial therapy
Probably Efficacious Standalone Interventions	Motivational interviewing/motivational enhancement therapy, third-wave cognitive behavioral therapies
Possibly Efficacious Standalone Interventions	12-step programs
Possible Adjunctive Interventions	Pharmacotherapy, exercise, yoga, mindfulness, recovery-specific educational settings, goal setting, progress monitoring
Modifications to Improve Existing Approaches	Digital strategies, culturally based programs

Source: Adolescent Substance Use Disorder Treatment: An Update on Evidence-Based Strategies, Table 1. Adolescent Substance Use Disorder Treatment Recommendations; Fadus et al; 2019

- Improve communication and understanding of available SUD services for youth among PCPs and other clinical and nonclinical providers.
- Increase evidence-based prevention programs for youth that target the most frequently used substances. In particular, education on the negative health effects of marijuana, which is one of the most used substances among youth in DC, is important because individuals under 21 years old have a higher risk for long-term, potentially irreversible cognitive impairments from cannabis use disorder.[22]
- DC should also explore opportunities for expansion of DC MAP services to include the Adolescent Substance Use and Addiction Program at Boston Children's Hospital-Massachusetts Child Psychiatry Access Program (ASAP-MCPAP) Consultation Line.

3. Implement models and expand existing models to facilitate integrated care.

Implementing Bodies: DHCF, DBH
Timeline to Implementation: Long Term

As discussed in Section 5.1, there are different service delivery models that can support integrated care for children, including Health Homes, CCBHCs, and the PCCM. The following are recommendations regarding those models:

- DC should pilot the implementation of the PCCM for children and track outcomes, with the aim of determining whether the PCCM model is effective for delivering integrated care to all children or special populations in DC. We recommend that any primary care organization that hires a master's-level behavioral health provider should be highly incentivized to adopt and fully implement the CCM model. Recommendation #2 in Chapter 4 outlines the financing infrastructure necessary to support implementation of this model.
- Also outlined in Recommendation #2 in Chapter 4 is the relaxing and expanding of eligibility requirements for the two types of DC Health Homes. That would allow more children to qualify for and benefit from the integrated care provided through these models.
- Additionally, as outlined in Recommendation 3 in Chapter 4, DC should establish a pathway for creation and payment of CCBHCs. A recent survey of 128 CCBHCs nationwide by the National Council for Mental Wellbeing found that CCBHCs expanded access to care and sharply reduced wait times for care.[208] As mentioned in Section 4.4, with current and emerging opportunities to adopt the CCBHC model statewide, it is critical for the District to establish a plan for organizations to be certified as CCBHCs by October 1, 2023.

Further, with the rapidly evolving integrated care landscape, flexibility in corporate structures will be needed. DHCF should ensure that providers, as they enter into contracts with MCOs, are able to assign their rights and obligations under provider participation agreements in the event of mergers, acquisitions, or other types of corporate restructuring. Allowing reassignment at the corporate level facilitates continuity and prevents disruptions in service provision.

Finally, DBH and DHCF should ensure that technical assistance resources and services for behavioral health providers on integrated care (such as the DC Integrated Care Technical Assistance Program) includes children-specific training and targets providers who serve children in the District.

4. Strengthen care coordination through increased training and reimbursement for both clinical and nonclinical providers, as well as improved and standardized directories.

Implementing Bodies: DHCF, DBH
Timeline to Implementation: Long Term

Care coordination needs vary depending on the complexity of health care needs, as depicted in *Figure 5A*. The following are some recommended strategies to improve care coordination:

- Ensure that all behavioral health care coordination meets the National Care Coordination Standards for Children and Youth with Special Health Care Needs[209] as highlighted *in this chapter*.
- Maximize the use of community health workers and peer specialists to provide care coordination to families. DHCF and DBH, along with CHWs, peer specialists, and relevant provider organizations, should specify and institutionalize the role of this nonclinical workforce in care coordination across various settings. Additionally, the agencies should develop efficient training programs for these roles and ensure they are competitively reimbursed for services.
- As DC moves to carve-in behavioral health services into managed care organizations, it is an opportune and critical time to standardize MCO provider directories, including directory links showing participating providers in any MCO-subcontracted behavioral health administrative organizations. A standardized directory can facilitate easier care coordination in settings external to MCOs. For example, care coordinators at a CBO can more easily support connections to care for any child (regardless of which MCO they belong to) if directories were standardized.
- Directories should also be required to update the providers who are accepting new patients monthly. According to MCO contracts, each MCO must electronically provide one provider directory within 90 days of contract award and then once a month. The directory must identify providers who are not accepting new patients, but that information only needs to be updated quarterly. If the list of providers who can accept new patients is updated only every three months, referrals are negatively affected and patients are connected to care more slowly.

5. Improve service accessibility through the Medicaid nonemergency medical transportation.

Implementing Bodies: DHCF, DBH
Timeline to Implementation: Long Term

Streamline the Medicaid non-emergency medical transportation (NEMT) service, increase its visibility, and expand the program to cover families who are uninsured or on other public health insurances. DHCF should move toward eliminating the three business days prebooking requirement to maximize service utility for beneficiaries; following the lead of current District MCOs, just-in-time NEMT can now be arranged conveniently through ride-sharing services, for example, Uber or Lyft. DHCF should closely monitor any signs that MCOs are limiting use of NEMT and take corrective action when necessary. Additionally, DHCF should utilize enhanced communication strategies to increase members' awareness and knowledge of those services.

6. Establish agreement and accountability on meaningful quality of care measures.

Implementing Bodies: DHCF, DBH, MCOs
Timeline to Implementation: Short-Term

Broad stakeholder agreement on a set of measures allows the District to benchmark our progress toward a responsive behavioral health care system that meets the needs of children and families in a high-quality and timely manner. The attendant challenge in inclusive, and broad agreement is the potential for outcomes to become narrowly defined and reduced to proxies of cost savings or more easily quantifiable metrics, such as hospitalization and/or emergency department use. Those types of measures, however important, are inadequate for any population of the behavioral health system but especially for children. A comprehensive, fully integrated system will meaningfully improve quality of life and functioning. Therefore, measurement of the system's success must track essential components of a system of care, as well as clinical and functional outcomes, which are distinct from hospital or crisis service utilization.

MCOs should work with DHCF and DBH to propose quality of care standards and measures and increase those standards and enforcement over time. MCOs should be allowed to disqualify/disenroll providers who do not meet quality of care standards agreed upon by DHCF and DBH. Additionally, MCOs should be required to report on quality of care measures that are disaggregated by race, ethnicity, and language. DHCF and DBH should incentivize equitable care by tracking the quality of culturally responsive care a person receives.

7. Improve understanding of beneficiary experience.

Implementing Bodies: DHCF, MCOs
Timeline to Implementation: Long Term

DHCF and the MCOs should jointly develop an enhanced understanding of "beneficiary experience" that encompasses family-reported and youth-reported information to gain insight into the experience that children and youth are having. That will require improvements regarding measurement of the child, youth, and family experience and data collection methods (e.g., qualitative data). DHCF should require MCOs to regularly report on results of enrollee surveys and measures based on key dimensions of the beneficiary experience (including care accessibility and network adequacy), with a specific view to whether the needs of children, youth, and families are being adequately served. DHCF should also employ third-party "secret shopper" firms to use standardized scripts and instruments to review accuracy of MCO provider directories for behavioral health availability, including services specifically for children's behavioral health.

8. Expand school-based behavioral health services.

Implementing Bodies: DHCF, DBH
Timeline to Implementation: Long Term

DBH's school-based behavioral health expansion program increases children and families' access to behavioral health services by providing these services in a place children and families already spend a lot of time: school. Through the school-based behavioral health program, students, teachers, school leaders, and families should be able to access all three tiers of behavioral health supports at school. Connection to additional behavioral health supports or other kinds of support services outside of the school setting should be seamless. To accomplish that, school-based behavioral health services should be expanded to fully meet the needs of all children attending DC's public schools. Given the near universal opportunity to access public PreK–3 and PreK–4 in the District, special attention should be given to how school-based behavioral health services can further flexibly meet the developmental, social-emotional, and mental health needs of young children and their families. Recommendation #12 in Chapter 4 outlines key components of the school-based behavioral health program that need continued and/or enhanced funding.

In addition to those components, it is critical to have effective communications designed to improve awareness of school-based behavioral health services: Students and their families are often unaware these services are available in their school or are unsure of how to access them. Each school develops its own procedures for referring students to its behavioral health clinician, and school leaders share that information with the school community in myriad ways. Effective communications tools explaining what services are available and how those services can help students, families, and teachers should be developed and disseminated to all schools, along with guidance and technical support for effective distribution to all members of the school community. Communications materials should be customizable to allow schools to add school-specific information regarding the clinician and the referral process, with easy self-referral directly to clinicians by students or their parents.

9. Implement service delivery strategies to identify and address social determinants of behavioral health.

Implementing Bodies: DHCF, DBH
Timeline to Implementation: Long Term

DBH and DHCF should create and implement plans to address SDOH and mitigate urgent behavioral health treatment needs. Specifically, behavioral health services across various settings should support meeting children's basic needs, such as housing, food security, education, and transportation.[210] Establishing collaborative relationships between social service, education, primary care, and behavioral health systems helps to foster quick referral protocols and eliminates repetitive intake processes.[211]

There should be SDOH screening for children and families that uses a trauma-informed approach at all appropriate health settings. SDOH screening at routine or emergency health visits must be accompanied by referrals, as necessary, to appropriate support programs/services. The widespread implementation of SDOH screening requires the development of protocols and sustainable financing mechanisms, as well as adequate human capacity in appropriate services/programs to address screening outcomes. As mentioned in Recommendation

#11 in Chapter 4, SDOH screening may be supported by the District's Community Resource Information Exchange (CoRIE) project and, more broadly, the District's designated Health Information Exchange (HIE). The DC HIE should include functionality to analyze aggregated data pertaining to identified SDOH, including socioeconomic status, educational attainment, food stability, health care access, exposure to violence, and housing security. Public reporting on such data will foster cross-system accountability, communication, and planning.

10. Encourage all behavioral health service delivery organizations, across the settings of child care, school, health, and social services to develop and implement a plan to deliver and measure culturally responsive and trauma-informed care.

Implementing Bodies: DHCF, DBH
Timeline to Implementation: Long Term

According to SAMSHA's Treatment Improvement Protocol Series, No. 59., a "well-defined and organized plan, coupled with a consistent organizational commitment, will enable organizations to initiate and accomplish the tasks necessary to promote culturally responsive services." In line with this, DBH and DHCF should encourage all providers receiving public funding for behavioral health services to develop and implement a plan to ensure that their organization delivers culturally responsive and trauma-informed services. Coupled with supporting such plans, DHCF and DBH should evaluate, standardize, and require reporting on measurements for organizational cultural competence (using for example, National Culturally And Linguistically Appropriate Services Standards, National Committee for Quality Assurance's (NCQA) Multicultural Health Care Distinction, Cultural Competency Organizational Assessment or COA360) and trauma-informed practices (such as TICOMETER). Additionally, the recently developed Self-assessment for Modification of Anti-Racism Tool (SMART), an organizational-level quality improvement tool designed to facilitate discussions about structural racism existing within behavioral health care structures, is a promising measure through which behavioral health care leadership can diagnose and address existing inequities in the service delivery system.[212] Last, DBH should consider offering trainings in the provision of culturally responsive and trauma-informed care that are tailored to DC's local context (which include diverse populations that are highly traumatized).

11. Improve family-centered care.

Implementing Bodies: DHCF, DBH, DC Health, OSSE
Timeline to Implementation: Medium Term

Involving families in the behavioral health care of children through family-centered practices can improve the behavioral health outcomes of children and their communities.[213] Further, taking into account the caregiving needs of parents and other caregivers of children and youth with behavioral disorders can help empower them to better care for themselves and their children.[214] As such, the District should consider the following strategies to improve family-centered care:

- Offer educational resources to behavioral health providers with information about family caregiver needs.[215]
- Review care management standards, hospital discharge planning, and risk assessment procedures to ensure that they meaningfully involve family caregivers.[215] With permission, grant family caregivers access to care plan information.[215]

- Provide clinical staff with practice guidelines and supervision for how to effectively engage families/natural supports.[216] Ongoing engagement of family and natural support facilitates optimal recovery for children. Close and trusting relationships between families/natural supports and children often allow families/natural supports to be the first to recognize both subtle progress and early signs of deterioration, making them strong partners in care provision.
- Systematically collect information about family/caregiver needs within behavioral health care settings and account for them in treatment plans.[215] That may require additional guidance in documenting adult issues in the child's chart, such as linking the adult caregiver chart with the child's as appropriate, to ensure adequate documentation and collection of information. For children with advanced functional impairment, the District can consider using a strategy similar to that implemented by Tennessee's Medicaid agency (TennCare) through its CHOICES in Long-Term Services and Supports program, in which MCOs are required to conduct formal assessment of caregiver needs and take them into account within care plans.[206]
- To support reimbursement dyadic or family therapy, the District should ensure higher reimbursement rates for family psychotherapy codes.
- Expand self-directed HCBS accessibility to children with behavioral disorders to maximize the opportunity to use home-based supports in lieu of more intensive care options that isolate patients from sources of social support.[217]

12. Continue strong work with behavioral health screening and strengthen successful connection to evaluation and/or treatment after a positive screen.

Implementing Bodies: DHCF, DBH, MCOs
Timeline to Implementation: Long Term

Medicaid MCOs should follow behavioral health screening requirements as mandated by the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit and the DHCF. While every child (0–21) should be screened through their pediatric primary care provider annually with a validated tool, we recommend a degree of continued flexibility to allow health care providers to implement screeners that fit their particular practice demographics, infrastructure, and workflow.

Ethical screening practice requires that referrals made for further assessment, diagnosis, and treatment must be immediately available. Ample health care practice-specific training, staff buy-in, and referral mechanisms must be in place to attend to needs that arise from the screening. Effort should also be made to incentivize providers to utilize the appropriate billing modifier to denote a positive screen. Additionally, MCOs should identify beneficiaries with positive screens and work to support successful connections to appropriate levels of care. DHCF should also report those data at a population level to determine trends in behavioral health screening and linkage to evaluation and/or treatment, if indicated.

6. WORKFORCE

For this report, "workforce" is defined as all people engaged in actions whose primary intent is to enhance behavioral health (which is an adaptation of WHO's health workforce definition such that it applies specifically to behavioral health). Based on this definition, the behavioral health workforce includes the wide range of behavioral health care providers (such as child and family psychiatrists, psychologists, social workers, counselors, peer support specialists) as well as health care support staff (such as psychiatric technicians).

6.1 Vision for the System

With reference to our guiding values for DC's Behavioral Health System for Children outlined in Chapter 1 and *Table* 5.A, our goal for DC's behavioral health workforce includes the capacity to deliver family-centered and trauma-informed care, with cultural humility and in a manner that promotes racial equity. Informed by local needs, the behavioral health workforce should be adequate, easily accessible, sufficiently compensated, and trained in evidence-based practices.

A Diverse, Adequate, and Accessible Behavioral Health Workforce

There should be adequate providers in the necessary specialties, across the spectrum of care, within the behavioral health workforce to be able to meet the current and future behavioral health needs of children in the District in a timely manner. For there to be adequate behavioral health providers for children, all MCOs should meet defined behavioral health network adequacy standards, and the government must routinely monitor and enforce those standards, as discussed in Chapter 4. *Table* 6.A highlights provider-to-patient ratios for certain behavioral health professions that have been recommended by professional organizations or in peer-reviewed research. Those ratios are included to provide broad context for our vision for workforce adequacy but are not specific recommendations for District implementation.

Table 6.A Suggested Provider to Patient Ratios for Selected Types of Behavioral Health Providers

Profession	Suggested Ratio	Source
School psychologist	1:500 students	National Association of School Psychologists (NASP)[a]
School counselor	1:250 students	American School Counselor Association (ASCA)[b]
Child psychiatrists	47: 100,000	American Academy of Child and Adolescent Psychiatry[c]
Substance Abuse Providers	1:48 individuals with SUD*	*BMC Health Services Research*[d]

Profession	Suggested Ratio	Source
Applied behavior analysts (providing comprehensive treatment)	8.1:100 children with ASD	Behavior Analyst Certification Board, *Psychiatric Services*[e]
Social Workers	1:250	School Social Work Association of America[f]

[a.] "School Counselor Roles & Ratios;" American School Counselor Association
[b.] "Beyond a Bigger Workforce: Addressing the Shortage of Child and Adolescent Psychiatrists – Pediatrics Nationwide;" David Axelson, MD; April 10, 2020
[c.] "A Needs-Based Method for Estimating the Behavioral Health Staff Needs of Community Health Centers;" BMC Health Services Research; 2013
[d.] "Supply of Certified Applied Behavior Analysts in the United States: Implications for Service Delivery for Children with Autism;" Psychiatric Services; 2020
[e.] "NASW Standards for School Social Work;" NASW
* Data represents necessary provider-to-patient ratio for individuals aged 12 and over; youth-specific data unavailable.

Moving beyond traditional behavioral health providers, DC should embrace an innovative, broader behavioral health care workforce for children that could be utilized more efficiently, effectively, and earlier in the care continuum.[218] That includes leveraging the power of families and peers in the behavioral health care of children by assigning them formal roles, such as family/peer specialists on expanded care teams. Studies have repeatedly found peer workers to be effective in assisting people with behavioral health conditions to connect to, engage in, and be active participants in different types of services across the continuum of care.[219]

Examples of Successful integration of Peer Support Specialists/Community Health Workers

The following are two program examples in which CHWs and peer support specialists have been successfully integrated in care teams and used in behavioral health.

A 2015 pilot program in Texas trained and integrated experienced CHWs into four FQHCs to support behavioral health services delivery to diverse populations. The purpose of the program was to explore the feasibility of CHWs working to support behavioral health in primary care settings.[220] CHWs received a 48-hour behavioral health training that included training on the SBIRT (screening, brief intervention, referral to treatment) model and an overview of behavioral health and common behavioral health issues. CHWs reported screening for behavioral health issues, outreach, and care coordination (e.g., answering telephones, making and tracking referrals, supporting medication management, scheduling office visits, and following up on missed appointments) as the most frequent activities engaged in.

Another example is the Los Angeles County Department of Health Services – Care Connections Program and Whole Person Care Program (WPC).[221] The WPC program embeds CHWs in the primary care setting to provide outreach, engagement, assessment, peer support, accompaniment to appointments, and other care coordination activities to targeted high-risk populations, such as those who are homeless or have SUD. The CHWs are not required to have any specific certifications but receive intensive training from the LA County DHS on core topics such as social determinants of health, motivational interviewing, using DHS assessment and care planning resources, homelessness, incarceration, mental health and SUD, safety, self-care, leadership, and advocacy skill-building.

It is critical that the behavioral health workforce reflects the diversity of the population it serves, especially considering that research has shown that patients who share the same race and culture as their health care professionals have stronger therapeutic alliances and are more likely to stay in treatment.[222] DC's population of children is racially, ethnically, culturally, and linguistically diverse; thus, there should be sufficient diversity alignment between children and providers to provide effective care. Further, given the variation of racial and ethnic composition across DC wards, it is important for diverse behavioral health professionals to be appropriately distributed in the District. That requires sufficient, long-term planning and funding to recruit underrepresented populations into DC's public behavioral health workforce. As an example of such a recruitment strategy, California identified financial support through scholarships and loan forgiveness programs to encourage underrepresented students to pursue careers in shortage areas.[223]

Minimal Workforce Turnover

Behavioral health managers and leaders in DC should support behavioral health professionals such that they have high levels of job satisfaction and low levels of burnout. Previous research has identified insufficient compensation, lack of professional growth opportunities, burnout, and administrative burden as contributors to high behavioral health workforce turnover.[223, 218] Behavioral health workforce turnover is not only costly, but it also affects therapeutic relationships and, thereby, impacts patient outcomes.[224] Some important strategies to retain clinical professionals in underserved areas that were identified by the Oregon Health Policy Board include career ladders, career development, supervision, and merit pay.[223] *Table E.2* outlines some supervision standards for selected behavioral health professions.

To address inadequate compensation packages, DC must implement strategies to evaluate the compensation of all types of behavioral health professionals working in the public health system and work toward providing competitive compensation. That must include routine review and updating of Medicaid reimbursement rates for all providers and services. Additionally, DC's behavioral health workforce retention strategies should be comprehensively reviewed and updated regularly based on data collected from local behavioral health professionals.

Adequate & Appropriate Education for the Behavioral Health Workforce

To provide high-quality services to children, DC's behavioral health workforce should have a solid educational foundation and be well-trained on up-to-date evidence-based and evidence-informed practices related to their profession. Educational and training requirements for behavioral health professions should at minimum meet those of national professional boards. Periodic review of educational and training requirements should be informed by feedback from stakeholders (including youth and families) about gaps in workforce competencies. Adequate education and training of local behavioral health professionals require sufficient qualified educators, integrated/interprofessional training opportunities, learning institutions, and organizational prioritization.[225] Essential continuing education and training for all behavioral health professionals should include cultural competency, cultural humility, family-centered care, multigenerational care, and trauma-informed care. Families and youth who use behavioral health services should have the opportunity to provide input on the content of educational materials on those topics, and these materials should be tailored to DC's context. Continuing education and training for behavioral health professionals should be tied to recertification and should be supported through funding and by organizational leadership.

Educational programs for all professionals that provide behavioral health services for children (including primary care physicians, nurse practitioners, and obstetricians) should be encouraged to develop curricula that emphasizes preventative care, early intervention, the social determinants of health, cultural competency, cultural humility, family-centered care, multigenerational care, and trauma-informed care. Behavioral health workforce training best practices acknowledge the role of trauma on the patient, as well as the potential for services delivered to either reduce or exacerbate traumatic response. Curricula of educational programs for behavioral health professionals should also be kept updated with emerging evidence-based practices, quality improvement strategies, and integrated models of care.[226] With the shift toward integrated care, interdisciplinary education and supervision for professional training (consistent with the WHO Framework for Interprofessional Education and Collaborative Practice) from the variety of professionals who provide behavioral health services for a child should be implemented, because it can reduce fragmentation, enhance collaboration, and improve health outcomes for children.[223] As standardized measurements of treatment response are emerging for child behavioral health, education and training in measurement-based care can promote more targeted interventions and better outcomes.[227]

Data for Behavioral Health Workforce Planning

Representative data regularly collected from the wide cross-section of all types of local behavioral health professionals should inform policy and financing decisions. The sole use of observations and/or anecdotes represents weak evidence to guide decision-making, which can lead to the misuse of limited financial and human resources. Data should be routinely captured to assess the adequacy, accessibility, diversity, and competence of the behavioral

health workforce. Further, data should be used to develop and then evaluate behavioral health workforce recruitment and retention strategies. Such data collection requires a centralized, permanent data infrastructure that can not only collect data from stakeholders (including behavioral health providers, consumers, and health care managers) but also analyze and disseminate that data to inform workforce plans and policy decisions.

While the behavioral health workforce data prioritized for collection should be tailored to DC's context, the minimum data set (refer to *Table 6.B*) to inform workforce planning efforts for the broader behavioral health workforce published by the University of Michigan's Behavioral Health Workforce Research Center does provide a starting point.[228]

Table 6.B Suggested Minimum Data Set Elements to Inform Workforce Planning

Minimum Data Set Theme	Data Elements
Demographics	Name, age, race/ethnicity, sex and gender, sexual orientation, place of birth and residence, military/veteran status, language skills
Licensure and Certification	Type of job-related licenses held, type of job-related certificates held, national provider, identification number, state identification/registration number
Education and Training	Degrees obtained and years of completion, field of study/specialty, completion of other educational programs (e.g., internships), current enrollment in degree program
Occupation and Area of Practice	Primary occupation, area of practice
Practice Characteristics and Settings	Employment status, number of current employment positions, number of hours and weeks worked per year, employment arrangement, use of telehealth, employer practice setting, hours per week spent on activities (e.g., clinical supervision, diagnosis), clinical or patient care provision, employment plans

Adapted from: "Table1. Summary of Minimum Data Set Data Elements for Behavioral Health Workers;" Improving Data for Behavioral Health Workforce Planning: Development of a Minimum Data Set; American Journal of Preventive Medicine; 2018

6.2 Current System

Adequacy & Distribution of DC's Behavioral Health Workforce

While there are several estimates of workforce capacity in DC, it is difficult to assess DC's active and available workforce within the public behavioral health system for children. Recent research suggests that the behavioral health workforce for children is inadequate and that there is also high behavioral health staff turnover in the District.[202] A 2018 US Health Resources and Services Administration (HRSA) report identified insufficient supply of psychiatric nurse practitioners, psychiatric physician assistants, addiction counselors, school counselors, social workers, and marriage and family therapists to meet demands in DC in 2016.[229] Additionally, the shortage of psychiatric providers is further exacerbated by the shortage of licensed psychiatric providers who accept Medicaid insurance. A 2014 journal article indicated that nationally only about 43% of psychiatrists accept Medicaid.[230] A DBH grant application noted that, as of July 2019, there were 21 child/youth-serving MHRS provider organizations, three child and youth outpatient SUD certified provider organizations, one child and youth residential SUD certified provider organization, and one parent with children SUD certified provider organization.[94] That data represents organizations that could have more than one behavioral health professional, but it could be interpreted as the minimum number of professionals in those specialties serving those on public health insurance in DC. Additionally, as of June 2019, DBH had 158 certified peers in the behavioral health system.[94]

Figure 6.A HRSA Designated Mental Health Professional Shortage Area

Source: Health Resources and Services Administration

The limited available data suggests that the behavioral health workforce in DC is not only inadequate but also unevenly distributed. In DC, there are a total of 10 mental health care Health Professional Shortage Area (HPSA)[xvi] designations, which comprises of one geographic area (Anacostia, shown in *Figure 6A*) and nine facilities (Bread for the City, Community Of Hope, Elaine Ellis Center Of Health, Family and Medical Counseling Service, La Clinica Del Pueblo, Mary's Center For Maternal And Child Care, Unity Health Care, Whitman-Walker Clinic, and Metro Health). As of September 2020, HRSA noted that 28 additional mental health providers are needed to achieve a population-to-provider ratio below the designated threshold in Anacostia. The uneven distribution of mental health workers was also suggested by a 2016 DC Health report that stated that the majority (>50%) of full-time equivalents for psychiatrists were located in Ward 2 and 3.[231] In an effort to address this uneven distribution, DC has established a Health Professional Loan Repayment Program (HPLRP) to repay the loans of eligible health professionals (including licensed and credentialed mental health providers) practicing full-time at HPLRP-certified sites and HPSAs in DC.[232]

Behavioral Health Workforce Training & Licensing

While DBH provides licensing for behavioral health organizations, DC Health through its Health Regulation & Licensing Administration (HRLA) is mainly responsible for the licensing, registration, or certification of behavioral health professionals. Licenses for behavioral health professions are provided by the respective health profession boards (whose members are typically appointed by the Mayor), including the Board of Medicine, Board of Occupational Therapy, Board of Psychology, Board of Social Work, Board of Professional Counselling, Board of Nursing, and Board of Marriage and Family Therapy. With respect to behavioral health professions, according to DC code §3–1205.01, a license is required to practice advanced practice addiction counseling, marriage and family therapy, massage therapy, medicine, naturopathic medicine, occupational therapy, professional counseling, psychology, social work, or speech-language pathology or to practice as an occupational therapy assistant or professional art therapist in the District. Registration is required to practice as a psychology associate, speech-language pathology assistant, or speech-language pathology clinical fellow, while certification is required to practice as an addiction counselor I and addiction counselor II. For some of those professions, the number of active licenses in FY2019 are outlined in Appendix E. The term of licensure and continuing education requirements varies across behavioral health professions. For all health professions, there is a continuing education requirement for two credits in LGBTQ cultural competency. Relatedly, MCOs must ensure that all providers comply with policies and procedures that promote cultural competency as outlined in the DC Language Access Act of 2004.[98,xvii]

DBH administers a Peer Specialist Certification Training Program to certify peer specialists for jobs within the community behavioral health provider network. One of the tracks within the Peer Specialist Certification Training Program is a Youth Peer Specialist Certification offered to current DC residents between ages 18–25 with at least a

[xvi] *One federal measure of mental health workforce shortages is the Health Professional Shortage Area (HPSA) designation, which can be applied to geographic areas, populations, or facilities that have a shortage of mental health care providers. It should be noted that those designations are not specific to providers for children. Further, the HPSA designations may be based on the population-to-psychiatrist ratio, the population-to-core-mental-health-provider (psychiatrists, clinical psychologists, clinical social workers, psychiatric nurse specialists, and marriage and family therapists) ratio, or both.*

[xvii] *According to the Government of the District of Columbia Office of Human Rights, the DC Language Access Act of 2004 requires the District to provide equal access to public services, programs, and activities for DC residents who cannot or have limited capacity to understand or communicate in English.*

high school diploma or GED and who have received services within the "child serving system in the Department of Behavioral Health."[233] To become a certified peer specialist, an individual must complete a classroom training and an 80-hour field practicum and then pass a certification examination. In addition to peer specialists, DBH provides training (that includes best practices for assessment of suicide risk) to the behavioral health professionals operating the Access Helpline.

Behavioral Health Workforce Credentialing

Behavioral health providers need to be enrolled and credentialed with each MCO to provide services to the DC managed care population.[234] According to the DC Medicaid Managed Care Quality Strategy, all MCOs must have written policies and procedures for the credentialing and recredentialing of all network providers, which should, at a minimum, comply with federal, state and NCQA standards.[98] While limited data regarding the average duration of the provider credentialing process are available, one District MCO estimated that the process takes approximately 45 to 60 days in 2020.[235] However, providers may be required to undergo credentialing with both an MCO and its subcontracted managed behavioral health organization if the MCO has chosen to partner with a third party to manage behavioral health coverage.[234] There are no limitations on the number of providers an MCO may contract with for services.

Behavioral Health Network Adequacy for Managed Care Organizations

According to DC's Medicaid Managed Care Quality Strategy, MCOs are required to submit to DHCF a list of all network providers and all provider contracts.[98] An external quality review organization annually performs network adequacy validation (based on time and distance standards for providers, as well as timely access measures). The most recently reported network adequacy validation was published in the *District of Columbia Managed Care Program 2020 Annual Technical Report* and did not provide specific data on behavioral health network adequacy.[112]

6.3 Gap Analysis

A comparison of DC's current workforce for the public behavioral health system for children to our vision highlights several key gaps that are discussed below.

1. Inadequate behavioral health workforce available to children on public health insurance

It is difficult to assess DC's active and available workforce within the public behavioral health system for children due to a lack of published data. However, recent research, including our family engagement efforts, have implied that there is a dearth of behavioral health providers for children across settings. Many youths in our family engagement forums felt that there were insufficient behavioral health services available for children in the District. Further, several parents/caregivers noted that when they were able to identify an appropriate provider, they frequently had long wait times to get appointments. The inability of families on public health insurance to access behavioral health providers without long wait times suggests that there are not enough providers to meet the behavioral health needs of children.

Further, as previously discussed in Gap 5 in Chapter 4, the *DC Managed Care Program 2020 Annual Technical Report* highlights that overall network adequacy standards as defined by MCO contracts are not currently being met.[112] Relatedly, there is no enforcement of network adequacy standards, and no clear monetary penalties exist in contracts for network inadequacy. Additionally, monitoring and review of network adequacy demonstrates clear gaps, amplified by inaccurate in-network provider directories. With the planned carve-in of behavioral health services into managed care programs, those challenges could negatively impact the availability and accessibility of behavioral health services by children.

2. An insufficient labor pool of diverse behavioral health professionals for children

While no data on demographics of the current behavioral health workforce in DC could be found, it is known nationally that there is a lack of diversity among the behavioral health professionals.[226] This national phenomenon aligns with District-level findings from our family engagement efforts, where children expressed that sociocultural differentials prevented providers from being able to understand them; therefore, children felt uncomfortable sharing. They noted that that hinders the building of trust between the provider and the child, which is needed in the therapeutic relationship. One youth stated, "They serve mostly minority youth, but I feel like I see their leaders, I see, like most of the therapists, they're white. And like how could a white person really, I'm not saying it's impossible, but how did they really be culturally competent to serve these people if they don't know what's our lived experience?"

3. Lack of cultural competency among behavioral health workforce

Based on a 2016 community needs assessment conducted by the District of Columbia Healthy Communities Collaborative, members of the DC community indicate that cultural competency is a priority need.[236] Further, a 2018 study revealed a troublesome lack of culturally competent perinatal mental health care access in the District, particularly in Wards 7 and 8.[237]

4. An unevenly distributed behavioral health workforce

The uneven geographic distribution of existing mental health providers further reduces access to critical mental health services to patients in HPSA, particularly in Wards 7 and 8, which are overwhelmingly members of Black and Latinx communities. This geographically uneven distribution increases racial inequities, resulting in even less access for populations in the shortage designation areas. As mentioned in the Current System section above, *Figure* 6A highlights mental health professional shortage areas in the District, mainly located east of the river, which have a larger population of Black and Brown residents. Additional maps, located in the appendix, also highlight the lack of inpatient workforce for children under 18 years of age in Wards 7 and 8. The uneven distribution of the behavioral health workforce is also compounded by the limited transportation options available in Wards 7 and 8 for families to travel to access these services. From our family engagement efforts, several parents/caregivers felt that some of the behavioral health services that they need for their children are not conveniently located. One parent/caregiver shared, "I have problems with getting quality services, unless I transport me and the kids way out of our community."

Complicating that situation, not all licensed mental health providers are qualified or specialize in the unique needs and treatment of children, and provider data may include providers who are no longer practicing or not taking new clients. It should also be noted that those provider shortages and geographic disparities predated the COVID-19 pandemic, and mental health needs have increased during the pandemic.

5. High turnover among behavioral health professionals

There seem to be inadequate and/or ineffective retention strategies for behavioral health providers who serve children on public health insurance in the District. Through our family engagement efforts, parents/caregivers often identified the frequent turnover of providers as a factor negatively impacting services received by children, with one parent sharing, "It seemed like everybody [behavioral health professionals] that I get that's good, they either retire or they get burned out." Previous research has identified supervisory support and emotional exhaustion (a component of burnout) as some of the predictors of behavioral health workforce turnover.[238] High turnover among behavioral health professionals has been associated with increased organizational costs related to hiring and training, as well as decreased service accessibility.[239]

6. Inadequate data for behavioral health workforce assessment and planning

While some behavioral health workforce data is currently collected at the time of license renewal application, it is not published publicly, and it is insufficient to measure the adequacy of the behavioral health workforce for children in DC. Without routine collection of comprehensive workforce data, opportunities to make informed decisions regarding workforce development are limited.

7. Challenges with behavioral health workforce credentialing

Each MCO is responsible for credentialing and recredentialing of its network providers, so providers must undergo separate credentialing processes for each MCO network that they wish to join. Further, providers may be required to undergo credentialing with both an MCO and its subcontracted MBHO if the MCO has chosen to partner with a third party to manage behavioral health coverage. These credentialing arrangements place greater administrative burden on providers and can prove a barrier to entering payer networks, potentially leading to narrower networks. Additionally, MCO contracts require credentialing to be completed within 180 days upon the MCO's receipt of all required documents,[237,xviii] which is an unreasonably long timeframe for providers.

8. Insufficient workforce trained in providing trauma-informed care

With approximately 47% of DC children having experienced a traumatic event,[241] there remains an unmet need for trauma-informed behavioral health care. That is exemplified in school settings, with a number of community leaders acknowledging the lack of trauma-informed practice in DC schools.[242] Additionally, a needs assessment conducted from 2019–2020 by the DC Health Title V team found that, in spite of the mental health expansion led by DBH and work conducted by the Wendt Center for Loss and Healing, there remain gaps in grief and trauma-informed pediatric health care.[243] Similarly, participants in a 2016 community needs assessment indicated that DC's behavioral health care system could be improved by adding services that address trauma and grief.[108]

9. Lack of infrastructure to support the growth and retention of non-traditional workforce

Financial Infrastructure

- Despite authorization of Medicaid reimbursement, challenges still exist for the peer support workforce. Low salaries/low reimbursement rates and difficulty integrating peers into care teams contribute to high turnover rates.
- Peer specialist payment mechanisms embedded within DC Medicaid are restrictive on what services peers are authorized to deliver and, thereby, prevent adequate accessibility. There are limitations on where peers can work in the District and challenges with sustainability for organizations that do not meet those setting qualifications and currently hire peers as a part of their workforce. According to DC Code,[244, 245, 246] certified peer specialists are authorized to provide Medicaid-reimbursable behavioral health rehabilitation services to consumers when working under the supervision of a qualified practitioner. Services provided by certified peer specialists are reimbursable through Medicaid in limited settings or funded through grant and the organization's operational dollars. Services are reimbursed through Medicaid only if they are provided in a community-based MHRS provider or other community-based setting or a residential facility of 16 beds or fewer.
- Natural supports (which are previously referenced in Section 5.2) are key components of DC's behavioral health system. However, the District lacks mechanisms to compensate natural supports for their role in care coordination, especially in times of crises, as well as their role as caregivers for children with severe behavioral health issues. Friedman (2020) notes, "there is danger in utilizing natural supports in lieu of formal services solely for cost-cutting."[247] At the same time, reimbursement of supplemental services utilizing natural supports could improve beneficiary experience, quality, and equity in the system.

[xviii] *See C.5.29.24.13 on page 129 of Contract CW83146 (Managed Care Organization (MCO) - Trusted Health Plan (District of Columbia, Inc., DBA CareFirst BlueCross BlueShield Community Health Plan) for the credentialing requirement on the number of days.*

Operational Infrastructure

- There are also barriers in supporting peer specialists, CHWs, and other paraprofessionals in team-based clinical care settings. Barriers include a lack of clearly defined roles/scopes of practice for paraprofessionals on the team and a lack of understanding from clinical team members on what peer specialists do and the value they bring with their lived and cultural experiences.
- There is also a need for continued and specialized training for peers and other paraprofessionals in the behavioral health workforce, as well as training for clinical team members on the role of paraprofessionals on their team. A lack of trust, shared language, and communication between paraprofessionals and clinicians on a team can impact the quality of care delivered and limit the growth of this workforce in integrated care settings.
- Relatedly, one local family-run organization has noted that supervision approaches for peer specialists may not always be appropriate for the education level and/or technical qualifications of the peer specialists. That may be due to regulatory burdens associated with reimbursement of peer services through the wrong mechanisms.

10. Challenges with engaging youth and families in peer specialists training

Overall, there is a lack of awareness regarding the availability of the certification programs offered by DBH. Many families and youth with lived experience who may be interested in doing this work are not aware of those opportunities unless connected to it through family-run organizations, which will require greater thought on how these training sessions are made more accessible to the public. Accessibility is also an issue for many families who go through the certification process. The training and exam can feel unattainable to many due to the process being too difficult, including literacy challenges while taking the exam or barriers with cost if they fail and have to pay to take the exam a second time.

There is value in having youth with lived experience to help other youth connect with services and navigate the recovery process. However, there are not enough youth peer specialists. Although DBH offers a youth peer specialist certification track, it has been difficult finding youth to participate for a variety of reasons. In conversation with a local family-run organization, the biggest obstacle for youth participating in peer training is building trust and using the right language to create a youth friendly atmosphere, free of stigma, in which youth feel supported and have the guidance to go through the peer certification process and become a part of the behavioral health workforce. There needs to be an acknowledgement that families and youth who participate in these training programs often experience trauma and have varying levels of experience in the workforce and therefore require a certain level of sensitivity and understanding from the trainer and supervisors.

11. Professional licensing processes limit the behavioral health labor pool

The District's health professional licensing process is inefficient and limits entry to the behavioral health workforce. Not all licensing boards provide opportunities for people to work while waiting to complete licensure requirements, such as passing national exams after graduating from degree or training programs. Endorsement processes, or other similar pathways for people who hold licenses elsewhere to gain licensure in the District, also lack meaningful opportunities for people to work while waiting for licensing board responses after application. Since licensing for both new health professionals and those licensed in other jurisdictions does not include the ability to work while waiting for a license to be issued (or denied), otherwise-qualified health professionals are removed from the pool of the District's behavioral health workforce.

At times, because of those restrictions, people who previously held roles in direct service, including interns in degree programs or those who held paraprofessional roles who become eligible for professional licensing, are forced to discontinue care for people with whom they have an ongoing relationship as part of a behavioral health team. For example, presently, a social worker cannot practice within the scope of any related work before they

attain licensing. Thus, students who maintain work in certain paraprofessional or supportive behavioral health positions and are near the end of their social work degree and board preparation are caught in an untenable position of being fined if they continue to work in related fields, such as peer specialists and CHWs.

The lack of a District license, despite being otherwise qualified and perhaps already having a license application pending, can also lead to organizations choosing not to hire people who otherwise would be the best candidate for a given role. Conversely, people not licensed in the District may choose not to complete licensure, even if qualified, because of their more urgent need for employment and income. The disruptions of transitions from paraprofessional or intern to professionally licensed roles, as well as the disruptions when seeking to hire people who are licensed in another jurisdiction, shrink the District's already thin behavioral health workforce.

6.4 Recommendations

In addition to the recommendations below, we also advise readers to consider the DC Health Matters Collaborative's recently published paper titled Improvements to Behavioral Health Integration and Service Provision in DC – Listening to our Behavioral Health Workforce and Youth, which outlines several recommendations to address behavioral health workforce challenges.

1. Implement strategies and incentives to create an adequate labor pool of diverse behavioral health professionals for children.

Implementing Bodies: DHCF, DBH, DC Council, MCOs, OSSE,
Higher Education Institutes, Provider Organizations
Timeline to Implementation: Short to Long Term

Our family engagement efforts revealed that many minority youth preferred behavioral health providers whom they can "relate to," and some expressed that there should be more providers of color to meet this need. That concurs with research findings that many people of color receiving behavioral health care preferred minority providers and treatment in their native language, even though matching clients to clinicians of the same ethnicity was not essential to treatment effectiveness.[224] Further, it is important to note that providers who have similar backgrounds to youth receiving care are more likely to form a strong therapeutic bond with clients and achieve better recovery outcomes as a result.[248]

Some strategies to consider for building an adequate pool of behavioral health professionals are:

- Develop training and summer programs that target minority transitional-age youth,[249] while promoting and providing incentives for work in the behavioral health field.[250] Career ladders should be highlighted in such efforts.[250]
- Develop formal recruitment strategies that extend to culturally and ethnically diverse organizations to foster diversification of the provider workforce.[251]
- Recruit community members, paraprofessionals, and peer mentors to increase the number of staff trained to deliver direct care to clients.[251] Use scholarships and loan repayments for underrepresented students to recruit and retain a diverse workforce.[223]
- Consider offering certification and licensing test preparation at free or reduced cost to District natives, particularly those who represent minority communities. Use pathway or pipeline programs, in which potential candidates for professional training are identified throughout the grade school and college years and introduced to the field at an early age, such as Arkansas's Health Care Student Summer Enrichment Program for Underrepresented Student Populations.[252]
- Area Health Education Centers (AHECs) located in the District should be leveraged to introduce diverse student populations to health care professions.[252] For example, consider building a program similar to the Summer Leadership Institute implemented by Hawaii within its Molokai AHEC, which provides health career presentations, relevant training, and cultural content in return for college credit.[252]
- DHCF may also consider incentivizing recruitment and retention of minority behavioral health professionals by enhancing reimbursement rates proportional to the extent that providers recruit and retain staff who effectively meet the diversity, inclusion, and equity needs of their clients.[210]

2. Incorporate best practices to improve the cultural competence among providers.

Implementing Bodies: DHCF, DBH, DC Health, CSAs, MCOs
Timeline to Implementation: Medium to Long Term

In addition to diversifying and distributing a high-quality children's behavioral health workforce optimally across the District according to need, cultural competency must be reflected in all provider interactions with patients. Respecting the lived experiences and responding to diverse needs of patients allows for building trust, which leads to effective treatment. When trust is absent, treatment is not productive or even abandoned, and patients risk further declining mental and physical health. But when trust is built between patient and provider(s), treatment effectiveness increases, which in turn can also improve provider satisfaction and can reduce burnout and turnover.

Ideally, a workforce will share at least some degree of the diversity of the population it is serving. Regardless of the degree to which this is achieved, all behavioral health providers at all levels and all backgrounds need continuing education on best practices, new research, and meeting the changing needs of the diverse population. Cultural competency, together with cultural humility, is achieved through a combination of training and clinical application with acknowledgement for the need to remain open to ongoing reflection.

- **Require continuing education and training on culturally responsive care, implicit bias, and understanding and dismantling societal and structural racism across the entire spectrum of behavioral health providers,** from psychiatrists and psychologists to peer support and CHWs. For instance, training on the Cultural Formulation Interview offers an evidence-based tool composed of a series of questions that assist clinicians in making person-centered cultural assessments to inform diagnosis and treatment planning.[253]

- **Include cultural competence planning and training as distinct quality of care measures for MCO evaluation purposes**, including tracking and enforcement by DHCF and other relevant agencies. That would include continuing education and training completion on cultural competency by large portions of the behavioral health workforce credentialed by MCOs, if not all, along with measures for applying cultural sensitivities in the communities served. Accessibility to services in multiple languages must also be measured and assured for the diverse population. Consider use of the CLAS framework[254] or similar standards.

- **Credential nontraditional health care providers, including peer support specialists and navigators, and reimburse them for culturally sensitive treatment and modalities.** This policy must also support culturally specific services, including services provided by CBOs that support individual and community well-being. People should have access to a variety of reimbursable and approachable avenues for their health care.[120]

3. Conduct research to understand and monitor behavioral health workforce turnover in the District.

Implementing Bodies: DHCF and DBH
Timeline to Implementation: Short Term

DBH and DHCF should conduct research to understand the organizational-level and individual-level factors contributing to DC's high turnover of behavioral health providers who serve children on public health insurance. Such research should include the collection of data that can be used to estimate the local turnover/retention rate of behavioral health professionals. Relatedly, it will be important for government agencies to establish a process to regularly monitor behavioral health workforce turnover/retention rates.

4. Implement strategies to minimize workforce turnover.

Implementing Bodies: DHCF, DBH, MCOs
Timeline to Implementation: Long Term

Behavioral health workforce retention strategies should be developed based on local research (refer to recommendation above). Further, evidence-informed strategies should be comprehensively reviewed and updated regularly based on data collected from local BH professionals. The following are some strategies to consider:

- **Ease administrative burden**—Minimize and simplify the extensive, perhaps excessive, documentation required from behavioral health professionals who provide services to those with public health insurance. That may be accomplished through reviewing administrative requirements issued by DC Medicaid and eliminating duplicative processes[255] or mandating and/or incentivizing plans to reduce prior authorization requirements for providers who meet specific performance and compliance targets.

- **Implement provider incentives**—Ensure that there are career ladders, supervision, career development, team-based work, continuing education, community amenities, experience-based step pay increases, and merit pay.[223] Research has indicated that immediate, meaningful cash incentives have a greater effect on retention in comparison to longer-term benefits such as retirement contributions.[223] However, nonfinancial incentives, such as employee awards,[257] are also recommended in reducing burnout and turnover.[258]

- **Offer sufficient compensation and fair scheduling**—Conditions for behavioral health professions in the public system should be examined to ensure there are living wages and fair scheduling practices, paid sick time, as well as paid family and medical leave. Additionally, it is critical that value-based payment arrangements accurately calculate costs and sufficiently reimburse nonclinical care positions, including care coordinators, discharge planners, and CHWs. Use of independent contractors should be evaluated to determine whether there are recruitment, retention, or quality differences compared with regular employees, and rates should be structured to allow the best mix of independent contractors, employees, or both on a service-level basis.

- **Improve training for behavioral health workers**—To enhance incentives for retention, consider supporting advanced training for bachelor's-level behavioral health workers and fellowship opportunities for graduate-level staff.[259] Further, given high levels of burnout experienced by behavioral health providers, behavioral health organizations should offer resilience training that may help

reduce burnout symptoms.[257] One such example in DC is the Compassion, Practice, Relationships and Restoration (CPR²) program developed by the Early Childhood Innovation Network and Children's National.[xix] It is important to note that while those training opportunities are important, they cannot replace structural and operational changes that will directly help to reduce burnout. The DC government should provide support to behavioral health organizations that are making structural changes to support workforce retention.

- **Create nonsupervisory expert tracks so people can stay in care delivery and receive adequate compensation for it**—Establishing a tiered payment mechanism that reimburses according to experience and education may further incentivize workforce retention.

- **Improve supervision for behavioral health workers**—Ensure behavioral health workforce is supported through adequate supervision. *Table E.2* highlights a number of maximum staff-to-supervisor ratios and supervision time requirements recommended for specific behavioral health professions. It also remains critical that organizations establish their own supervisor-to-staff ratios and supervision times that work for their context. Additionally, research has noted that supervisors' feedback should be based on live observation of actual practice and client feedback/outcomes in community mental health services,[260] and supervision of therapists should incorporate evidence-based practices, such as modeling and role-play.[261] Supervisors whose teams include peer specialists should receive special training and support to know how to help peers be successful in the behavioral health workforce.

5. Provide adequate support to child-serving behavioral health providers through Medicaid reform.

Implementing Bodies: DHCF and DBH
Timeline to Implementation: Short Term

DHCF needs to identify child-serving behavioral health providers with limited or no experience in the managed care market and provide them with technical assistance and onboarding support during the shift to a fully managed care Medicaid program. Below are examples of support strategies from other states that DHCF and DBH may consider to support reform implementation efforts:

- Virginia's multiphased training strategy in which experts trained and provided feedback to behavioral health providers and administrators in new curricula associated with reform efforts, who then trained providers in each of the state's major regions.[262] Trained providers were positioned as "regional champions" and offered guidance and support to providers in their region who were unfamiliar with the new curricula.[262]

- Texas's behavioral health carve-in preparation strategy in which the state required MCOs to pass a readiness review to demonstrate capacity for providing relevant services.[55]

- New York's strategy in which the Office of Addiction Services and Supports and Office of Mental Health contracted the Managed Care Technical Assistance Center of New York (MCTAC) and Community Technical Assistance Center of New York (CTAC) to provide ongoing training and technical

[xix] *CPR² provides tools and strategies to help improve participants' capacity to manage stress, burnout and to promote self-care. The program utilizes a pre- and post-test design and begins by assessing participants' stressors and goals. CPR² consists of biweekly, small-group, evidence-based activities designed to enhance skills-building, resilience, and social cohesion. Sessions include mindfulness practices, mood ratings, psychoeducational modules, and reflective journaling. See Newsletter December 2019; Early Childhood Innovation Network; 2019.*

assistance to providers.[263] The co-director of CTAC/MCTAC summarized the organization's role as "a bridge between system transformation and clinical or practice transformation."[263]

6. Implement strategies and incentives to improve distribution of children's behavioral health providers.

Implementing Bodies: DHCF, DBH, DC Council, DC Health
Timeline to Implementation: Long Term

Distributing the full range of child behavioral health providers across the entire District will maximize resources. Psychiatrists and psychologists can be reserved for patients with more intense behavioral health needs, at a costlier reimbursement rate, if an adequate supply of social workers, peer support workers, and other behavioral health providers are available for patients with less intense need. But a deficit of providers in any provider category can affect the optimal service delivery of all. Recommended strategies to improve the distribution of children's behavioral health providers include:

- **Increase funding and promote the District's Health Professional Loan Repayment Program** to expand the reach of children's behavioral health providers in underserved areas. Increased loan repayment can support the recruitment and retention of primary and specialty behavioral health providers as well as nonclinical staff in HPSAs and medically underserved areas, such as Anacostia. Emerging evidence demonstrates that scholarship and loan repayment programs are effective in achieving long-term retention of participants in the communities in which they serve.
- **Recognize and pay behavioral health organizations as teaching clinics.** Treat behavioral health provider organizations that hire recent graduates and provide clinical supervision similarly to reimbursement provided to hospitals and FQHCs for their roles in educating the health care workforce. See community-based training as human capital investment, even when there is turnover as people achieve higher levels of independent practice and licensure.

7. Enable integration of peer specialists, community health workers, and other nontraditional behavioral health professionals across settings.

Implementing Bodies: DHCF, DBH, CSAs, MCOs
Timeline to Implementation: Short to Medium Term

The District has provided strong leadership regarding integration of peer (adult and youth) specialists into MHRS settings through training, certification, and Medicaid reimbursement. Now is the time to advance the next-generation behavioral health workforce by robustly incorporating nonlicensed workforce extenders, including paraprofessionals, peers, navigators, and CHWs into primary care, specialty behavioral health care, early learning, and other community-based settings. Peer-operated centers, family-run organizations, and other natural and informal supports must be recognized for the vital contributions they already make to the lives of District residents with behavioral health conditions and turned to as the necessary complement that they already are to the behavioral health workforce continuum. This type of integration requires adequate reimbursement, compensation, and training/education for this workforce. Integration bolsters accessibility through a team-based approach that includes the individuals whom many community members contact first and trust the most.

More specific examples of integration strategies are:

- Provide ongoing training and refreshers to clinicians and supervisors on the role of paraprofessionals (peers, CHWs, etc.) on the team to help bridge the gap between clinicians and nonclinicians. Provide cross-trainings with both clinicians and paraprofessionals. It is important to build trust and relationships between team members and address stigma regarding staff with lived experience. Such training should promote the sharing of client information between peer and nonpeer staff, as well as cooperative service planning.[264]

- Work with peer specialists to develop clearly defined roles and scope of work on the team that allows them to incorporate their lived and cultural experiences, such as peer specialists providing training to nonpeer team members on issues of recovery, trauma-informed care, advocacy, wellness promotion, etc.[265]

- Ensure strong training opportunities are available for individuals interested in becoming peer specialists, as well as ongoing professional development and training opportunities for current peer specialists. While the role of a peer specialist will differ across settings and teams, a District-wide set of minimum-identified competencies may be beneficial for peer specialists. It is important for such competencies to balance the preservation of peers' unique strengths and technical proficiency.[266]

- Introduce billable mechanisms and funding that is integrated into department budgets to promote the availability and use of natural supports for children who are experiencing acute or chronic behavioral health issues, as well as behavioral health crises.

- Allow sufficient Medicaid billing for the wide range of peer support services. As the government continues to explore avenues for compensating peer specialists, we emphasize the need for Medicaid reimbursable mechanisms.

8. Support engagement and recruitment of youth peer behavioral health specialists.

Implementing Bodies: DHCF, DBH,
Timeline to Implementation: Short Term

A peer specialist specifically for youth may help be a bridge between children and behavioral health providers (such as therapists, psychiatrists, etc.) as well as a bridge between children and parents/caregivers. In that manner, youth peer specialists can build children's trust toward the behavioral health system and their own support network, which may ultimately increase retention in care and improve outcomes. Youth peer specialists are different from adult peer specialists in that they have lived experiences in the child behavioral health system and often in the adult system, which helps them to better support children and youth.[267] Youth peer specialists may be particularly helpful for special populations such as transition-age youth and children who identify as LGBTQAI+.
While DBH does offer a youth peer specialist certification, there are not enough youth becoming certified. Recommendations to increase engagement and recruitment of youth peer behavioral health specialists include:

- Increase awareness and promote DBH youth peer certification opportunities on platforms and in settings that youth mostly frequent, such as social media and in schools.

- Ensure that the peer certification process and exam is accessible and easy for residents. This includes taking into consideration literacy, having someone to guide youth through the process, offering multiple pathways to becoming certified, and opportunities to retake the exam without additional costs.

- Maintain virtual training to improve accessibility. However, in-person trainings should also be offered to accommodate those without reliable access to the internet and technology.

According to Youth MOVE National,[268] —a youth and young adult-led advocacy organization focused on elevating youth and young adult voices, developing national peer standards, and providing technical assistance to states who want to provide peer support— states need to consider the workforce environment and implement youth engagement strategies.[267]

- It is important to develop a continuum of youth engagement activities for youth and young adults with lived experience to create a base of youth and transition-age youth who are prepared to join the youth peer workforce.[267] Youth engagement opportunities can include advisory groups, advocacy groups, informal youth peer support groups, youth summer internships and mentoring programs, and other opportunities to incorporate the youth voice in communities. That also helps to develop youth leadership and advocacy skills.

- Provider organizations and agencies must consider workplace culture through implementing policies and practices that support and welcome youth peer specialists.[267] That includes building trust; placing value on youth-driven care, lived experience, and youth voice; and understanding that for many youth peers, this is their first entry into the workforce and many are still in active recovery. Examples include providing ongoing education opportunities, internal supervision, mentorship, and help for youth peers to develop self-care plans and receive counseling to support retention.

9. Incorporate best practices to improve the trauma-informed care and trauma responsive interventions among providers.

Implementing Bodies: DHCF, DBH, CFSA, CSAs, MCOs
Timeline to Implementation: Long Term

DBH should take the lead in convening a District-wide trauma-informed task force, composed of all the relevant health agencies, along with Justice, Police, Education, Housing, Human Services, and other public serving components of the administration. Community organizations that touch the District population directly or indirectly should also be full members of this collaborative work. The Johnson City Model of Trauma Informed Care offers a successful example of community-wide partnership and evidence-based trauma-informed care at a system level.[269] That includes the training of health professionals at all levels, other community-facing public servants, and even private businesses so that they may better understand the trauma in the lives of their workforce and create more resilient workplaces.
Consequently, all partners in a District-wide trauma-informed task force must then make training and best-practice solutions available to their workforce to apply in their practices. Trauma-informed care is most effective when it is applied across the entire spectrum of population services.[270]

10. Create and maintain a database to inform behavioral health workforce planning.

Implementing Bodies: DBH, DC Health, DHCF
Timeline to Implementation: Short Term

Data collection on the behavioral health workforce in the District should be regular and complete, capturing at least the minimum data set identified by the University of Michigan Behavioral Health Workforce Research Center, summarized in *Table 6.B.*[228] DBH and DC Health should collaboratively establish a data collection approach that could include an annual behavioral health workforce needs assessment along with ongoing data collection during the licensure process. Assessing the current workforce makeup is necessary to assess the gap between current and target workforce levels. Only then can the District make appropriate resource allocations for recruitment, retention, and appropriate distribution of behavioral health providers across the District.

11. Mandate uniform credentialing requirements and a quicker credentialing turnaround time for all MCOs.

Implementing Bodies: DHCF
Timeline to Implementation: Short Term

To make it easier for child-serving providers to join MCO networks, DHCF should require uniform credentialing requirements for all MCOs. As part of that requirement, all MCOs should be required to accept DBH certification as meeting MCO standards and credential DBH-certified behavioral health provider organizations and FQHCs at the organizational level (rather than at the individual staff level). There needs to be a consistent process for determining which organizations are paneled and credentialed through group practice standards and facility standards. Whether or not MCOs are required to credential at the organization or individual level, DHCF should require electronic exchange of provider organization staff records using standardized processes, forms, and formats to be adopted by all MCOs. We support use of Council for Affordable Quality Healthcare as a centralized platform for paneling or credentialing by all MCOs contracted with DHCF.

In addition to standardizing the credentialing requirements and process, we also recommend amending MCO contracts such that credentialing must be completed within 45 to 60 days upon the MCO's receipt of all required documents.

Taking those steps will reduce barriers to joining the MCO networks and support the building of an adequate network of child-serving providers.

12. Allow supervised practice for people seeking initial licensure waiting to complete national exams or waiting for application approval or denial, and allow provisional practice for people licensed in other jurisdictions while waiting for district license application approval or denial.

Implementing Bodies: DC Health Professional Licensing Boards
Timeline to Implementation: Short Term

The District's health professional licensing boards should, by default, allow people seeking initial licensure 120 days from the date of submitting a complete application to work under supervised practice while waiting to complete and pass any required national exam. In the event that a candidate for licensure fails a national exam on their first attempt, boards should, by default, allow at least 90 additional days of supervised practice authorization to make a second attempt and successfully pass the exam.

Implementing supervision for yet-unlicensed recent social work graduates benefits the students, patients, and behavioral health agencies. Recent graduates receive valuable on-the-job mentoring, supervision, and ongoing training. Additionally, allowing new graduates to practice and learn while studying for and saving for their exam can have an equitable impact across the profession. Simultaneously, graduates bring new research and fresh experience to agencies attained in their own education. Patients and the community benefit from the expanded workforce, which increases access to critical behavioral health services and the ability to expand additional programming. That is particularly important because increasing rates of behavioral health diagnoses and lingering effects of traumas including COVID-19 and systemic racism all lend to increased need in the District in the coming months and years. Additionally, the District's health professional licensing boards should, by default, allow people who hold a license in another jurisdiction a provisional right to practice for 120 days while waiting for District license application approval or denial. In the event an applicant is found to have some deficiency meeting District licensing standards, the applicant should be allowed to continue provisional practice for a time period the board believes is reasonable to ameliorate the deficiency, so long as the applicant otherwise remains in good standing with the relevant District board and remains in good standing with the other jurisdiction where the applicant is licensed.

The District's health professionals deliver care within a regional market encompassing the District, Maryland, and Virginia, and the District attracts residents from across the country. With significant expansion of telehealth within behavioral health since the onset of COVID-19 and related national competition to attract people to the District's behavioral health workforce, it is even more important that applicants who hold licenses elsewhere, after applying for District licensure, can begin to practice as soon as possible once hired while giving the licensing board time to complete any application review that it requires.

For the District's behavioral health services reimbursed by Medicaid, the importance of expediting entry to professional practice for those needing professional licenses for the first time or from other jurisdictions cannot be understated. Permission for supervised or provisional licensure is a necessary first step, short of receipt of an issued license, to begin paneling, credentialing, and other activities that link professional care to Medicaid billing and reimbursement for treating District Medicaid beneficiaries.

7. INFORMATION & COMMUNICATION

According to the WHO (2010), "sound and reliable information is the foundation of decision-making across all health system building blocks. It is essential for health system policy development and implementation, governance and regulation, health research, human resources development, health education and training, service delivery and financing."

The information and communication system for a behavioral health system is complex because it requires the collection, transference, and dissemination of different types of information, occurring at different levels, to meet a wide variety of objectives, including individual patient treatment, resource management at health facilities, public health surveillance, health communication, and policy guidance.

Given the growing role that technology plays in information collection/transference/dissemination, there is substantial overlap between Chapter 7 and Chapter 8. This chapter focuses on a broad understanding of information flow and related policies within the behavioral health system for children in DC, while Chapter 8 focuses on the technology used for communication and information-sharing.

7.1 Vision for the System

A **strong behavioral health information system** (BHIS) should connect all relevant partners to ensure that health information users (including health care providers, patients, policymakers, community members, researchers, etc.) have appropriate and timely access to valid, reliable, permissible, understandable, and comparative data.[2] A Health Information Exchange (HIE), which will be discussed in Chapter 8, typically refers to a type of technology that supports the exchange of information and can be seen as critical to a BHIS. A BHIS should support all other building blocks of the behavioral health system for children in DC, because it should have the capacity to collect, store, analyze, and disseminate different types of information (refer to *Table* 7.A) that can be used in:

- Behavioral health service delivery;
- Behavioral health care coordination;
- Behavioral health system policy development and implementation;
- Governance and regulation;
- Behavioral health research;
- Behavioral health human resources development;
- Financing for the behavioral health system; and
- Behavioral health education and training

Policymakers should prioritize implementing a strong information system because it has the potential to reduce health care costs and improve behavioral health outcomes for children.[271] Additionally, a behavioral health information system is a key component for monitoring and promoting **equity**, because it should capture and disseminate critical data, such as service coverage, service use, and health outcomes stratified by sex, race, ethnicity, socioeconomic status, and geographical location.

Table 7.A. Types of Information from Different Levels that Should Be Captured by a Health Information System (HIS)

Health planners and decision-makers require many different kinds of information, including:	A HIS should have the capacity to handle data from different levels of the behavioral health system, including:
Inputs to the behavioral health system and related processes (policy and organization, health infrastructure, facilities and equipment, costs, human and financial resources) **Behavioral health determinants** (socioeconomic, environmental, and genetic factors) and the contextual environments within which the health system operates **Performance or outputs of the behavioral health system** (availability, accessibility, quality and use of health information and services, responsiveness of the system to user needs, and financial risk protection) **Behavioral health outcomes** (mortality, morbidity, disease outbreaks, health status, disability and wellbeing)	**Individual-level data** about the patient's profile, behavioral health care needs and treatment, which serve as the basis for clinical decision-making. **Health facility-level data** from facility-level records and administrative sources, which enable health care managers to determine resource needs, guide procurement decisions, and develop community outreach. High-quality data from health facilities can also provide immediate and ongoing information relevant to public health decision-making, **Population-level data** are essential for public health decision-making and generate information not only about those who use the services but also, crucially, about those who do not use them.
Adapted from: WHO (2008)	*Adapted from: WHO (2008)*

Successful BHIS implementation is complex and relies on a combination of organizational, technological, and human factors.[272] *Table 7.B* highlights key organizational and human factors that should be present to implement a strong HIS, while *Table 8.A.* (see Chapter 8) highlights the key technical factors that should be present. A successful HIS also requires comprehensive, ongoing evaluation. Overall, an effective BHIS should contain or facilitate the HIS components listed in *Table 7A, 7B,* and *8A*. It should have centralized databases, standardized processes and quality assurance procedures.[273]

Table 7.B Characteristics of Successful HIS Implementation Adapted from Sligo et al., 2017

Organizational Factors	Human Factors
• Visionary leadership of the organization and implementation process • Communication between levels of the organization and between management, clinicians, and information staff • Central and local government support • Clear management and governance structures, task orientated structures, and minimal staff turnover • Adequate funding to purchase and implement the HIS	• Perception of the benefits of the HIS by end users • Dedicated effort to foster high levels of trust and early engagement with end users • Sufficient time for well-resourced training and testing • Ensure public information is easy to access and understand

Information Flow From Government Agencies to the Public

Messaging and information from government agencies should be clear in their delivery across all platforms, updated regularly to ensure accurate information at all times, and be user-friendly. Further, given that District residents may enter behavioral health services through several different agencies, it is important that all information sharing from government agencies contain clear and consistent messaging across agency platforms to ensure an any-right-door policy.

Effective government communication is an important tool for eliciting public support for behavioral health initiatives and building trust through increased transparency. Research suggests that distribution of credible information motivates observable behavioral changes within social networks.[274] Quality public messaging, including behavioral health awareness campaigns, is a particularly important link in the personal health education chain, with research showing health and economic benefits from mental health campaigns.[275,276] Public and private stakeholder input is critical in developing and sustaining effective public messaging. Key components of a children's mental health awareness campaign in Maryland are highlighted below.

A Maryland Public Awareness Campaign: Children's Mental Health Matters!

The Children's Mental Health Matters! Campaign has been ongoing for more than 20 years, with the goals of raising public awareness of the importance of children's mental health and substance use; helping reduce the stigma of mental health; and connecting families, educators, and providers throughout Maryland with resources to help children. The campaign is led by two nonprofits, with several government agencies as partners. The following are some activities that the campaign implements to achieve its goals:

- **School Champions:** Maryland schools can sign up to become a School Champion and will receive mental health support resources (including morning announcements, ready-to-go content for social media and publications, and student activities).
- **Community Champions:** Maryland organizations can sign up to be Community Champions that commit to raising awareness through events, education, and advocacy.
- **Resource kits:** These are available for parents, educators, and students.
- **Social media presence:** Through Facebook, Instagram, and Twitter accounts, the campaign shares mental health information and resources.
- **Book club:** This includes conversation prompts to help adults, children, and youth have meaningful conversations about the content presented each month.

According to the campaign's 2021 Wrap-Up Report, over 270,000 students in Maryland were supported through campaign resources.[277] For 2021, there were 472 school champions and 169 community champions. Based on a survey of 2021 champions, nine out of 10 respondents were satisfied or very satisfied with the campaign results.

User-friendly government websites can also be an important avenue for sharing timely information with the public. One exemplary government behavioral health website is HealthyMindsPhilly.org, developed by Philadelphia's Department of Behavioral Health and Intellectual Disabilities Services (DBHIDS), which educates the public and provides screening tools, as well as shares information on crisis services, other behavioral health services, and social support services.[278] According to the website, it is "an online tool and resource designed to support and improve the mental health and well-being of all Philadelphians" and it was "intended to look and feel different than traditional government sites."[279]

Information Flow From Service Providers to the Public

Effective information-sharing and communication from service providers to the community increases patient-centered care and shared decision-making and improves patient satisfaction. Communication from service providers to the public should align with principles outlined in *Table 5.A.* (i.e., family-driven, family-centered, youth-guided, cultural attunement, trauma-informed, racial equity). To ensure alignment with those principles, community

members should be involved in the process of deciding what information is shared and how it is communicated to their broader community.

Components of Effective Health Communication Strategies

- **"Use of research-based strategies to shape materials and products and to select the channels that deliver them to the intended audience;**
- **"Understanding of conventional wisdom, concepts, language, and priorities for different cultures and settings;**
- **"Consideration of health literacy, internet access, media exposure, and cultural competency of target populations;"[280]**

Service organizations should ensure information is clear, concise, easily understandable, and accessible, taking into consideration what platform or tool is best to use and format and whether information is needed in multiple languages. There are a number of platforms and tools that providers can use to share information and communicate effectively with their consumers, including information technology, social media, service provider webpages, mobile devices, etc.

When sharing information via websites, the WHO suggests that organizations design compatible content, which means ensuring webpages work on multiple platforms and browsers; can be adequately displayed on different types of devices (e.g., smartphones, tablets, laptops, etc.); and takes into consideration file sizes for users with slow internet connection or low bandwidth.[281] When utilizing various information technology platforms or mobile devices, service providers must ensure compliance with HIPAA laws and state privacy laws and use appropriate safety measures when communicating electronically, particularly for unencrypted forms of communication (i.e., typical emails and text messaging).[279] An example of effective information sharing through the use of information technology is allowing consumers access to their EHRs and health data, which strengthens consumers' ability to be an active voice in their care and make informed clinical decisions.[283] The use of EHRs and other health technologies will be explored further in Chapter 8 of this report.

Information Flow Among MCOs, Service Providers, and Government Agencies

Clear, consistent communication among government agencies, MCOs, and providers is necessary for the optimal functioning of the behavioral health system. Government agencies should prioritize provider and MCO engagement to guide initial decision-making and continually optimize implementation of best practices. In that regard, government agencies should offer technical support to service providers, with the opportunity for feedback, especially during any behavioral health reform efforts, to promote a shared understanding.

Intermediaries between government agencies and service providers can be important for facilitating communication. For example, Philadelphia's DBHIDS established an EBP coordinating body to serve as a government/provider intermediary during its behavioral health system reform efforts.[284] EBP coordinators provided technical and financial support resourced by DBHIDS to providers to promote EBP implementation.[284]

Building trustworthy data-sharing tools and issuing specific guidance about the nature of collaboration and data-sharing expected from providers also fosters information-sharing between governing agencies and providers.[285] Guidance offered to providers should include information about the provider's role in data sharing, a clear definition of the relevant public health problem(s) to be addressed, and the impact of data sharing on service delivery and service users.[286] Further, clearly defining who has access to which data under federal and local health information privacy laws and regulations can help to avoid confusion that may unnecessarily impede data sharing.[287]

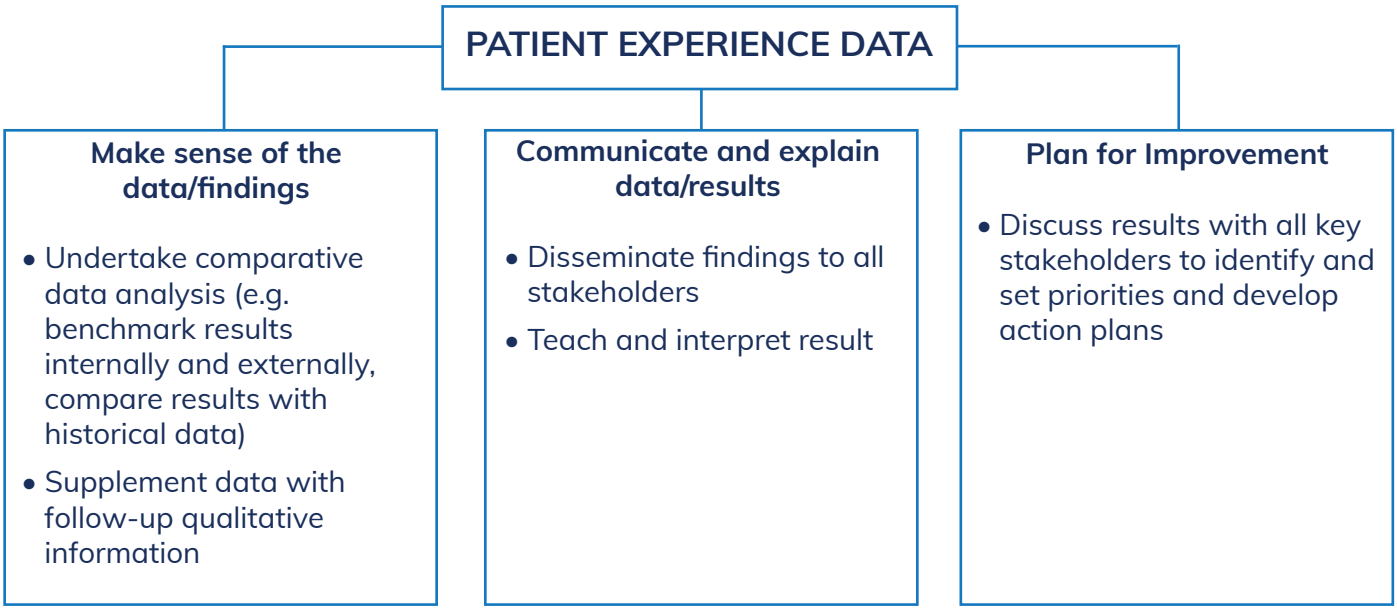
Feedback From the Public to Government Agencies, MCOs, and Service Providers

Communication from the public to service providers, MCOs, and/or government agencies is critical for iterative improvements toward an efficient, effective behavioral health system. An ideal behavioral health system should include routine formal measurement of customer satisfaction that is used to inform provider feedback and technical assistance. Further, patients who provide meaningful input through specific feedback and engagement efforts should be compensated for their time and efforts.

On a related note, CMS has issued a final rule for states to implement a quality rating system (QRS) for Medicaid and CHIP (42 CFR § 438.334), though states do not have to comply with that requirement until CMS finalizes and releases specific guidance. As of February 2021, 13 states currently have a rating system, of which patient experience can be one measure.[288] The primary goal of a QRS is to help inform beneficiaries of MCO products, and a secondary goal is to improve health plan performance, including financial incentives such as bonuses and auto assignment for enrollees not selecting a specific plan. This customer satisfaction data should also be directly incorporated into MCO-required Quality Improvement Plans and inform agencies' technical assistance to providers and MCOs to improve customer satisfaction.[216]

Once feedback is collected, it is critical that it is used to inform health care decisions. In that regard, *Figure 7.C* presents a framework that documents steps to be taken when using such data through three overarching processes.[289]

Figure 7.C. A Framework for Understanding and Using Patient Experience Data to Improve Health Care Quality



Kumah E, Osei-Kesse F, and Anaba C. Understanding and Using Patient Experience Feedback to Improve Health Care Quality: Systematic Review and Framework Development. *Journal of Patient-Centered Research and Reviews*, 2017;4(1):24-31.

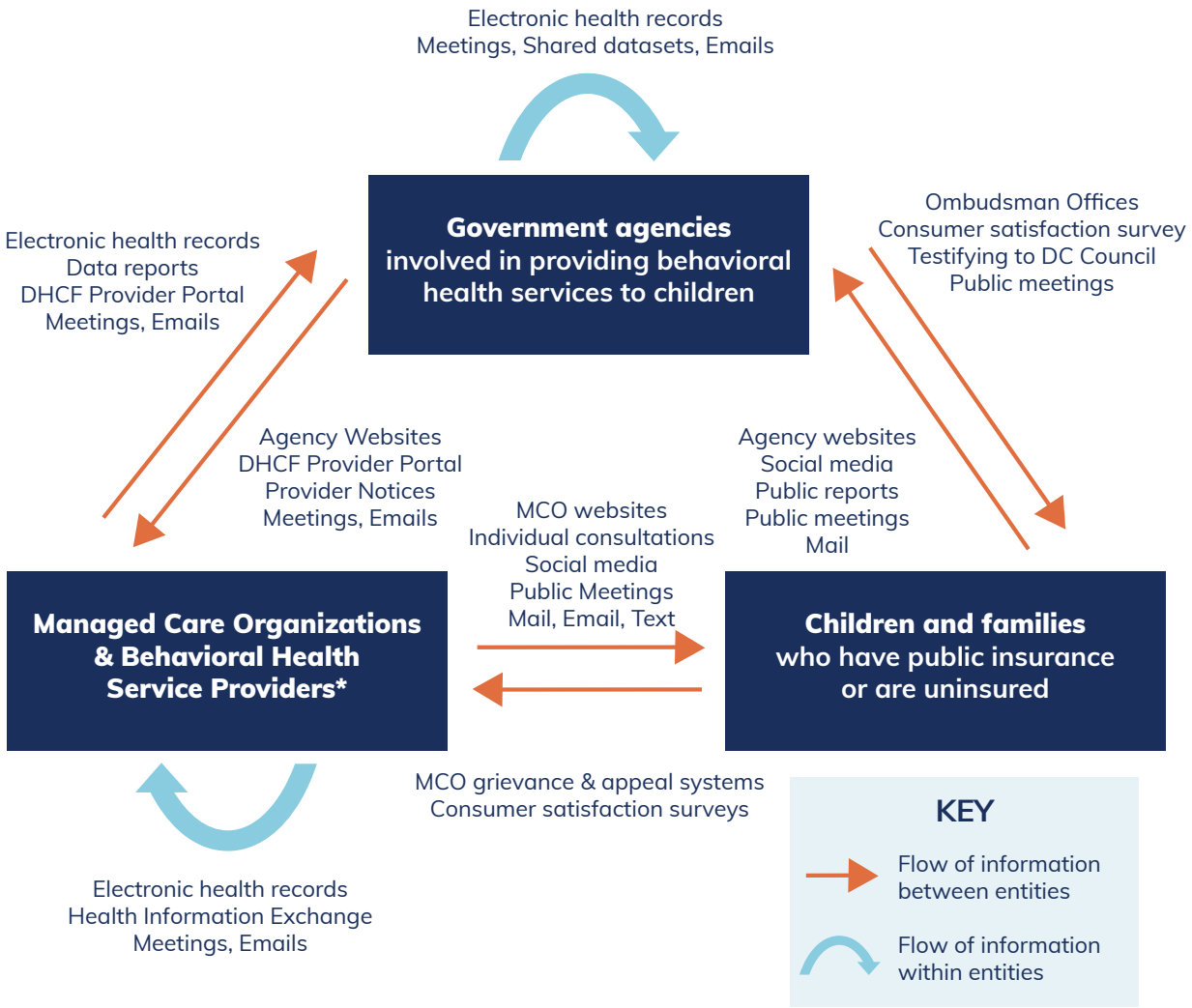
Finally, it should be noted that eliciting retrospective feedback from the community is not a substitute for proactively engaging community stakeholders in decision-making processes. Section 3.1 describes our vision for meaningful engagement with community stakeholders at the leadership level in more detail.

7.2 Current System

The District has made significant strides in its health information system. In 2018, DHCF developed a five-year roadmap called the *State Medicaid Health IT Plan for 2018-2023* in fulfillment of a requirement by the Centers for Medicare and Medicaid Services.[290] That plan outlines the following four priority areas for better connecting residents and providers with health information: supporting transitions of care; collecting and making effective use of social determinants of health data; providing analytics for population health; and leveraging HIE for public health.

Figure 7.D. highlights three main groups of entities that information moves between in the behavioral health system for children in DC, along with examples of the media and facilitating bodies that transfer information between the entities. *Figure 7.D.* is not comprehensive but is meant to provide a snapshot of some media and facilitating bodies for information transfer between and within entities. Also, it should be noted that while it appears that there are existing routes for the flow of information between all types of entities, some of those routes do not exist for all organizations within an entity type. For example, all service providers do not use an electronic health record system that facilitates the flow of patient data to government agencies. The limitations of those "information routes" are explained in subsequent paragraphs.

Figure 7.D. Information Flow in DC's Current Behavioral Health System for Children



***MCOs and service providers have some distinct communication mechanisms with government agencies and children but are grouped together in this diagram for simplicity.**

From Government Agencies to the Public

There is no standard platform to communicate behavioral health information to the public. Each agency develops and maintains its own community engagement strategies, which often include both online information sources and paper-based communication. Online communication engagement requires DC residents to have access to WI-FI or broadband and a device. It also requires a level of technology literacy, such as navigating the different webpages and social media platforms.

Agency Websites: Most agencies have their own website, where they regularly post information, updates, and resources. However, those websites contain information for a variety of stakeholders and may not be easy for families and youth to navigate. According to DBH's *Open Government Report* in 2014, DBH provides timely updates to the public on its website, including information on new initiatives, descriptions of services; public events/meetings; and a twice-yearly report on service costs, utilization, and access to mental health services.[291] DBH also uses its website to post announcements regarding contract opportunities and funding availability for grant initiatives. Additionally, DBH is required to respond to Freedom of Information Act (FOIA) requests and uses the FOIAXpress software to process FOIA requests and share information.

Several agencies collectively maintain the DC Support Link website, which serves as a behavioral health resource link, where individuals can connect to supports and services in the District. Additionally, DBH maintains the DrugFreeYouthDC website to provide information and resources to youth and families in all eight wards on drug prevention. DC also has an open data webpage called Open Data DC to promote data transparency and accountability. The webpage includes different story maps, data sets, and web maps for use by agencies and the public, but it is difficult to navigate.

Social Media Engagement: In terms of public communication, several agencies use social media platforms (including Facebook and Twitter) to share information with DC residents. For example, OSSE, DBH, and DHCF all have Facebook pages. The deputy mayor for Health and Human Services, the mayor, DBH, and DC Council regularly provide updates via Twitter.

Public Hearings: Agencies also provide the public with information regarding performance each year. That information is provided to the DC Council and then posted on the DC Council website for the public to access. However, there are sometimes delays with the provision of this information on the DC Council's website.

From the Public to Government Agencies and Service Providers

Currently, there is no systematic or standard way for families and youth to give feedback on their experiences with accessing and utilizing behavioral health services in the District or to provide input for service planning.

Feedback on Behavioral Health Services

Provider organizations and managed care organizations have different methods for collecting feedback directly from consumers. AmeriHealth implements one-week follow-up pulse surveys via text message (with questions such as "How long did you have to wait for a visit?" or "Are you satisfied with the visit?") as a tool for beneficiaries to give feedback. MCOs collect patient satisfaction and experience data (qualitative and qualitative) using various processes. MCOs currently use the Agency for Healthcare Research and Quality (AHRQ) Consumer Assessment of Healthcare Providers and Systems (CAHPS). That survey collects data from consumers on their experiences with receiving services (i.e., in-person care or telehealth) or related to specific conditions.[292] Additionally, in accordance with 42 C.F.R. § 438.400, each MCO has its own grievance and appeal system for consumers. Further information on feedback on behavioral health services can be found in Section 5.2.

With respect to DBH programs and services, certain consumers may also have the opportunity to provide feedback through DBH's annual consumer satisfaction surveys conducted through the Consumer and Family Affairs Administration. Additionally, the DBH Ombudsman Office is intended to serve as a neutral and confidential

intermediary to support District residents who use DBH programs or services or work with its certified providers. Residents can file a complaint (informal process) with the DBH Ombudsman Office or a grievance (a formal written process established by federal and District law) with the Consumer and Family Affairs Administration.[293] Similarly, DHCF has the Office of the Health Care Ombudsman and Bill of Rights, which consumers can contact to file complaints about their health plan or provider.[294] The Office of the Health Care Ombudsman and Bill of Rights acts as a neutral body that can assist with resolving problems concerning health care bills, health coverage, and access to health care.

DC residents are also given the opportunity to provide testimony to the DC Council regarding their experiences with the different agencies, but that requires some procedural knowledge and available time to deliver testimony during regular business hours.

From Service Providers to the Public

There are a number of ways in which service providers communicate information to the public. One obvious method is direct communication to their patients and families. Another method is posting updates on their webpages. There are several guides service providers put together to help families navigate and access resources. For example, Resilient Communities DC, funded by DC Health, contains information for Wards 7 and 8 on resources available in their communities related to a variety of areas, such as mental and physical health, housing, food, child care, as well as information and resources related to COVID-19.[295] Another example includes the DC Health Check Child and Adolescent Mental Health Resource Guide (maintained by DC MAP) in which individuals can look up mental health resources by location and insurance type.[296] Individuals can also search for resources (e.g., social services) by type of resource and zip code using the Aunt Bertha Connect or UniteUS tools, in which service providers (e.g., community based organizations, nonprofits, hospital providers, etc.) provide information.[297]

Between Service Providers and/or Government Agencies

Information relevant to the behavioral health of children in DC is shared between service providers and/or government agencies through multiple mechanisms, such as electronic health records and other Health IT. Please see the technology section for more information.

Privacy Laws

There are different rules in DC for behavioral health information that are stricter than HIPAA. The District Mental Health Information Act places some limits on sharing mental health information that are more stringent than HIPAA for District providers, though these restrictions have been significantly reduced through a series of amendments in recent years.

Additionally, 42 CFR Part 2 governs substance use treatment, and it is separate from and more stringent than HIPAA, and DC cannot make any changes to federal law. That helps to protect individuals from discrimination and stigma but also hinders providers in knowing who is in substance use treatment. DHCF has secured CMS matching funding to contract for CRISP DC to develop a consent management solution to document when an individual has granted permission to disclose or redisclose information about their participation in substance use treatment, consistent with 42 CFR Part 2, which may help more provider organizations to adopt use of HIE or to share instead of simply receiving information. This e-consent procedure also enables providers in the SUD system of care to see information from physical health providers and for physical health providers to see select substance use treatment data.

7.3 Gap Analysis

A comparison of DC's current BHIS to our vision for the BHIS highlights several key gaps that are discussed below.

1. Insufficient leadership support and investment for the district's behavioral health information and communication systems

The District has shown some leadership support for behavioral health information and communication systems, as reflected by the dedicated information technology units led by Chief Information Officers within both DBH and DHCF, as well as the *State Medicaid Health IT Plan for 2018–2023*. The many challenges with the information system specifically for behavioral health for children reveal inadequate investment from leaders of the public behavioral health system in DC. Government agencies have not exhibited or facilitated the organizational factors listed in *Table 7.A* for successful implementation of a well-functioning BHIS.[298] Further, there has been insufficient oversight to ensure that each organization involved in collecting, analyzing, storing, and/or disseminating information has the necessary financial and human resources.

2. Lack of standardized data collection methods and reporting standards leading to inadequate and poor-quality data for providers and government agencies

There is no one standard method or metrics used to collect and/or report on several types of information that are critical for the effective planning of the behavioral health system for children. That includes data on the active behavioral health workforce, service usage/health outcomes data stratified by sex, race, socioeconomic status, ethnic group, geographical location, etc. Although behavioral health providers are collecting some of that information, it is not aggregated or analyzed in a way that makes it readily useful for the public, policymakers, providers, and others to make better clinical care, health systems, or policy decisions. Furthermore, it is difficult to track or navigate real-time availability of services and where to access specific services.

3. No well-known, user-friendly, public platform to communicate behavioral health information for children

While government agencies generally maintain their own websites and social media accounts, they are often difficult to navigate because the published information targets a variety of stakeholders. The DC Support Link website was created as a centralized "information hub" for accessing information on behavioral health resources, but it is not user-friendly, especially for adolescent users. Further, through our family engagement efforts, children were unable to point to specific places to access information about behavioral health services, with some dubiously stating that school or online may have information about services. That suggests that even though there are multiple sites with information on behavioral health resources, the sites are not well-known.

4. Lack of public awareness on child behavioral health services and issues

Our recently conducted focus groups also revealed that both youth and parents are lacking information not only about the availability and quality of behavioral health services for children in DC but also behavioral health disorders. Most children felt they were uninformed or underinformed about available services. Some parents/caregivers felt that children were not sufficiently educated about behavioral health, including the issues that they can face and healthy coping strategies. That was supported by one child who stated, "a lot of people are experiencing mental health and not seeking help because … they don't know that they're going through a mental health episode." Overall, these findings suggest that current methods of communication to the public from both government agencies and service provider organizations are not effective and/or sufficient.

5. Insufficient engagement of community organizations in behavioral health communication for families

Government agencies, MCOs, and behavioral health service providers do not maximally engage with natural community intermediaries on their potential role as communicators of behavioral health information and resources to families. Community centers, recreation centers, family-run organizations, family support groups, family success centers, faith-based institutions, family strengthening collaboratives, and public libraries interact with DC families regularly and may even be the first point of contact when children experience behavioral health issues. Thus, these organizations are poised to share accurate information on the public behavioral health services in DC to connect children to care. However, some community organizations have expressed that current resources dedicated to maximizing their involvement in behavioral health communications are insufficient and/or not sustained.

7.4 Recommendations

1. Develop transparent privacy and confidentiality policies and data-sharing agreements among agencies to support information sharing among providers, MCOs, and government agencies.

Implementing Bodies: DHCF, DBH, HIE Policy Board, CRISP DC, MCOs
Timeline to Implementation: Long Term

One strategy within the District's *State Medicaid Health IT Plan for 2018–2023* that should be prioritized to enhance information sharing and communication is the development of "transparent policies that align with privacy and security best practices and undergo review on an ongoing basis." DHCF, DBH, the HIE Policy Board, CRISP DC, different provider types (including behavioral health providers), and MCOs should work together to develop clear regulations and guidance on patient data (including behavioral health data) that can or cannot be shared, the level/types of data each can have access to, and how the data can be used. In particular, to improve information sharing from behavioral health providers, clear guidance and exchange policies around behavioral health data sharing will need to be implemented. That will require updates to the District's privacy laws and standardization across different organizations on interpretation of HIPAA. It will also require education to residents, providers, and payers once guidance has been developed. Further, DHCF and CRISP are in the midst of a project to build consent management options into the District's designated HIE, which will require additional education and technical assistance.[xx] Finally, we acknowledge the need for data sharing among agencies' information systems (such as CFSA and ICH information systems), however this recommendation also has technological implications, which are explored in detail in Chapter 8.

2. Develop a surveillance system for population-level behavioral health data and behavioral health services data for children.

Implementing Bodies: DBH, DHCF, DC Health, MCOs
Timeline to Implementation: Long Term

Such a surveillance system is needed for transparency and accountability and to support research and planning by all. The surveillance system should facilitate routine, ethically sound data collection in the District on the behavioral health issues affecting children, as well as on behavioral health service delivery. It is important for community members to be meaningfully involved in the development of the data collection process to ensure that these processes are respectful and reflective of the community's needs. This system can provide local measurements of prevalence, incidence, severity, risk factors, social determinants, functional outcomes, and access to care,[62] with data disaggregated by race, ethnicity, age, and geographic location as appropriate. At a minimum, data should be routinely collected on key indicators and case definitions for surveilling substance abuse and mental health that were identified by the Council of State and Territorial Epidemiologists' Workgroup for Substance Abuse and Mental Health Surveillance.[299]

[xx] *Please see Chapter 8, Recommendations 1 and 2 for further details.*

There should be adequate capacity for data collection, analysis, and dissemination to establish regular standardized reporting to all relevant stakeholders.[62] Over time, this data should become the evidence informing benchmarks/standards for behavioral health services for children and guiding clinical practices. While data sources for this surveillance system can include the biennial data from the Youth Risk Behavior Surveillance System and data from appropriate indicators monitored through the DC Healthy People framework, additional sources need to be identified and/or created. The DC Health Information Exchange should be used to the greatest extent possible as a single, shared data reference source and should become a source of information for collaborative learning and system analysis and planning. This surveillance system should include a public repository for appropriate population-level data to facilitate transparency and encourage data-driven decision-making throughout the District.

3. Require uniform standards for data collection and minimal standards for reporting.

Implementing Bodies: DHCF, DBH, MCOs
Timeline to Implementation: Short Term

DHCF should require MCOs to adopt uniform standards for data requests and provide a standard format and process of data collection to be used by all MCOs and providers. Behavioral health data collection within the MCOs must be able to represent the unique issues and metrics of the specific behavioral health patient population, as well as work toward a greater understanding of publicly insured populations under an integrated managed care system. The data reported by MCOs should include metrics specifically targeting children and families, including dollars per child spent on behavioral health services and service utilization rates for children. Additionally, data should be stratified by sex, race, age, socioeconomic status, and geographical location, when possible. Public reporting about collected metrics should be frequent enough—perhaps quarterly—for DHCF, MCOs, provider organizations, and members of the public to call for a change of course if performance appears to be falling short. To ensure closed loop communication and transparency with the public on how the data collected is used, such as with beneficiary experience surveys (e.g., CAHPS), data should be regularly published and shared back with beneficiaries. Further, government agencies, MCOs, and behavioral health providers must ensure equitable access to this information, particularly for those who do not have sufficient access to technology.

4. Develop and periodically update a comprehensive behavioral health awareness strategy for children and families in DC, with leadership from DC youth and families.

Implementing Bodies: CBOs, DHCF, DBH, DC Health, OSSE, DCPS
Timeline to Implementation: Short Term

To lead this endeavor, we recommend establishing a multisectoral workgroup specifically concentrated on information and communications issues related to children's behavioral health. Members of this workgroup must include relevant CBOs, government agencies, specialists in health communication/health education, service providers, and parents/caregivers and youth who can reflect real health literacy needs of the community.

An annual children's behavioral health campaign can address gaps in public awareness regarding the availability of behavioral health services for children in the District, including a variety of nongovernmental messengers with

the appropriate training and sustained resources to share this information and how to access these services. Such a campaign can also aim to increase behavioral health literacy, especially around behavioral health problems and their treatments, among parents/caregivers and youth. Any information provided needs to be updated regularly to ensure accuracy and, thereby, build trust.

This campaign should target parents/caregivers, educators, and youth separately and must involve multiple types of communication media (written and electronic) in different settings (schools, health care facilities, recreation centers, church groups, libraries, and communities). Maryland's Children's Mental Health Matters! Campaign highlighted in Section 7.1 provides some examples of how to implement a District-wide behavioral health campaign across community and school settings. It is critical for DC families and youth to be leaders in the development of this campaign to ensure the most appropriate communication tools and media are used. Additionally, development must also include individuals who speak languages other than English to assure the campaign is accessible and reaches a broader audience

This campaign must be consistent and recognizable across platforms, both public and private, throughout the District. In this regard, we recommend creating a dedicated website for children's behavioral health, which can have a URL related to the campaign's slogan to improve ease of recall. An excellent example is Philadelphia's Healthy Minds Website, which was highlighted in Section 7.1. In addition to this recommended website, all relevant DBH, DHCF, DOH, and other government websites should be coordinated and updated so that they relay consistent, clear, accessible, easily understood messages and provide user-friendly links to helpful sources where patients and families can take action or find providers and other helpful resources.

8. TECHNOLOGY

For this report, "technology" refers to the application of organized knowledge and skills in the form of devices, medicines, procedures, and systems developed to solve a behavioral health problem and improve quality of lives (WHO, 2008).

Technology has become a fundamental part of delivering behavioral health services, especially during the COVID-19 pandemic where a greater emphasis has been placed on telehealth services. Technology not only supports telehealth, but it also impacts the ways in which behavioral health information and data are stored, viewed, and shared by service providers, government agencies, and the public.

8.1 Vision for the System

Proper use of technology in the behavioral health system for children in DC can have several benefits, including a reduction in administrative burden for providers, better care coordination for families, and more timely service delivery for children. In light of such benefits, our vision for the behavioral health system for children in DC includes maximal use of technology, where appropriate, in a manner that respects privacy and confidentiality of patients and adheres to the guiding values outlined in Chapter 1.

The following paragraphs discuss our vision for four areas of technology that are particularly relevant for children's behavioral health. More generally, some key technological factors that should be present to implement a strong behavioral health information system are highlighted below.

Table 8.A Characteristics of Successful Health Information System Implementation
(Adapted from Sligo et al., 2017)

Technological Factors
• Existing information, communications and technology infrastructure must be able to assimilate the new system. • Good "fit" between the needs of the users and the technology before, during, and after HIS implementation, which is balanced against the requirement for interoperability • Adequate design, testing, prototypes and the ability to adapt the technology as required • HIS should be easy to use, clear and understandable, easy to learn to operate, flexible, have easy navigation with easy-to-remember tasks, easily customized, have quality interface design, and require little training.

Health Information Exchange/Health Information Technology

Health Information Exchange (HIE) is beneficial in that it improves data sharing across systems and helps to reduce fragmentation of information and communication. It improves the flow of information and communication among residents, service providers, payers, and public health agencies. Overall benefits for HIE include improved patient-centered care, improved transitions of care and care coordination, reduced health care costs, improved ability to access and analyze valuable clinical data, reduction or elimination of duplicative or unnecessary procedures or tests, improved

patient monitoring and disease management, greater access to population health, etc.[300]

The goal of implementing a comprehensive HIE/Health Information Technology (HIT) system is to achieve full interoperability, which is the capacity to send and receive meaningful health information from multiple sources between different systems and locations.[283]

HIE is the electronic movement of health-related information among organizations according to nationally recognized standards.

Source: National Alliance for Health Information Technology (2008)

Types of Information Needed to Support an Interoperable HIS

- **Individual longitudinal health data:** An individual's complete health record, including both provider-generated (e.g., medical visit records) and person-generated (e.g., wellness, fitness and socioeconomic) data
- **Within episodes of care:** Data from medical devices, labs, billing, EHRs and quality reporting
- **Between care settings:** Episode of care data that seamlessly moves from one care setting to another (e.g., from hospital A to hospital B or from a hospital to a post-acute care provider)
- **Marketplace:** Population health and research data that enables: 1) a feedback loop to providers, helping them deliver improved, personalized care; and 2) marketplace innovation

Source: Sharing Data, Saving Lives: The Hospital Agenda for Interoperability; American Hospital Association; 2019

Behavioral Health and HIE/HIT

The exchange of health information and data is vital in enhancing behavioral health care, especially as the behavioral health care landscape moves toward greater integration with primary care and other health settings. Behavioral health providers should have access to comprehensive clinical information across medical and behavioral health care to be able to understand the whole person, increase bidirectional exchange between physical and behavioral health care teams, and improve ability to address co-occurring physical and behavioral health conditions.[301] That includes access to visit notes, discharge summaries, notifications of encounters outside their practice setting, and medication history (e.g., compliance, prescriptions, pharmacy contact information, etc.).

One such method of increasing HIE and HIT for behavioral health providers is through the increased adoption of certified EHRs, which is discussed in greater detail in the next section. Additionally, one literature review found that the highest use of HIS occurred at sites that incorporated workflow in the design of the HIE and identified proxy users.[302] Proxy users could include nurses, social workers, peer support workers, and other provider types. Increased participation of HIE among behavioral health organizations requires provider buy-in and engagement, increased technical assistance, education and outreach, and financial incentives to buy necessary data systems and technology.

According to SAMHSA and the Office of the National Coordinator (ONC) for HIT, critical HIT components to support behavioral health include consent management, such as data segmentation for privacy[xxi] and privacy management, medication management, clinical decision support (integrating behavioral health screening and assessment tools with behavioral health treatment planning), system access controls (managing data access rights), and secure communication tools that facilitate direct exchange.[303] SAMHSA developed a free, open source tool to integrate with EHR and HIE systems to help facilitate data segmentation and consent management called *Consent2Share* (C2S).[304] C2S was designed to be in compliance with federal and state privacy laws including 42 CFR Part 2, which helps to support the exchange of sensitive behavioral health information. It has two major components: Patient Consent Management, "a front-end, patient-facing user interface which allows patients to define their privacy policy and provide informed consent," and Access Control Services, "a backend control system designed to integrate with

[xxi] *Data segmentation for privacy is: "the process of sequestering from capture, access or view certain data elements that are perceived by a legal entity, institution, organization, or individual as being undesirable to share." See Find Resource for Behavioral Health IT; Health IT Playbook; The Office of the National Coordinator for Health Information Technology; 2018*

EHRs and HIESs and provide privacy policy configuration, management, decision making and policy enforcement."[304] In addition to behavioral health privacy laws, HIE/HIT must also consider privacy and data-sharing laws specific to children and youth and should include child and youth providers in developing and testing technologies.[298]

Two examples of states that have increased use of an HIE for behavioral health include Arizona and New York which are discussed further below.

Strong HIE Adoption by Behavioral Health Providers in Arizona and New York

Arizona developed an HIE system specific to behavioral health care called the **Behavioral Health Information Network of Arizona (BHINAZ)**, sponsored by seven nonprofit behavioral health organizations. The BHINAZ system collects, stores, and shares data from a wide range of behavioral health service providers, including substance abuse programs, crisis professionals, general mental health practitioners, and children's behavioral health specialists, in three separate repositories for clinical data, documents, and patient consent.[305] Although the behavioral health network is a separate HIE system, it connects to that of the state's physical health care HIE system, which does not collect data related to 42 CFR Part 2, to allow for bidirectional exchange between physical and behavioral health data that can be shared. The BHINAZ system was designed to take into account behavioral health privacy laws by developing a secure method for collecting consent within the BHINAZ's EHR system that allows patients to opt in to the HIE for 365 days or until they turn 18. The BHINAZ network also developed an education program for providers, which included materials on how to gain patient buy-in and permission; the importance, benefits, and how to use it for both the patient and provider; privacy and security measures taken; etc. To ensure that providers would not only participate in the BHINAZ system but also use it, the BHINAZ network provided assistance on how to embed the behavioral health HIE system into existing organizations/provider workflow to make the system a part of daily practice, as well as partnering with providers to pilot different aspects such as how the data is structured, interfaced, and used.

The **Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES)** is a HIE system developed by the New York State Office of Mental Health (OMH), which uses HIPAA-compliant web applications to allow for sharing Medicaid billing claims and encounter data and state health administrative data.[306] Data is gathered from New York state psychiatric center health information database; OMH Child and Adult Integrated Reporting System (CAIRS) database; Assisted Outpatient Treatment database; Department of Health Health Home and Care Management database; and from data entered by providers on screening and assessments, safety plans, etc. Evaluation of the PSYCKES program revealed a resulting 30% reduction in quality concerns and $2.9 million in pharmacy cost savings.[306] To facilitate implementation of the PSYCKES, the New York State OMH developed a variety of training materials, including short how-to videos, user guides, regularly updated guidance, and webinars. Those training materials include information such as enabling access to client-level data, using the system in a clinical setting, etc. The OMH also implemented a Quality Improvement Collaborative focused on supporting best practices.

Electronic Health Record (EHR) Systems

EHRs are an important part of a strong BHIS. As highlighted by the Agency of Healthcare Research and Quality, EHRs for children require special considerations because this population has unique health care needs and requires interoperable exchange of data.[307] As such, data within an EHR system for children and adolescents should be exchangeable across sectors and settings, including primary care, child welfare, school, and behavioral health systems. The evidence base widely supports integrated EHR as an effective tool for promoting care coordination and collaboration between physical and behavioral health providers.[308,179] To facilitate such integration efforts, relevant government agencies should have

An EHR refers to health-related information on an individual that conforms to nationally recognized interoperability standards and that can be created, managed, and consulted by authorized clinicians and staff across more than one health care organization.

Source: National Alliance for Health Information Technology (2008)

consultations with a variety of health professionals, including child behavioral health professionals, to understand and address concerns, such as differences in information-sharing procedures and differences in confidentiality standards across disciplines.

Collection of data through EHR should be used to inform clinical decision-making.[308] It is important for data collected to include sex, race, age, socioeconomic status, and geographical location, when possible, to allow for stratification by subpopulations as this facilitates rapid identification of health disparities.[179] Additionally, EHRs should provide accurate billing code guidance as this can reduce administrative burden.

Further, EHR measures should directly capture patient health outcomes and treatment process fidelity measures to assess treatment quality.[180] Treatment process fidelity measures monitor the extent to which providers are following treatment protocols, which may prove useful in issuing provider feedback as well as differentiating between patient outcomes attributed to provider error and those determined by the protocol itself. An example of successful leveraging of EHR data for quality improvement is that of the New York City Regional Electronic Adoption Center for Health (NYC REACH) program, which developed one-page dashboards issuing provider feedback regarding EHR use and clinical quality outcomes.[309] Providers using the dashboard have consistently reported that it is helpful in assessing their EHRs.[309]

Given that costs related to EHR system purchase, installation, and training are the primary barrier to EHR uptake for behavioral health providers, especially in small practices,[310] EHR system implementation efforts should include technical assistance that reduces installation and training costs for providers. In addition, clinical training programs should be modified to meet real-world computer literacy demands elicited by EHR systems.[311] Training should also teach providers how to incorporate EHR into daily workflows to maximize care quality, for example, by engaging clients through screen-sharing while taking notes, using EHR information to facilitate conversations about treatment adherence, or generating graphs to evaluate treatment progress.[311]

Telehealth

A strong telehealth system should be user-friendly, minimize barriers to health care access, and ensure the same level of patient confidentiality as in-person health care services. To maximize telehealth's potential to increase value in health care, its design should be patient-centered, allowing patients to view, share, and upload records while assisting providers in managing information and relationships with service consumers.[312] Telehealth platforms should also allow the addition of natural supports to the health care visit as appropriate to facilitate care management and coordination.[312] Further, telehealth systems should allow similar functions as an in-person visit, where possible, including registration, diagnostics, therapy, and care coordination as necessary at a low cost.[312] While telehealth should increase the convenience and timeliness of services, quality must not be sacrificed, because it should also remain based upon scientific knowledge and as effective as in-person care.[312] In that regard, the organizational structures and procedures necessary for effective and sustained telehealth delivery should be established, including mechanisms for quality monitoring.

> ***Telehealth is defined as the delivery and facilitation of health and health-related services including medical care, provider and patient education, health information services, and self-care via telecommunications and digital communication technologies.***
>
> **Source: NEJM Catalyst (2018)**

An effective telehealth system should also take into account the inequitable access to digital resources, such as reliable internet access, that persists across socioeconomic divides.[313] Given the consequences of unreliable broadband access on remote education and telehealth resources during the COVID-19 pandemic, states have taken various measures to use 2020 Coronavirus Aid, Relief, and Economic Security (CARES) Act funding to invest in an accessible broadband structure.[314] For example, Missouri used $5.25 million to purchase hotspots for FQHCs and Community Mental Health

Centers, specifically for the purpose of improving access to telehealth. Vermont contributed $17.4 million to build the necessary infrastructure to connect private residences and businesses to high-speed internet and has created a temporary subsidy program to help qualifying households to pay for internet services.

Mobile Health (mHealth)

Given the ubiquity of smartphones, especially among younger generations, behavioral health care providers and health system administrators should maximize use of mobile health (mHealth) technology as appropriate for service delivery, education, and administrative functions. The benefits of mHealth extend beyond the patient-provider interaction, allowing for portability and flexible features that can be personalized to the condition and circumstances. mHealth is also a platform to address inequity in behavioral health care, since location and accessibility to providers are not primarily relevant in mobile health.[315] It is a great way to increase access to services among under-resourced populations, reduce costs, and improve patient experience.[316] As a complement to therapeutic interventions and medication, it is a relatively inexpensive component, costing only the expense of apps and provider interactions, if warranted.

> ***Mobile health, or mHealth, refers to the use of smartphones, tablets, and other mobile and wireless devices in both public health and health care.***
>
> **Source: mHealth and FDA Guidance; Health Affairs; 2013**

mHealth tools are valuable at all stages of behavioral health care, can be one-directional or two-way, and can be self-managed or professionally linked. At the initiation of care or as an introduction to behavioral health services, mHealth can increase comfort in an anonymous or semi-anonymous setting and alleviate stigma by offering gentle introductions to behavioral health service objectives. Web-assisted therapy, support and information in between therapy sessions, web-assisted self-help, and real-time survey completion and biometric data are all beneficial tools to patients in treatment. In fact, researchers have found that app-based homework and Ecological Momentary Assessment (an updated version of the personal diary) activities have better participation rates than pen-and-paper homework for younger patients,[317] given their reliance and ease of use of smartphones and technology. Biometric sensors available through smartphones and wearable sensors allow for tracking, diagnosis, and management of various physiological conditions. In particular, electrodermal metrics and heart rate variability allow for the data collection on rates of stress and anxiety; the opportunity to better manage mental health conditions are welcome advances that result in improved well-being and quality of life.[318] mHealth tools, such as text messaging support, can even benefit patients and providers as treatment comes to a close, improving long-term outcomes and maintaining gains.[319]

mHealth also holds an opportunity for optimizing a value-based payment system of behavioral health managed care. Whereas traditional fee-for-service behavioral health and physical health are built upon reactive, symptom-based care, mHealth utilizes monitoring of health habits, biometrics, and other symptoms in real time that can be reviewed, analyzed, and applied to treatment to improve outcomes, reduce negative consequences, and benefit well-being.[320] Regulatory frameworks must be able to preserve patient-provider communication security, without compromising access.

Text-Based Behavioral Health

A form of mhealth is text-based behavioral health, which refers to the use of a mobile device to exchange text messages with a behavioral health provider.[321] Examples include Talkspace and Sanvello.[321] Given the popularity of text messaging as a mode of communication, especially among youth, text-based behavioral health holds great potential to increase the accessibility of behavioral health services to young people. Text-based behavioral health services have consistently shown therapeutic benefits for a wide range of behavioral health diagnoses.[322,323] A review of mobile mental health studies showed that text messaging was used in a wide range of mental health situations, notably substance abuse (31%), schizophrenia (22%), and affective disorders (17%). Text messages were used in four ways—reminders (14%), information (17%), supportive messages (42%), and self-monitoring procedures (42%)—and in combination.[324] However, given that texting is a relatively new medium of therapy and that there are unique risks for confidentiality breaches inherent to mobile-based therapy platforms, establishing clear guidelines and regulations is particularly important.

8.2 Current System

Health Information Exchange/ Health Information Technology [325]

DHCF leads the state's health IT policy and strategies in collaboration with several organizations. The DC HIE, which is governed by DHCF under DCMR 8701.2, is a system of HIE entities that provides tools and collates information from multiple sources to support secure electronic exchange of health information. HIE organizations are not required to participate in the DC HIE, but if they choose to, they can participate as either:

1. Registered HIE entities, which are organizations that demonstrate that they meet or exceed core minimum privacy, security, and access requirements for health information exchange identified by DHCF and District stakeholders in the DC HIE Rule; or
2. Designated HIE Entities, which is an organization that applies and is selected to support the development and maintenance of HIE services among the District Registered HIE entities and participating organizations in the District.[326]

Chesapeake Regional Information System for our Patients (CRISP) DC is the District's designated HIE, which works with the DC government and providers to implement HIE services such as:

- **Encounter Notification Service (ENS):** This tool sends real-time alerts to providers when their patients are admitted or discharged from the hospital. It can be tailored to the provider organizations.
- **Patient Care Snapshot and Query Portal:** This tool provides health information such as a patient's recent visits, procedures, and medications, in addition to a detailed list of organizations, providers, and care managers who have an existing relationship with the patient. The portal allows for providers to access more in-depth clinical information on their patients from across institutions.
- **eCQM Tool and Dashboard:** This is an electronic clinical quality measurement tool and dashboard for assessing performance against key measures. It allows providers to calculate and report clinical quality measures (CQMs).

There are different levels of uptake of the CRISP HIE among service providers in DC. Some providers upload their panel and can see data that is being received but are not sending data from their own health records. There are also progressive levels of full data sharing. Most organizations are not sharing mental health clinical data, but some are. DHCF and CRISP track progress of District-wide HIE adoption and use through development of an interactive tool. Currently, the tracker includes licensed clinical social workers but does not list other behavioral health provider types. However, according to an October 2020 report, Enlightened Inc., which provides technical assistance to organizations on HIE, was working with 42 behavioral health organizations, 31 of which are participating with CRISP and can view data, and five of the 31 can send and share clinical data.[327] Currently, when a patient is discharged from the hospital, CRISP is used to send real-time notification to the next care provider, and the hospital sends more detailed transitions of care information several days to a few weeks later.[109]

Electronic Health Record Systems

There are a number of different tools and EHRs that health care providers in the District currently use. EHR adoption in the District increased significantly after the passage of the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009. As of 2018, 89% of District physicians and every District acute care hospital, FQHC, and long-term care facility utilize EHRs. However, the number of different EHR systems in use makes it difficult to share information across the behavioral health care system and results in redundancies. Behavioral health provider organizations were not included in the eligibility for HITECH financial support to adopt or expand use of EHRs, which has delayed mental health and addiction treatment provider adoption of EHRs, especially Certified EHR Technology (CEHRT) that meets national standards for data exchange interoperability.

Each government agency involved in the provision of behavioral health services to children uses its own information systems (and therefore requires regular interagency meetings and communication to coordinate care across agencies).[187] For example, CFSA stores data from behavioral health assessments in its data management system, FACES, while DBH uses several different EHR systems. Saint Elizabeths Hospital uses Avatar as the EHR system. DBH uses Incedo as its medical billing software from which some patient data can be extracted. Additionally, DBH uses the Integrated Care Application Management System (iCAMS) and the District Automated Treatment Accounting System Web Infrastructure Technology System (DATA WITS) as its EHR systems for mental health services and substance use services, respectively.[66] Currently, most DBH mental health provider organizations use iCAMS. DBH configured iCAMS so it receives files from Partially Integrated Providers, which allows the aggregation of data from external sources. Partially integrated provider organizations use their own EHR systems and send data to iCAMS. Furthermore, many community-based provider organizations and FQHCs use a different EHR system called EClinicalWorks (eCW). When looking at the number of consumers served, most consumers are serviced by organizations that use private EHRs. Unlike iCAMS, eCW is configurable at the provider level, because each organization owns their own license.

One specific example of the use of iCAMS by DBH staff co-located at CFSA is to connect children directly with DBH Core Service Agency (CSA).[187] There have been several challenges with the iCAMS system since its introduction. Some provider organizations experience difficulties with iCAMS's limited functioning capabilities that do not allow providers to customize iCAMS for their own organizational needs. That is challenging because some provider organizations do not have the ability to buy their own EHR system because it is not built into their costs or rate setting. They also do not always have the staff to do their own data analytics or systems work. Current behavioral health data exchange between providers occurs manually, often via fax.[328]

Data Warehouse

This is the ability to aggregate data from multiple data sources including from EHR and financial systems. At a systems level, the District does not currently have the transparency to understand how behavioral health is operating. The current process for populating the data warehouse is insufficient. This is a challenge across multiple agencies (DBH, DC Health, DHCF).

Community Resource Information Exchange (CoRIE)[329]

The District of Columbia is in the process of implementing the CoRIE project to increase capabilities of the DC HIE. It is a joint project between the DHCF, the DC Primary Care Association (DCPCA), the DC Hospital Association (DCHA), and CRISP DC. The project aims to streamline social determinants of health data sharing in a standardized format to allow for a more consistent way for data to be shared between health and social service providers and systems. The project would integrate existing technological systems used by CBOs, as well as standardized SDOH screening tools and referral processes used by health care providers and MCOs. This system would close the communication loop between health care providers and CBOs and help to ensure follow up with patients through patient alerts.

Certified EHR Technology

On a federal level, EHR standards have been established and enforced through the ONC Health IT Certification Program, established under authority granted by the Public Health Service Act (PHSA).[330] CEHRT requirements have been used for a number of federal EHR use and interoperability incentive programs, including Promoting Interoperability Programs (PIP).[330] DC currently participates in PIP, for which use of CEHRT is a condition that providers must fulfill to receive incentives. However, the final year for program participation is 2021. The ONC's 2021 Open Notes rule will update and expand the operating standards and data-sharing requirements for EHRs to become or remain ONC Certified.

Telehealth

Due to the COVID-19 pandemic, the District has made significant progress in advancing telehealth delivery and guidance during this past year. Many of the telehealth regulations that were relaxed during the public health emergency were made permanent through DHCF rulemaking, and the FY21 Budget Support Act made updates to the

DC Code of Law (See DC Code of Law 29 DCMR § 910). Some changes include allowing reimbursement for services when the individual receiving care is in the community and not in a health care facility and allowing reimbursement for audio telehealth. With the increase in telehealth use, the District must ensure families are provided with additional support to access cellphones with talk and data plans, Wi-Fi in homes, and internet broadband service capable of delivering tele-video for telehealth services. MCOs are also responsible for ensuring reimbursement of telehealth services as written in their contracts: "Telemedicine C.5.28.33.1 The Contractor shall cover and reimburse healthcare services delivered through Telemedicine, in accordance with 29 DCMR § 910." Before the COVID-19 pandemic, the District supported telehealth reimbursement practices, having passed the D.C. Telehealth Reimbursement Act of 2013, which requires Medicaid to "cover and reimburse for healthcare services appropriately delivered through telehealth if the same services would be covered when delivered in person."[331]

mHealth

Currently, the use of mHealth applications and tools in the District of Columbia are not widespread and not reimbursed or a part of the Medicaid fee schedule. The use of those types of technologies for behavioral health is relatively new in the District. For example, AmeriHealth Caritas DC, an MCO contracted in the District, partnered with Mindright to provide text-based coaching to youth ages 13–25, particularly youth with Medicaid and/or impacted by trauma. Mindright is a low-barrier access point to engage youth in emotional support services. The service was formally rolled out with enrollees in July 2021 but was piloted with AmeriHealth's youth wellness advisory council pre-pandemic with overall positive feedback. Because coaching is not a Medicaid reimbursable service, AmeriHealth provides this service as a value-added benefit to its enrollees. Youth using Mindright, have access to coaches (supervised by licensed clinicians) via text anytime they like to discuss support strategies related to topics such as managing stress and depression. Coaches are able to connect youth with AmeriHealth's care coordination team if clinical services are needed and are able to escalate to school-based mental health providers and ChAMPs when necessary. AmeriHealth has also recently partnered with Ginger[332] to provide on-demand mental health support to its enrollees.[333] Ginger offers text based coaching as well as mindfulness, counseling, and psychiatric services via telehealth. The telehealth services offered are Medicaid reimbursable, and AmeriHealth covers the coaching as value added services for its enrollees.

Additionally, the District has made progress in the use of mHealth for pregnant and new mothers. The DHCF partnered with text4baby, in which expectant or new mothers can register to receive free text messages with information about caring for their babies' and their own health.[334] AmeriHealth Caritas DC has also partnered with Babyscripts (also partners with George Washington University and MedStar Washington Hospital Center OB practices) to provide a remote monitoring maternal health care app to its pregnant enrollees.[335] The digital tool recently added a maternal mental health component to its app that provides depression screenings and perinatal health resources. Improvement on health outcomes is measured by using the HEDIS measures. Mayor Bowser also recently announced, during the fourth annual National Maternal and Infant Health Summit, a partnership with Canopie to provide free access to its research-based maternal mental health program and app focused on prevention and treatment of perinatal mood and anxiety disorders.[336] Further, a comprehensive study of Wyoming Medicaid's Due Date Plus app used by enrolled pregnant women estimated a 3:1 return on investment (ROI) based on cost avoidance. Benefits of participation included earlier initiation of prenatal visits and fewer preterm births.[337] Preterm births are correlated to a host of physical, behavioral, and intellectual complications throughout childhood and into adulthood, so reducing preterm births has widespread health and economic consequences.

Last, to advance the use of mHealth technologies in the District, the George Washington University established an mHealth Collaborative, an interdisciplinary group that has received grants from government, industry, and private foundations to develop and test mobile health applications for improving health.[338]

8.3 Gap Analysis

1. Different data systems with functional limitations

In stakeholder interviews, behavioral health providers reported challenges with current behavioral health data exchange, including exchanging data manually through fax.[325] They also reported that data is often stored across multiple systems, including iCAMS and DataWITS, which do not offer data sharing capabilities.[325] The District does not have a true BHIS because behavioral health information processing is fragmented, with different health care organizations and government agencies using different information systems. That produces multiple, parallel information streams for specific facilities and populations that are not integrated. The issue of integration is especially challenging for many behavioral health providers who are not using certified EHRs.

2. Insufficient adoption of the District's HIE and EHRs by behavioral health providers

There is insufficient uptake among behavioral health providers in participating in the District's HIE system, CRISP DC. The National Council's Behavioral Health Organizations' Adoption of Health IT and Readiness for Meaningful Use survey explored reasons for low adoption rates of EHRs by behavioral health providers.[339] Providers' two main reasons were lack of financial incentives and lack of trained health IT staff. That was particularly true for smaller behavioral health provider organizations that shared concerns around administrative burden and lacking the resources to implement and maintain an EHR system. Another concern expressed was the need for specific technical assistance that addresses behavioral health providers' needs and incorporates use of EHR into practice.[339] Additionally, MACPAC's report Integrating *Clinical Care through Greater Use of EHRs for Behavioral Health* outlines similar barriers to adopting CEHRT among behavioral health providers, such as the lack of guidance/assistance on which EHR product to purchase that will best meet the needs of their behavioral health practice and costs related to purchasing and installing the system and training staff.[337]

3. The District's HIE functionalities do not fully align with behavioral health providers' and agencies' needs

The following outlines key missing functionalities in CRISP, the District's HIE:

- **Privacy and data-sharing laws:** Federal law and regulations limit the exchange of behavioral health data/information without a patient's express consent. Additionally, 42 CFR Part 2 rule limits/prohibits the sharing of substance use information. Current HIE and EHR systems in the District were not designed with security components for handling confidential behavioral health information and would need an explicit behavioral health consent form built into the system for patients to either opt in or out of sharing their behavioral health information, as well as data segmentation, which enables the patient to choose which information can be shared. Although CRISP gives patients the ability to opt out of sharing their behavioral health information, it does not yet allow data segmentation, in which patients can choose specific information to share. Therefore, if a patient does choose to opt out, none of their health information will be shared. CRISP does not accept or share any SUD information and also currently lacks the capabilities to electronically capture and manage the necessary written consents.[341] However, DHCF and CRISP are in the midst of a project to build consent management technology into CRISP to overcome this barrier.
- **Care coordination, social determinants of health, and social services:** CRISP does not support care coordination between behavioral health providers, CBOs, social service organizations, and physical care providers. To facilitate greater care coordination using Health IT, CRISP needs to include a standard system to facilitate referrals between multiple entities in which the patient receives services. The CoRIE project mentioned in the Current System section of this chapter is currently working on streamlining social determinants of health data sharing and integrating CBOs' data collection systems into CRISP, but it still needs to develop the functionality that would allow for use of SDOH and behavioral health screening results to connect with CBOs.

- **Population health data analytics:** There is a separate set of software tools that reconfigure data out of EHR and claims data to help people understand how the individuals enrolled in their practice are collectively experiencing their health services and care (for example, how to understand chronic disease management and current acute-level situations). There is currently very little available to all District provider organizations that work for behavioral health at a population and systems level.

4. Inadequate District-specific research and guidance on mHealth in behavioral health care

While apps and other mobile technology is plentiful, little to no connection has been made to formalize mHealth within the District's health system as a formal aspect of behavioral health care. Organizations, such as AmeriHealth Caritas DC, have begun to implement use of digital tools for behavioral health that serve as a low-barrier access point to resources and coaching (i.e., Mindright and Ginger mentioned in Section 8.2) that can increase engagement and utilization of behavioral health services. However, those opportunities are early in their implementation and strategies to increase buy-in among enrollees, and providers are essential for scalability. Further, many of the services, such as coaching, are not currently Medicaid reimbursable.

The District could encourage more research into mHealth best practices that parallels this growing field. While mobile apps have multiplied immensely and cellphone use among the general population and adolescents especially has become almost universal, quality research of mobile apps and other mHealth tools is severely lacking.[315] Seeing as mobile technology is not bound by District boundaries, this gap is not unique to DC but is relevant to the utilization of any tools in a clinical setting or with quality metrics of an MCO. As the District explores avenues for growth in mHealth, there will be a need to update relevant policies and financing structures. There is no ability to bill for mHealth services outside of telehealth.

5. Disparities in access to broadband, Wi-Fi, and mobile devices affect sustainable access to telebehavioral health

While DC has made great progress in closing the digital divide[342] through initiatives such as DC-Net, DC Broadband Education Training and Adoption,[343] and Tech Together,[344] critical gaps remain. In particular, a great deal of progress that the District has made in promoting digital access has been accomplished through temporary federal funding.[343] Given the time-limited nature of this funding, the long-term future of the District's digital infrastructure is prone to falling into the longstanding pattern of digital disparities fostered by systemic inequities. More generally, there is a dearth of published literature on the factors enabling digital disparities in DC and potential mechanisms for reducing them.

Of note, the digital divide was exposed and exacerbated during the COVID-19 pandemic,[345] prompting the District's more recent attempts to reduce disparities in access to the internet and technology. One such initiative is Internet for All for DC students, which provides eligible children access to one year of free at-home internet and is dependent on funding from the CARES Act. According to the American Community Survey 2019 one-year estimates, approximately 7.6% of DC households did not have an internet subscription.[346] While one-year of internet will be beneficial to many children, it does not represent a sustainable solution for telehealth access.

6. Limitations on telebehavioral health created by licensure requirements

One of telebehavioral health's most impactful benefits is the ability to connect people with behavioral health providers at a distance. However, federal and state licensing laws may limit the geographic scope of telebehavioral health by only allowing patients access to providers who have a current license in the jurisdiction where they reside.[xxii] However, the COVID-19 pandemic brought the need for both more behavioral health services and for people to be able to access them in a safe manner to avoid exposure to the coronavirus. That required federal and

[xxii] *For example, if a clinician is located in Maryland but is providing services remotely to a patient in Washington, DC, via telebehavioral health, the provider must be licensed in the District, the place where the patient is located. See Removing Regulatory Barriers to Telehealth Before and After COVID-19; Brookings; 2020.*

state governments to take actions to allow for this necessary expansion, which included waiving the previously stringent licensing requirements to allow providers to treat people remotely in other states.

During the public health emergency in the District, DC Health waived the licensure requirement for health care providers who held an appropriate license in good standing in another jurisdiction.[347] This allowed providers licensed elsewhere to connect with District residents even if the provider was not licensed in Washington, DC. It allowed the reach of telebehavioral health to grow and become more accessible for District residents. Now that the public health emergency has ended in the District, the licensing waiver has expired.[xxiii] However, the DC Council is looking to take legislative action that may extend the period of licensing.[348] That could impact many providers' ability to continue to provide the virtual services that they have been delivering for the past year due to needing to be licensed within the District. That also puts the continuum of people's behavioral health care at risk, as well as future access to more expansive and accessible telebehavioral health services.

7. Timely access to discharge summary information within CRISP is insufficient to meet District residents' needs

Currently, the time it takes for providers to receive detailed discharge information from hospitals through the EHR is insufficient to meet District residents' needs.[109] This process is often too slow, taking anywhere from a few days (on average five days) up to a month.[109] The HIE Policy Board, CRISP Inc., DC Hospital Association, hospital providers, and DHCF are currently working to address this gap through potential improvements to clinical and technical workflows. According to findings submitted by the HIE Policy Board Operations, Compliance, and Efficiency (OCE) subcommittee from an analysis conducted in October 2019, only about half of discharge summaries were submitted through CRISP within 48 hours, and discharge summaries are not always complete.[349] The time it takes for community-based behavioral health providers or other health professionals involved in a patient's care to receive critical information regarding discharge can delay timely access to follow-up care as well as impact care coordination and effective transition of care planning.

The HIE Policy Board OCE Subcommittee found that the main reason for the delay in discharge information being shared with CRISP is that hospital providers, due to national standards, have up to 30 days to finalize and sign encounter notes.[350] However, through the Promoting Interoperability program, CMS requires patients to have access to their electronic health information via a patient portal within two business days of discharge; therefore, unfinalized data is already being shared.[350] Further, CRISP policies do not currently allow for the exchange of unfinalized summaries.[350]

[xxiii] *Those practicing in DC under a licensure waiver lost permission to practice on September 25, 2021, 60 days after the end of the public health emergency. Regional Update: Interstate Telemedicine Waivers During COVID-19; Montgomery County, MD Medical Society; 2021.*

8.4 Recommendations

1. Implement strategies to improve participation and use of CRISP by behavioral health providers.

Implementing Bodies: DHCF, DBH, HIE Board, CRISP DC
Timeline to Implementation: Long Term

Strategies should include:

- **Financial incentives:** Provide financial incentives through the use of grants or other funds to support behavioral health providers adoption and use of HIE. Since behavioral health providers were left out of the CMS Meaningful Use EHR incentives, other alternative means should be developed at the state and local levels. Those could include providing grants to cover the cost of buying an EHR or establishing rate-setting methodologies that support creating a position for a dedicated IT staff person, particularly for smaller organizations.
- **Technical assistance:** Although technical assistance has been offered through Enlightened Inc., further technical assistance and education on specific behavioral health workflows and implementation should be offered to providers. Education to providers should also include development of use-case scenarios specific to behavioral health and adolescent health information.
- **Education and guidance:** Both should also be provided to patients regarding HIE, opt-in/opt-out consent options, and privacy laws and rights using clear and concise language. Similarly, primary care providers and other non-behavioral health providers should receive education on behavioral health privacy and data-sharing laws to understand what information can and cannot be shared and how to have conversations with people they serve to consent to share all, some, or none of their protected health information, with a bias toward helping people to understand the benefits of data sharing. IT vendors will also need education on privacy laws and how behavioral health data should be managed when developing tools for HIE, particularly as it relates to 42 CFR Part 2.

As DHCF and the HIE Policy Board update the State Health IT Plan for the next five years, a greater emphasis should be placed on behavioral health data sharing and technologies.

2. Develop and improve CRISP functionalities to meet the needs of behavioral health providers and relevant government agencies.

Implementing Bodies: DHCF, DBH, HIE Policy Board, CRISP DC
Timeline to Implementation: Medium Term

- **Privacy and data sharing:** Given recent changes to regulatory guidance and federal requirements, such as the open notes rule mandated by the 21st Century Cures Act and changes made to 42 CFR Part 2 regulations through the CARES Act, and as new changes occur, CRISP DC, DHCF, and the HIE Policy Board will need to continuously enhance CRISP system functions and capabilities to reflect these changes. That will require the District to update its own HIE policies as new regulatory guidance

is released. Providers will need technical assistance to update their electronic systems, workflows, and privacy notifications to adjust as each of those changes occurs. A public awareness campaign explaining the changes, including how they impact consumers; what they need to know; as well as when, how, and what consent is obtained, should also complement those changes.

- **Care coordination, social determinants of health, social services, and other organizations/public agencies:** Develop the capability of the CRISP system to integrate CBO and social service organizations' data to facilitate care coordination and decrease duplicative reporting. For example, the CRISP system should have the capabilities to allow all care team members, including paraprofessionals (e.g., peer support), to be able to view, report, and share information. When documenting, practitioners (including care coordinators, case managers, and peer navigators) should include detailed notes and information, such as services the family has already received, engagement strategies that have already been tried with the family, what has worked well, what has not worked well, barriers specific to the family, etc. Similarly, the CRISP system should be used to facilitate information and data sharing across other child-serving systems, including CFSA, DYRS, ICH, school systems, etc. That may include developing data-sharing agreements and adopting a universal consent form but will also require alignment across agencies and organizations. By integrating data and increasing information sharing across systems, this will help to bridge the gap across systems of care, reduce duplicative screenings and other procedures, and reduce administrative burden for providers by having one system to access information.
- **Population health data analytics:** For providers and government agencies, it is important for CRISP to facilitate aggregated data collection, analysis, and publication to facilitate system-level learning. Part of the steps to achieve that involves cost (e.g., developing or buying and implementing the necessary technology tools, hiring, training, and retaining staff), as well as having the workforce and policies in place to respond to the data analytics and group-level data.

3. Remove barriers and increase incentives to collect and exchange behavioral health data through EHR systems that are interoperable with CRISP.

Implementing Bodies: DHCF, DBH
Timeline to Implementation: Long Term

Interoperable patient data can streamline patients' service utilization and improve patients' experience. Given this, all EHRs used by BH providers should be interoperable with appropriate systems, especially the District's HIE. To encourage certified EHR adoption by behavioral health provider organizations, the DC government should provide financial incentives. We recommend the following EHR-related recommendations based on the findings from a national BH roundtable on *Using Information Technology to Integrate Behavioral Health and Primary Care* be considered:

- EHR systems need to be enhanced to include clinical decision support related to behavioral health, such as clinical decision support for Medicaid-assisted treatment and treatment recommendations based on screening and assessment results. Specific fields related to treatment plans, goals, and referrals should be included instead of one section for progress notes, as well as specific language and terminology related to behavioral health to support behavioral health documentation in EHRs. That may also require rebalancing expectations regarding creation of unique documentation for each person

served, which supports person-centered care versus use of standardized documentation elements consistent with evidence-based or evidence-informed standards of care.

- As of July 2021, the United States Core Data for Interoperability (USCDI) released new standards for data classes and data elements that should be included in EHR systems and the HIE, as mandated by the Cures Act. Examples include clinical notes (i.e., Consultation Note, Discharge Summary Note, History & Physical, Procedure Note, Progress Note); care team members (i.e., Care Team Member Name, Care Team Member Identifier, Care Team Member Role, Care Team Member Location, Care Team Member Telecom); goals (i.e., patient goals, SDOH goals), medications, problems (i.e., SDOH Problems/ Health Concerns, Date of Diagnosis, Date of Resolution); assessment and plan of treatment;[xxiv] etc.[351] The rule also requires patients to have direct access to their electronic health information. Behavioral health providers, primary care providers, and other providers that maintain EHRs will need to ensure compliance with this rule to increase interoperability across EHR systems, which will help to increase patient access to their digital health data as well as increase care coordination.
- Develop standards and functionality to manage referrals within EHR systems and across care settings. Examples include appointment reminder features, alerts to providers regarding missed appointments and prescriptions not refilled, scheduling real-time referral appointments, etc. The ability to assign an individual to manage follow-up for the patient should also be developed.

4. Equitable access to broadband, Wi-Fi, devices, and other components necessary for telebehavioral health use.

Implementing Bodies: DHCF, DBH, Office of the Chief Technology Officer (OCTO)
Timeline to Implementation: Long Term

While the District's efforts to make technology more accessible are important, it is essential that long-term investments are also made to address the underlying structures enabling the digital divide. Further, there are a number of often-overlooked components necessary for effective telehealth service delivery that must be addressed.

- Conduct local, community-based research that identifies the underlying mechanisms enabling persistent disparities in DC's digital access.
- Partner with libraries or community organizations to provide safe, private, and comfortable spaces for telehealth users who are experiencing homelessness, experiencing housing insecurity, or otherwise lack access to these spaces.[352]
- Partner with local technology developers to create innovative and sustainable solutions to telehealth use barriers, such as the development of low-cost broadband and Wi-Fi technology.
- Subsidize mobile device repair and trade-in programs.[353]
- Identify and encourage adoption of Culturally and Linguistically Appropriate Service Standards relative to telehealth services and provide guidance for their use.[352]

[xxiv] *Includes SDOH Assessment Structured evaluation of risk (e.g., PRAPARE, Hunger Vital Sign, AHC-HRSN screening tool) for any Social Determinants of Health domain such as food, housing, or transportation security. SDOH data relate to conditions in which people live, learn, work, and play and their effects on health risks and outcomes. See United States Core Data for Interoperability; the Office of the National Coordinator for Health Information Technology; 2021*

5. Provide technical assistance to the District's behavioral health providers to support the provision of ethical and high-quality telehealth services.

Implementing Bodies: DHCF, DBH
Timeline to Implementation: Short Term

With increasing use of telehealth services, the government must establish the organizational mechanisms, including technical assistance to providers, needed to sustain the delivery of high-quality, evidence-based, and equitable telehealth services. The need for technical support was highlighted in a recent study examining behavioral health provider perspectives on the use of telehealth in Michigan.[354] The study concluded that further training in service provision can improve quality of care. Another relevant study evaluated a systems-wide telehealth training for behavioral health providers, which included information on evidence-based practices, ethical factors, technology considerations, documentation processes, determining when telehealth is appropriate, and crisis management planning.[355] That research noted that behavioral health providers were interested in continued training opportunities beyond an initial telehealth training.[355] Further, considering that the use of telehealth for behavioral health services for children has therapeutic limitations and physical limitations,[356] technical assistance must include tailored support to behavioral health providers who serve children.

6. Encourage use of mHealth by behavioral health providers and MCOs.

Implementing Bodies: DHCF, DBH
Timeline to Implementation: Long Term

DHCF should consider innovative ways to expand access to Medicaid reimbursable behavioral health services through mobile technology. Those could include partnering with organizations currently piloting behavioral health digital tools in the District to examine data on cost savings and improved outcomes. DBH and DHCF should also regularly review the technological landscape, including mHealth tools, to determine what is available, applicable, and appropriate to behavioral health service delivery for children. That should also include regularly published guidance to behavioral health providers and MCOs on how to integrate mHealth into health promotion and behavioral health treatment. Providers in the District's behavioral health managed care system should permit and encourage mHealth tools using the 3 Security Rule standards as articulated by the American Psychiatric Association, employed appropriately and reasonably. They should cover administrative, physical, and technical safeguards.[357] The District or MCOs should offer regular training to providers on optimally integrating mHealth tools into their practice at the beginning, middle, and end of behavioral health care to increase utilization of this community benefit and improve patient outcomes where they can be directly applied to care.[324]

7. Expedite District licensing requirements to meet the demand for telebehavioral health.

Implementing Bodies: DC Health Professional Licensing Boards
Timeline to Implementation: Short Term

With the expansion of telebehavioral health due to the pandemic, maintaining and continuing the growth of service delivery via telehealth has necessitated changes in licensing policies to preserve the accessibility to behavioral health services that cross District borders.[358] To address the limitations created by current licensure requirements in the District, the DC health professional licensing boards could take several approaches.

First, some advocates have been pushing for states to extend pandemic rules regarding cross-state licensure. Arizona, for example, made permanent rules based on pandemic protocols that allow for out-of-state medical providers to practice telehealth for residents so long as they register with the state and their home-state licensing is in good standing.[359] Therefore, the District in line with Arizona could make the temporary COVID-19 licensure waivers permanent and allow professionals outside of the District to be able to waive in and serve District residents as long as they are in good standing in their home state.

Second, DC health professional licensing boards should also consider adopting the model of expedited endorsement.[360] That would require the licensing boards to set criteria that would allow those who qualify to receive a license to practice in the District at an accelerated rate.[360] For example, in Iowa, if a person qualifies for expedited endorsement per the set criteria, they submit fewer application items as part of the licensure process, thus allowing a more speedy acceptance to practice in Iowa.[361] The average amount of time taken to receive an Iowa license is 60–90 days.[362]

Regardless, as recommended in Chapter 6, while the DC health professional licensing boards are reviewing licenses of individuals who hold one in another jurisdiction, by default those awaiting review should be allowed a provisional right to practice for 120 days while waiting for District license application approval or denial. That will allow applicants who hold licenses elsewhere to begin practice as soon as possible while giving the licensing board time to complete any application review that it requires.

8. Ensure timely access to discharge summaries with CRISP.

Implementing Bodies: DC HIE Policy Board, CRISP DC, DC Hospital Association, Hospital Organizations
Timeline to Implementation: Short to Medium Term

To increase timely access to follow-up care and facilitate effective transition planning and care coordination, hospitals need to reduce the amount of time it takes to send a patient discharge summary from hospital EHRs to the CRISP system for next-care providers to access. The HIE Policy Board OCE Subcommittee, CRISP, DHCF, DC Hospital Association, and hospital providers have explored several strategies to standardize hospital discharge summary information and increase real time access to this information upon discharge, and are continuing to work to improve the necessary clinical and technical workflows.

The HIE Policy Board OCE Subcommittee suggested the following transition of care data elements should be prioritized for exchange in the District Designated HIE to facilitate an effective transition of care at the time of discharge: discharge diagnosis, discharge medications, reason for visit, and medication allergies.[xxv] Hospital organizations should ensure at a minimum that those data elements are made available within 48 hours of discharge, in alignment with federal guidance that requires patients to have access to their electronic health information within 48 hours of discharge. The District should adopt that new timing expectation as providers transition to the USCDI file format for this type of information.

[xxv] *For additional details regarding the HIE OCE's plan for prioritizing and phasing in transition of care data elements, see Recommendation on Transition of Care Data Elements; District of Columbia Health Information Exchange Policy Board; 2020.*

9. SPECIAL POPULATIONS

There are specific populations of children within the District who require special consideration and tailored behavioral health services due to social and environmental risk factors, as well as increased barriers to accessing quality care.

Each subsection of this chapter will discuss one of eight special populations of children in DC, as follows:

9.1 Children With or At Risk for Autism Spectrum Disorder
9.2 Children in Foster Care
9.3 Children Experiencing Homelessness
9.4 Children Who Identify as LGBTQIA+
9.5 Youth in the Juvenile Justice System
9.6 Transition Age Youth
9.7 Prenatal to Age Five
9.8 Children Who Speak Languages Other than English

This will be followed by a final subsection highlighting recommendations for these special populations.
While these populations will be discussed separately, it is important to note that there are significant intersections among these special populations. Additionally, many special populations have complex behavioral health needs, which cross numerous agencies with separate objectives for the child or family. Therefore, developing a well-functioning system of care[xxvi] is essential to break down silos and better meet the behavioral health and related needs of children.

Although this chapter focuses on eight key subpopulations of children, it does not comprehensively capture all subpopulations of children who require special consideration. Other special populations include, but are not limited to, children who are hard of hearing, children who are not literate, children who are refugees, and children with parents/caregivers who are veterans.

9.1 Children With or At Risk for Autism Spectrum Disorder

A current landscape of behavioral health services available for children with or at risk for Autism Spectrum Disorder (ASD) is outlined in a report titled Current Landscape of Behavioral Health Services for Children with Autism Spectrum Disorder Insured by Medicaid in Washington, D.C. by the Community Mental Health CORE (Collaboration, Outreach, Research, Equity) at Children's National Hospital. Some key landscape features that were highlighted in the report are noted below.

In 2017, the Individuals with Disabilities Education Act (IDEA) estimated that the prevalence of ASD at 1.3% for youth ages 3–21 in D.C., while the National Survey of Children's Health (NSCH) estimated the figure at 2% for youth ages 3–17 in 2017 and 2018.[363] More data is needed to estimate the current prevalence of ASD in children with D.C. Medicaid.[363] In 2012, the CDC estimated that the ASD prevalence in youth covered by D.C. Medicaid was 0.65%.[363]

[xxvi] *According to Painter et al. (2018), a system of care (SOC) framework provides a coordinated continuum of community-based services and supports for at-risk youth. It incorporates meaningful partnerships with youth and families and addresses individual cultural and linguistic needs through a supportive infrastructure.*

Recognizing limitations of currently available data and assuming that the actual prevalence is between 0.65% and the general D.C. youth ASD prevalence reported by NSCH of 2%, we would expect that there are likely between 585 and 1,800 youth covered by D.C. Medicaid with ASD.[xxvii]

In D.C., access to ASD evaluations are critically limited by extensive wait times, delayed referral processes, insurance gaps, and low reimbursements for D.C. FFS Medicaid. According to the DC Collaborative for Mental Health in Pediatric Primary Care, the average wait time for a formal ASD diagnostic evaluation is three to 24 months.[364] However, experts recommend that the wait time between referral and ASD diagnosis remain at or below five months.[365] That is critical because early identification of ASD in children is important to ensuring improved outcomes later in life.[366] Further, barriers to accessing ABA services present one of the greatest gaps in care for children with ASD in the District, largely related to the limited number of ABA providers who accept D.C. Medicaid.

To create a pathway to care within the school setting, D.C.'s Office of the State Superintendent of Education (OSSE) administers Strong Start, Early Stages, and special education and related services within public schools. Strong Start provides evaluations for developmental delays and implements early intervention services for children 0–3 years old. Early Stages provides Individualized Education Program (IEP), special education, and related services as needed for children ages 3–5. The public school system continues IEP and special education services for children with ASD throughout grade school.

Through a recently approved demonstration program ("Behavioral Health Transformation" section 1115(a) Medicaid demonstration), the District received authority to provide new behavioral health services and enroll specific professionally licensed individuals to be reimbursed by the Medicaid program between January 1, 2020, and December 31, 2024. The waiver left an unchanged current policy relative to ASD services, due to explicit language in the District's 1115 waiver that states, "services associated with screening or treatment of Autism Spectrum disorders by these behavioral health care providers is not included."[367] However, the District is taking initial steps to address that through the Neurobehavioral Health Program Enhancements, included in DHCF's fiscal year 2022 budget. That enhancement will allow licensed practitioners to bill Medicaid's FFS program independently for providing neurobehavioral health-related procedures.

Additionally, to address the barriers highlighted above, particularly the need for a public-private District task force for ASD, the DC Autism Collaborative (DC-AC) was launched in summer 2020. The DC-AC is a multidisciplinary, public-private coalition of community organizations and District-wide convening groups, local government agencies, health care professionals, health insurance plans, advocacy organizations, and parents to strategically address barriers to ASD care and advocate for solutions that will increase early and equitable access to high-quality ASD diagnosis, treatment, and coordinated care. Based on a needs assessment survey conducted in early fall 2020, four subgroups were created (Policy; Developmental Monitoring, Screening, and Evaluation; Education, Outreach, and Engagement; and Early Childhood Transition Points). While the DC-AC addresses the need for a District-wide task force, it currently relies on philanthropic funding and therefore will need more sustainable funding mechanisms to continue.

9.2 Children in Foster Care

According to the American Academy of Pediatrics, behavioral health is the largest unmet health need for children and youth in foster care nationally.[368] That is due to a variety of reasons, such as experiencing ongoing and complex trauma; lack of stable presence of—or relationship with—at least one nurturing, responsive caregiver; disruptions in routines or constant life transitions; family relationship problems; and increased use of psychotropic medications for this population. Recent local statistics support high behavioral health needs among youth in foster care—in the District, 95 children, or 14% of all children in foster care (mostly females), have required psychiatric hospitalization, and 28 children, or 4% of all children in foster care, having spent time at a psychiatric residential treatment facility in FY 2020.[xxviii] While

[xxvii] *These figures are extrapolated using the DHCF approximation of the number of children enrolled in D.C. Medicaid, which is 90,000.*
[xxviii] *In FY2020, 693 children total were in foster care. "Performance Oversight Hearing Fiscal Year 2020-2021, 'Child and Family Services Agency,'" Government of the District of Columbia, 2021*

DC has noted a recent decline in the number of children in foster care, with 693 children in foster care in December 2020 compared to 1,542 children in FY 2012, it remains important to ensure that this population continues to receive accessible, high-quality behavioral health services.[369, 370] DC Medicaid, currently through its FFS program, extends coverage to foster youth under age 21 who meet eligibility criteria, including DC residency, U.S. citizenship or eligible immigration status, and enrollment in DC foster care under CFSA custody.

In 2018, CFSA implemented the Mental Health Redesign, a change in practice to attempt to expedite and improve access to mental health treatment by providing in-house services to children in foster care.[371] Under the redesign, there are two main components to CFSA's behavioral health services for children in care.

- First, CFSA's Office of Well Being (OWB) now provides four dedicated in-house therapists as well as one psychiatric nurse. OWB screens, assesses, diagnoses, and provides short-term mental health treatment to children entering care.[xxix] It is important to note that CFSA in-house services are meant to be short-term (three to six months with the ability to extend to 12 months) mental health treatments that children need when they first enter or re-enter foster care.[371] In FY 2020, CFSA in-house mental health clinicians served 90 children.[370]
- The second component of CFSA's behavioral health services is for children in care who are determined by the CFSA in-house team to need more or longer-term services. If so, the child will be referred to DBH for behavioral health services. CFSA currently contracts with MBI Health Services, LLC., a DBH Core Service Agency. In FY 2020, 16 of the 90 children receiving in-house services were referred to MBI.[370]

For a child in care to be connected with behavioral health services, they must complete several steps.

- First, a child in care must receive a mental health screening and assessment, which are conducted in-house at CFSA. In FY 2020, 16% of the children entering care who were eligible for mental health screening did not receive the screening within 30 days of entry into care.[370] And for the 84% of children who did receive a screening within 30 days of entry into care, it is unclear when exactly they received the screening.[370] The longer it takes to screen a child, the longer it takes to execute the next steps in the behavioral health continuum for children in care.
- The second step, which is the time to link children with a provider, is typically short. Children referred to DBH are typically linked to a CSA on the same day of receipt of the referral.[369]
- The third and final step is the time of linkage to receipt of the first service. That is where a majority of issues in access delays arise. In FY 2020, 141 children and youth involved in foster care were referred for mental health evaluations through DBH. However, in FY 2020 the time to link for receipt of a first service with DBH was 41 days.[372] As for CFSA, the average time between mental health evaluations and the delivery of services is 28 days in FY 2020.[370]

It is important to note that part of CFSA's redesign can involve switching providers for children in care. Switching providers disrupts therapeutic alliance, can cause a loss in treatment momentum, and impacts the outcomes of behavioral health treatment.[373] In practice, the child will be doing well with the CFSA provider but then must transition to a DBH provider because the maximum amount of time OWB can serve a child has been met. CFSA and DBH know this transition is coming; however, it still takes a long time to link the child with a new provider. It is not only a lapse in treatment because of connection time, it is also a lapse in services, because the child has experienced a loss of one provider and must build rapport with another provider. It is imperative to note that children in care are already struggling with loss; therefore, other types of transitions and changes are more difficult with which to cope. Adding another loss (that of the therapist) in the child's life, due to bureaucracy, does not contribute to the therapeutic healing process.

The feeling of loss due to access delays in behavioral health can make it difficult for a child to stay engaged in behavioral health services. In discussion with stakeholders who have expertise in this area, it can be very difficult, especially for older youth, to re-engage in behavioral health services when there are delays in connecting them with

[xxix] *The CFSA in-house services include a variety of therapy modalities including child-centered play therapy, grief and loss therapy, cognitive behavioral therapy (CBT), Trauma Systems Therapy (TST), Functional Family Therapy (FFT), Trauma Focused Cognitive Behavioral Therapy, Multisystemic therapy, child parent psychotherapy, and Parent Child Interaction Therapy (PCIT).*

providers. It is also unclear that CFSA is achieving its own goal of avoiding significant delays connecting children to necessary behavioral health treatment. As of now, a child does not receive CFSA-delivered treatment substantially more quickly than if the child was simply referred to a DBH provider.[xxx] Additionally, there is the complication that the child still may be subject to transfer to a DBH provider later on, which could result in disruption to continuity of care. That process ultimately moves further away from the goal of quickly connecting a child to necessary behavioral health services.

In addition to DBH clinicians and the internal CFSA mental health therapists, there are other services in the CFSA behavioral health system, including prescribing psychotropic medicine to children in care. Historically, at the national level, overprescribing psychotropic medication has been prevalent among youth served by the foster care system,[374] [375] and anecdotally, that has been noted in the District. Experts have called upon child welfare systems to mitigate this problem by improving screening, assessment, and treatment planning, carefully taking into account safety concerns surrounding polypharmacy and overmedication.[376] For example, it has been shared that the current short appointment times of psychiatry can be extremely problematic, because it is very difficult to properly evaluate how medication is impacting a child and what changes need to be made. In addition, experts have emphasized the importance of shared decision-making and informed consent as well as prescription quality monitoring, which can help to alleviate polypharmacy and overmedication.[376]

Additionally, CFSA in collaboration with DBH provides substance use treatment. However, of the children in care who require substance use treatment, a very small percentage voluntarily receive initial treatment or engage with services. In FY 2020, 50 foster youth were referred by an Adolescent Substance Abuse Treatment Expansion Program (ASTEP) provider for a substance use assessment. Of the 50 youth, only seven agreed to assessments, of whom only five showed up to their appointments.[370] The current system for substance use treatment uses the Adolescent Community Reinforcement Approach, or A-CRA, and has substance use specialists who respond to any in-house substance use referral and provide substance use screening to determine the appropriate level of care needed.

Children from DC in foster care can also access crisis mental health services and supportive services. In recent years, CFSA has made several changes to the services it offers. Prior to FY 2019, both biological and resource parents had access to CFSA's Mobile Crisis Stabilization Services run by Catholic Charities. However, in FY 2019, CFSA and Catholic Charities refocused the services solely on resource parents.[377] That significantly reduced the number of calls that came in for Mobile Crisis Stabilization Services.[xxxi] At the end of FY 2020, due to underutilization, CFSA ended its contracted services with Catholic Charities and brought the services in-house under the Resource Parent Support Unit. For FY 2020, CFSA and its partners received 69 calls requesting crisis mobilization services (of which 45 calls resulted in a dispatch of services to the youth's location).[370] Further, CFSA partners with Courtney's House to provide trauma recovery to survivors of child sex trafficking and those at risk of sex trafficking, which includes 24-hour crisis intervention services.[370]

Other services CFSA offers include peer support to parents with children currently in the foster care system, with a goal of reunification. The peer specialists lead groups focused on topics such as fatherhood, co-parenting, addiction, and coping with mental health issues. Finally, to support older youth through intensive transformative mentoring and life coaching, CFSA partnered with the Department of Youth and Rehabilitation Services (DYRS) Credible Messenger Initiative.[370] Credible Messengers, who are full-time staff, foster daily intensive support through activities such as evening group sessions, support circles, and crisis intervention, with 24-hour support available.[370]

It is noteworthy that CFSA places some children in foster care in Maryland due to the small geographic borders of DC and the unique makeup of housing options. Children in foster care placed in Maryland foster homes remain eligible for services in DC and can also receive services from a CFSA-contracted mental health service provider in Maryland.[370]

[xxx] *According to the Department of Behavioral Health FY20-21 Performance Oversight Responses and CFSA FY20-21 Performance Oversight Responses, it currently takes 28 days for service to begin in-house at CFSA and 41 days for a child to be connected with DBH behavioral health services.*

[xxxi] *In FY19, the mobile crisis stabilization service received 41 calls, 16 of which required the dispatch of services. That was a significant drop as compared to FY18, where there were 219 calls and all required a dispatch of services.*

While availability may dictate short-term care planning, attention should also be paid to the complications these cross-boundary services can cause in the longer term. Issues and concerns include distance between placement and service provider or school services and the increased stress of long commutes during an already stressful time; placement instability and the consequence of either changing service providers or acquiring transportation; and transition of services upon reunification—this is not an ideal time to change providers, yet location and transportation options may limit the ability to continue with the current provider.

9.3 Children Experiencing Homelessness

According to the Metropolitan Washington Council of Governments, 1,420 children (below 18 years old) in DC experienced homelessness in 2020.[378] Over the past few years, the District has made significant strides in addressing and reducing homelessness, with a particular focus on youth homelessness to prevent adult homelessness. In 2014, the DC Council passed the End Youth Homelessness Act of 2014 and the LGBTQ Homeless Youth Reform Amendment Act of 2014. DC also established an Interagency Council on Homelessness (ICH) to help inform and guide strategies on meeting the needs of individuals and families who are homeless or at risk of becoming homeless in the District. To that end, ICH developed a comprehensive plan, called Solid Foundations DC, to end youth homelessness by 2022.[379] The Solid Foundations DC planning group is composed of DHS, ICH, an ICH Youth Committee, and a Youth Action Board that includes youth with lived experience of homelessness. In addition, DC Code 4-753.01 establishes a Continuum of Care for homeless individuals and families including crisis intervention, outreach and assessment, temporary shelter, permanent supportive housing for eligible individuals and families experiencing chronic homelessness, and services to reduce risk of homelessness for LGBTQIA+ youth.[377]

1,420

children in DC experienced homelessness in 2020.

The plan identified several of the special populations focused on in this report as being at greater risk of becoming homeless, including gay, lesbian, bisexual, pansexual, or queer/questioning youth; child welfare system-involved youth; and justice system-involved youth, who make up 31%,[381] 21%, and 24% of youth experiencing homelessness in DC, respectively.[382] Youth with unmet behavioral health needs were also identified as being at greater risk for homelessness. Additionally, homeless youth were more likely to experience higher rates of substance use and high levels of mental health disorders, as well as increased rates of suicidal ideation, suicide attempts, and deaths by suicide.[383] Some of the strategies identified to end youth homelessness in the plan include partnering with youth-serving agencies, DBH, and DHCF to increase behavioral health engagement and continuity of services through expanding services in nontraditional settings and identifying opportunities to ensure services are billable by Medicaid.[379]

DHS leads the District's response in addressing youth homelessness. DHS has a total of 210 beds to serve transition-aged youth (ages 18–24 years old) experiencing homelessness (of which 100 beds are specifically for youth who identify as LGBTQ).[384] If capacity is reached at youth-specific facilities for transition-aged youth (which occurred at two facilities in FY 2020), youth are referred to an adult program.[384] Sasha Bruce House, which has capacity to serve 15 youth, is the sole shelter bed facility for children below 18 years old. DC does not have any beds specifically reserved for youth under 18 years old who identify as LGBTQIA+. DHS provides direct grants to CBOs, which include Sasha Bruce, Latin American Youth Center, and Zoe's Doors. Those organizations provide services such as youth drop-in centers, which also provide help to access a variety of behavioral services (e.g., crisis intervention, conflict resolution, counseling services, etc.). Within housing facilities and drop-in centers, case managers are tasked with linking youth to community-based providers for behavioral health services.

DHS also provides the Youth HOPE program to transition-age youth who are homeless or at risk for becoming homeless.[385] Services include family counseling and mediation, workshops on mental health and supportive services, short-term crisis intervention and counseling, and short-term case management. LGBTQIA+ youth experiencing homelessness can also receive services, such as mental health services, substance use treatment, medical care, crisis intervention, and case management from housing programs offered through the Wanda Alston Foundation (i.e., Wanda's House in Ward 7 and Alston's Place in Ward 1) and the Supporting and Mentoring Youth Advocates and Leaders (SMYAL) Housing Program.[386, 387] Also available is Wayne Place, a transitional housing program funded through DBH and CFSA that offers educational and job training for transitional-age youth who would otherwise be homeless.[388]

Many of the programs for homeless youth are funded through local dollars, with some District providers receiving federal dollars to fill in funding gaps.[389] Additionally, the District was awarded $4.28 million dollars through the Department of Housing and Urban Development for the Youth Homeless Demonstration Program in FY 2020.[390]

A number of gaps exist in the behavioral health support system currently in place for children experiencing homelessness. As the ICH identified, housing stabilization services for precariously housed youth coupled with conflict resolution, skill development, and referrals to other community services could divert 5% of young people from homelessness, although the District does not currently offer such a program.[383] Further, due to the lack of homeless shelters specified for youth, many young people experiencing homelessness must use supports designed for adults, which may be unsafe.[383] A needs assessment conducted in 2020 noted that individuals experiencing homelessness found accessing DBH services difficult, given the extra steps required for enrolling in or recertifying for DC Medicaid without a home address.[391] Those steps were particularly challenging for individuals experiencing homelessness who had SUD, given that the disorder can affect decision-making capacities required for those tasks.[391] Further, despite the fact that LGBTQIA+ youth make up over 30% of the total number of youth experiencing homelessness, only 9% of youth housing programs have expertise in working with LGBTQIA+ youth.[392] As discussed further in Section 9.4, there is a need for targeted cultural competency training within homeless services given the challenges LGBTQIA+ youth face when using existing supports within the District. Many of these challenges highlight the need for additional research identifying factors that enable youth homelessness, which could help to strengthen the development and implementation of interventions to address youth homelessness.

In 2015, the District was one of the first cities to begin implementing an annual census documenting demographical data of unaccompanied youth experiencing homelessness.[383] Additional data on DC residents experiencing homelessness is available through the Homeless Management Information System. However, the full potential of District-level data to inform youth homelessness interventions has not yet been realized.

The current data infrastructures in place within the behavioral health, criminal justice, and foster care systems are siloed from the HMIS system. However, there are a number of models of data integration between HMIS and health care and social service systems within other states that have facilitated improved care coordination. The best examples of that type of integration utilize a central data warehouse or repository, working across sectors to establish secure data sharing protocols; those are discussed later in this chapter.[393]

It is important that relevant data are made available to care coordinators, homeless service providers, advocates, and other stakeholders who are essential to planning and coordinating efforts to end youth homelessness. In addition, making relevant homelessness and housing instability data publicly available, for example, through a real-time[394] online dashboard serves to inform local stakeholders in their efforts to address homelessness and increase public awareness and engagement with this problem.[395] While the DC Youth Count census data describing homelessness experienced by DC youth[382] is a critical step toward informing future interventions, there are limitations to this type of annual, point-in-time (PIT) data, which often inaccurately portray the state of homelessness given the transitory nature of the problem.[396]

Data suggest that homeless shelters can be unsafe for LGBTQIA+ youth, and instances of anti-LGBTQIA+ harassment, discrimination, and assault are not uncommon in these settings.[397, 398] There is a strong association

between health disparities faced by LGBTQIA+ populations and such experiences of victimization.[399, 400, 401] Relatedly, perception of safety is among the most robust predictors of suicidality and suicidal behaviors in transgender and gender nonconforming (TGNC) individuals.[402] As such, efforts to improve youth behavioral health outcomes should ensure that LGBTQIA+ youth feel safe when using DC homeless shelter services by enacting structural safety measures and adequate staff training. Below illustrates how homeless shelters can be made safe for LGBTQIA+ youth.

Safe Shelter Components

- Individuals are assigned to shelter accommodations (e.g., use of gender-specific restrooms) that feel safest to them based on their gender identity.
- Shelter staff do not disclose an individual's transgender status to other staff or clients.
- Physical accommodations allow adequate safety, including:
  - Restroom stalls that can be locked.
  - Shower and restroom doors/curtains that do not have large gaps, allowing adequate privacy.
  - Reasonable accommodations to requests for alternate shower or sleeping arrangements.
  - Monitoring of shower doorways or entrances to control entrance and exit as appropriate.
  - Availability of beds located close to night staff.
- Staff use preferred pronouns.
- Information about District anti-harassment and anti-discrimination policy is widely available and posted in spaces that are visible to staff and clients.

Source: "Model Policy & Legal Guide for Homeless Shelters & Housing Programs," Transgender Law Center, 2016

9.4 Children Who Identify as LGBTQIA+

This report uses the term LGBTQIA+ to describe individuals who identify as non-heterosexual or non-cisgender but may use other terminology that matches the source being referenced to maintain fidelity to research findings. We acknowledge and respect that appropriate inclusive terminology has been evolving.

LGBTQIA+ youth are at heightened risk for a number of adverse experiences, including homelessness[403] and peer victimization.[404] While representing 6.2% and 12.3% of DC's middle and high school youth population,[405] respectively, gay, lesbian, bisexual, pansexual, or queer/questioning youth in DC make up 31% of individuals experiencing homelessness under age 24 in DC[381] and are at increased risk for behavioral disorders, as demonstrated by both national and local data.[403, 405] In the same vein, data from the 2019 DC YRBS survey shows that LGB youth are more likely to report suicidal ideation, suicide attempts, and substance use than their heterosexual, cisgender peers.[19]

Based on those increased risks, this population warrants specialized services to increase protective factors. Despite the heightened need for supportive services for DC's LGBTQIA+ youth, there are currently only a few programs and services dedicated to this population, mostly available through CBOs and hospital-based clinics. Further, existing supports are often inaccessible to LGBTQIA+ youth. As an illustration, a survey conducted by the health policy Kaiser Family Foundation found that twice as many transgender individuals (not specific to youth) in DC were uninsured than in the general population.[406] Because of heightened behavioral health needs met by a small supply of services, many of the District's behavioral health services that are tailored to the LGBTQIA+ community experience high volume and cannot accept new patients. Further, 3.4% more people identifying as LGBTQ reported being unable to see a doctor because of cost than non-LGBTQ individuals.[405]

Preventive services are also scarce. Although stressors common to the LGBTQIA+ experience, such as peer or family rejection and homelessness, are inseparably linked to behavioral health outcomes,[407] there is currently no District-

wide mechanism in place for systematically identifying LGBTQIA+ youth at risk for behavioral health concerns, such as the FAPrisk screening tool created by The Family Acceptance Project.[408] The FAPrisk screening tool is an evidence-based instrument proven to be highly accurate in predicting depression, suicide, and substance use risk in LGBTQ youth,[409] which can be integrated into the workflow of health professionals serving youth to identify the need for behavioral health services and inform service delivery and referral.[410] Relatedly, the need for safe spaces (defined as "a supportive and affirming environment for lesbian, gay, bisexual, trans/transgender, and queer (LGBTQ) students"[411]) was identified in family and youth engagement efforts through this project. The Trevor Project reports in its *2021 National Survey on LGBTQ Youth Mental Health* that access to safe spaces is linked to lower suicide attempt rates within the LGBTQIA+ youth population.[412] Further, there was a recent report that a number of LGBTQIA+ youth experiencing homelessness in the District claim having been victimized by homeless services staff or consumers as a result of discrimination and inadequate cultural competence training within those settings.[413]

The Trevor Project reports in its 2021 National Survey on LGBTQ Youth Mental Health that

Access to safe spaces is linked to lower suicide attempt rates within the LGBTQIA+ youth population.[412]

In addition to culturally tailored service settings, there is a need for treatment modalities tailored to the behavioral health needs of the LGBTQIA+ youth population. Specifically, evidence supports the use of behavioral health interventions that are designed to meet the needs LGBTQIA+ youth, such as adapted versions of commonly used treatments (e.g., Transgender Affirmative Cognitive Behavior Therapy) and other evidence-based interventions (e.g., Effective Skills to Empower Effective Men) that target sexual and gender minority stress[xxxii] as a driver of behavioral health risks in LGBTQIA+ youth.[414] However, a review of DBH-supported services and the wider behavioral health care system in DC reveals that these services are not currently provided in the DC area.

In 2005, through the Office of Gay, Lesbian, Bisexual and Transgender Affairs Act of 2005, the District established the Mayor's Office of Gay, Lesbian, Bisexual, and Transgender Affairs (MOGLBTA).[415] That office was created with the goal of empowering LGBTQ residents, addressing their concerns, and providing resources for at-risk LGBTQ populations through connecting LGBTQ residents to services and resources, hosting events, providing community grants, and advocating for beneficial programs and policies.

DCPS has also established a number of important initiatives to support LGBTQ youth, including the LGBTQ School Liaison program, which recruits school staff and places them in advocacy roles for LGBTQ youth attending DCPS.[416] Recruited LGBTQ school liaisons are trained in policy, health awareness, resources, and District events.[416] They distribute educational information, engage families of students, and coordinate LGBTQ school-based events.[416] Further, in 2011, DCPS submitted a plan to create an inclusive school community for LGBTQIA+ students and staff. Critically, this plan acknowledges heightened behavioral health risk within the LGBTQIA+ population and calls for DCPS to partner with DBH to provide Question, Persuade, Refer (QPR) suicide prevention trainings and a workshop offered by the Trevor Project focusing on LGBTQIA+ youth suicide prevention for school staff.[416] It also calls for DCPS to provide a workshop to school social workers informing them of community resources for LGBTQIA+ youth and training on its LGBTQ anti-bullying and anti-discrimination policies to all school administration and staff. Also important, it presses DCPS to offer skill-building resources for parents to foster family acceptance, which is critical to youth behavioral health.[417]

[xxxii] *According to Heredia et al (2021), "minority stress theory suggests that LGBTQ communities are at greater risk for mental and physical health problems because they face greater exposure to social stressors related to prejudice and stigma. Minority stress theory differentiates between distal (e.g., rejection, prejudice, and discrimination) and proximal (eg, internalized queer-negativity, expectations of social rejection, and perceived need for identity concealment) stress factors that accrue overtime, leading to chronically high levels of psychological distress, ineffective coping, and high-risk health behavior." See LGBTQ-Affirmative Behavioral Health Services in Primary Care; Primary Care: Clinics in Office Practice; 2021.*

Through a LGBTQ Health and Wellness Initiative grant from the Washington AIDS Partnership, Children's National established a Youth Pride Clinic, which provides comprehensive primary and mental health care to LGBTQ youth and young adults, ages 12–22. Other services include hormone replacement therapy, sexually transmitted disease/sexually transmitted infection treatment and PrEP (HIV prevention pill), individual and family therapy for transgender youth, and support and education about LGBTQ issues for families. The clinic care team includes a pediatrician, psychotherapist, and health educator. It also offers LGBTQ cultural competency training to health care providers in the District. As an extension of Children's National, the Youth Pride Clinic accepts DC Medicaid Managed Care insurance as well as a number of private plans within DC, Maryland, and Virginia.[418] Children's National also operates the Positive Reevaluation of Urogenital Differences (PROUD) Clinic, which specializes in treating differences of sexual development, providing resources to families and services such as psychological and psychosocial support, hormonal therapy, surgical reconstruction, etc. The PROUD clinic has an interdisciplinary team that includes a psychologist, psychiatrist, geneticists, endocrinologist, urologist, and gynecologists.

The Gender Development Program at Children's National provides developmental gender evaluation and consultation services for a broad range of gender diverse, transgender, and gender exploring children and adolescents.[xxxiii] Through its partnerships with the Divisions of Endocrinology and Pediatric Gynecology, as well as Adolescent Health, the Gender Development Program provides multidisciplinary youth gender care in the DC region, following the World Professional Association for Transgender Health (WPATH) Standards of Care.[419] The Gender Development Program also has a subspecialty program serving gender-diverse and transgender youth with neurodevelopmental differences through the Gender and Autism Program. The Gender Development Program and related multidisciplinary services accepts DC Medicaid Managed Care insurance as well as many of the private plans within DC, Maryland, and Virginia.

Whitman-Walker Health is a CBO with expertise in LGBTQ health services and HIV. It provides free mental health services to youth ages 13–24, including individual and group therapy, peer support and education, and a focus on trauma recovery and LGBTQ identities. Whitman-Walker accepts DC Medicaid Managed Care and FFS plans[420] and offers sliding-scale discounts for patients who are uninsured or under 200% of the federal poverty level.[421]

The DC Center for the LGBT Community offers individual and group trauma-informed mental health support services for LGBTQ survivors of violence and crime in the District. To receive services, the individual has to be at least 18 years. Individuals seeking services under age 18 are referred to Whitman-Walker or SMYAL. The counseling services provided are grant funded and free to those who are in acute crisis or do not have insurance or ability to pay. The program works with individuals to find providers in-network for those with insurance. Services include intake, triage, crisis stabilization and counseling, individual and group psychotherapy, continuity of care services, and social and peer support workgroups.

9.5 Youth in the Juvenile Justice System

In 2019, 1,550 youth under age 21 were involved with the District's juvenile justice system, down from 1,937 in 2017.[422] DYRS estimates that in 2018, 17% of youth involved in juvenile justice were 18–21 years old, 75% were 15–17 years old, and 8% were 14 years old or younger.[423] Juvenile-justice-involved populations experience significant need for behavioral health services. Research has established that juvenile-justice-involved youth experience a greater prevalence of SUD than their peers.[424] Further, an analysis of Medicaid claims data and Juvenile Social Files (JSF) conducted by the Criminal Justice Coordinating Council (CJCC) for the District of Columbia found that 96% of juvenile-justice-committed youth in DC met at least one DSM-V diagnosable behavioral health condition.[425]

1,550 YOUTH

In 2019, 1,550 youth under age 21 were involved with the District's juvenile justice system

[xxxiii] *The Gender Development Program was founded in 1997 at Children's National, and at the time of its founding, it was one of the first pediatric programs nationally for gender-diverse and transgender children.*

In 2020, the CJCC released the *A Study of the Root Causes of Juvenile Justice System Involvement* report, which found that some of the greatest factors impacting involvement include homelessness, childhood maltreatment, and experiencing ACEs. The analysis highlighted that 10.7% of justice involved youth in DC experience homelessness, 19.2% reported abuse, 49.1% reported neglect, 50.5% were suspended, 35.7% have comorbid disorders, 38.2% were eligible for an IEP, 6.4% have a psychotic disorder, 14.6% exhibit externalizing mental health disorder diagnosis, and 88.3% had Medicaid insurance for greater than one year.[426] In that report and in the CJCC virtual public meeting, "Responding to COVID19 and the Call for Racial Justice: A Conversation with Juvenile Justice Agencies," there was an acknowledgement of the need to address systemic racism in the juvenile justice system and criminalization of Black youth, given that justice-involved youth are predominantly Black (91%).[427] Additionally, the need for alternative strategies, such as de-escalation, conflict resolution, mediation, etc., were discussed to reduce school suspensions and use of courts. The Root Causes Analysis also conducted interviews in which it identified barriers to accessing services, such as the need to engage and market services and programs to families, ensuring that the person engaging families is culturally competent, ensuring that justice-involved youth continue to receive services in the community once they exit the system, increasing access to behavioral health and social service supports to families of justice-involved youth, helping youth and their families to navigate services, and minimizing requirements to participating in programs.[425]

DYRS is the agency that oversees justice-involved youth. The agency implements the Positive Youth Justice approach, which includes a focus on restorative justice, behavioral health, life skills development, conflict resolution, and relationship building. For court-involved youth, behavioral health staff are available on-site to provide behavioral health screenings and assessments, address behavioral health needs, monitor youth at risk for suicide or self-harm, and connect youth to evidence-based treatments, such as multisystemic therapy (MST) and functional family therapy (FFT).[428] MST is an evidence-based treatment currently provided through DBH for youth ages 12–17. In conversation with stakeholders who have expertise regarding the District's juvenile justice system, MST was acknowledged as something that is "desperately needed" for kids in the system and a critical way to keep children at home, in their community. However, there is currently only one provider organization providing MST, which is not enough to meet demand. Relatedly, the shortage of child- and adolescent-specific behavioral health providers (explored further in Chapter 6) also impacts justice-involved youths' access to behavioral health services in DYRS.

Another important gap highlighted through stakeholder feedback was the disruption in continuity of care for youth who enter into DYRS. Stakeholders shared that once a youth enters into DYRS, their Medicaid coverage ends. DYRS pays for and provides services. If a youth was receiving services with a particular community provider prior to entering DYRS, they go through the screening and evaluation process again and, if determined to need services, will receive a new provider through DYRS. That disrupts the relationship and trust building that has happened with the previous provider. Furthermore, youth who receive services at the Youth Services Center also experience a disruption in services and relationships if they transition to New Beginnings. Last, stakeholders expressed the need for alternative forms of therapy (e.g., art therapy) to be more widely available to youth and to increase engagement in services at DYRS. While the court decided to end oversight of DYRS due to significant improvements and progress made, the report highlights gaps in delivering behavioral health services that still need to be addressed, particularly regarding the quality of assessments, treatment, and discharge-related services as well as timeliness of services.[429]

There are a few additional behavioral health programs offered to justice-involved youth through partnerships with several government agencies, including DBH, CFSA, DHS, and MPD.

- The Alternatives to the Court Experience (ACE) Diversion Program is a partnership between DHS, Court Social Services (CSS), the Metropolitan Police Department (MPD), the Office of the Attorney General (OAG), the DBH, and community-based service providers.[430] It assesses the needs of the diverted youth who commit low-level delinquency offenses, links youth and their families to individually tailored support and behavioral health services, and monitors successful program participation. The program's goal is to address underlying issues that cause the negative behaviors and prevent the youth from reoffending and getting a juvenile record. Entry into the program is through referrals from MPD or OAG.

- Parent and Adolescent Support (PASS) is a program for youth ages 10–17 who commit status offenses.[431] The program aims to reengage youth in school, increase family functioning, and decrease the likelihood of future involvement in the juvenile justice system for status or delinquency offenses. The program, with support from DBH, utilizes evidence-based approaches such as strength-based intensive case management, FFT, and Transition to Independence Process (TIP). Families are not eligible for PASS if they have an open case with CFSA or if the youth has an active case with CSS or DYRS. During FY 2020, PASS served 364 youth; 191 received intensive case management, 77 received PASS Crisis and Stabilization Team services, and 96 received FFT services.[384] In addition, PASS staff served 63 youth diverted to DHS' ACE diversion program due to an influx of truancy and delinquency cases.
- The Family Court Social Services Division, also known as the District's juvenile probation agency, serves youth awaiting trial and those on probation. Part of its service offerings includes the Child Guidance Clinic, which provides clinical services (e.g., individual and group psychotherapy, screenings and evaluations, outpatient programs, etc.) to youth ages 11–18 and their families.
- The Juvenile Justice Initiatives Juvenile Behavioral Diversion Program (JBDP) is a mental-health-based specialty court through the D.C. Superior Court Juvenile Division.[432] It provides intensive case management and mental health services to youth under age 18 in the juvenile justice system who have serious mental health concerns and includes comprehensive monitoring and addresses emotional, behavioral, and substance use needs. There are three tracks based on eligibility: pre-plea (first time, nonviolent youth), predisposition (youth entering a plea), and post-disposition (youth with medium level offenses, offered probation). Services are provided through the DBH provider network and supervised by CSS. In 2020, 57 youth participated in the program, 30 of which received CBI services and 15 received HFW services, but the program also has seen a decrease in participation in the program since the COVID-19 pandemic began.[372]

9.6 Transition Age Youth

Generally in the District, transition-age youth (TAY) refers to the 16–25 year old population. Nationally, TAY usually have high rates of mental health disorders but often do not receive services due to challenges with engaging this population, reluctance to begin or to continue treatment, and low mental health literacy rates.[433] In the FY20–21 Substance Abuse Prevention and Treatment and Community Mental Health Services Block Grant application, the District recognized that there were unmet service needs for TAY, including the need for seamless provision of behavioral health services and recovery supports as they transition into adulthood, especially for TAY who are involved with multiple systems.[94] With the District's two distinct child-serving and adult-serving behavioral health systems (which includes different providers and funding streams), many youth who receive behavioral health services in the child-serving system often discontinue services as they enter into adulthood. Furthermore, adult behavioral health services are not often tailored to meet the unique needs of the TAY population, can be disruptive to the TAY, and forces them to adjust to new providers and treatment plans. Recognizing that need, DBH proposed the following initiatives for TAY:[94]

- Healthy Transitions/Our Time—focused on filling service and treatment gaps available for young adults 16–25.
- Our Time Exploration—focused on filling service gaps that address the integration of substance use disorder and mental health treatment services specifically for young adults 16–25.
- It's Time to Let Help In—focused on reducing stigma around mental health,
- First Episode Psychosis/Youth Blossom Program—early interventions to address first psychotic break for
- Transition Age Youth Housing—supportive independent housing for young adults 18–25.
- TAY Supported Employment—focused on connecting young adults 16–25 with career-focused employment.
- TAY Professional training—focused on training DC providers who work with the TAY population to better connect and work with young adults.

In FY20, DBH received several grants from SAMHSA to develop a SOC for TAY; increase access to behavioral health services and recovery supports; to provide education and counseling; reduce stigma; and increase community knowledge and support through expanding and strengthening services offered to TAY.[372] DBH reported in its FY20–21 performance oversight response that due to less-than-anticipated spending and COVID-19, there was a delay in awarding contracts. Further, the grants for Positive Transitions Youth, Young Adult, and Our Time Exploration have ended with the recognition that additional planning will be needed to deliver services to TAY.

The Department of Behavioral Health currently implements two evidence-based services specific to TAY: TIP and Adolescent Community Reinforcement Approach (A-CRA).[434] A-CRA is described in Chapter 5, regarding substance use treatment for youth, and is focused on ages 12–21, which misses the 22- to 25-year-old population. The TIP model provides services to TAY, ages 14–29, who have emotional and behavioral health challenges. Services are provided in the TAY's natural environment and include the individual and their family in planning and preparing for the transition into adulthood.[434] There are currently five TIP providers: Community Connections, Wayne Place, MBI, the PASS program, and Life Enhancement Services program. TIP is Medicaid reimbursable using the Community Support code H0036 but without any enhanced rate to implement services tailored to meet model fidelity.

According to a local family-run organization, there needs to be greater engagement of TAY in the District and development of services and programs in which the TAY feel supported, are free of stigma, and are provided with the skills and knowledge needed to engage in their own treatment and recovery planning. There also needs to be greater coordination between child- and adult-serving behavioral health providers.[435] Services for transition-age youth must address mental health and psychosocial needs specific to the unique needs of youth transitioning into adulthood. Those services must be trauma-informed and community and youth driven and include mentoring/peer support. For example, Cornerstone, a small-scale randomized controlled trial and qualitative study in a New York outpatient mental health clinic, was designed to develop and test a mental health intervention specific to transition-age youth with serious mental health conditions to improve mental health symptoms, mental health service use, stigma, trust, and life outcomes.[433] It includes the following components: a licensed master's level clinician who serves as a case manager; a peer mentor, called the recovery role model (RRM); in vivo community-based practice; and knowledge and skills-based groups. Peer support models, discussed in Chapters 5 and 6, have also gained support nationally in supporting this population.

9.7 Prenatal to Age Five

Infant and early childhood mental health (IECMH) strongly impacts a child's behavioral health and well-being, even into adulthood. Quality, evidence-based Prenatal-to-Five programs and community resources are essential tools in this relational health that build strong, supportive, and positive relationships with a primary caregiver in infancy and early childhood, one of the strongest predictors of healthy emotional state.[433] Prenatal-to-Five programs offer a solution-focused approach promoting safe, stable, and nurturing relationships (SSNRs) that can turn off the body's stress machinery, proactively promote skills essential to respond to future adversity, and promote future resilience.[436]

Birth rates in the District have declined from 56.4 per 1,000 population in 2010 to 48.8 per 1,000 population in 2018, similar to decreasing U.S. birth rates.[437] Yet, DC Action notes that the percentage of District population under three years of age has increased 20% in five-year averages in the same time frame.[438] According to DHCF, 44% of all births in 2018 were financed by the District, with 35% of all births to women enrolled in Medicaid.[439] With a shifting DC population, infant and early childhood behavioral health services and the network adequacy to provide those services must reflect the needs of this population and expand to better serve the District. DC offers several programs with behavioral health services for infants. One such program is HealthySteps, an evidence-based, team-based pediatric primary care program implemented at multiple DC sites that promotes the health, well-being, and school readiness of babies and toddlers through full integration of behavioral health education and services into primary care, with an emphasis on families living in low-income communities.

A number of IECMH programs involving the primary caregiver(s) are also offered in DC. Dyadic therapies, including PCIT and CPP through DBH's Parent Infant Early Childhood Enhancement Program, Mary's Center, MedStar Georgetown University Hospital, and Community Connections (DC SEED). PCIT is currently reimbursed by MCOs, whereas CPP is reimbursed through both MCOs and MHRS. Additionally, the Early Childhood Innovation Network's Family Well Being Program offers CPP to families as part of its full range of services;[xxxiv] Children's National Hospital's Early Childhood Behavioral Health Program and Medstar Georgetown University Hospital also offer both CPP and PCIT to families. Although those services are covered through DC Medicaid, DC does not currently use a specific dyadic billing code for PCIT through either MHRS or MCOs. In contrast, CPP does have a specific billing code when billed through MHRS.

Perinatal mood and anxiety disorders (PMADs) can impact an infant's or child's behavioral well-being. Pediatric practices across the District perform PMAD screenings, such as the Edinburgh Postnatal Depression Scale (EPDS), when possible, and the District reimburses for up to four PMAD screens in the baby's first year.[440] Expansion of PMAD screenings and referrals in many inpatient and outpatient health settings is occurring at a rapid pace throughout the city. Screening followed by information and resource sharing along with connections to behavioral health services can prevent escalation to more severe PMAD conditions; network adequacy and provider availability are essential to complete this loop.

Preventive services for at-risk children/families reduce the incidence of more serious mental conditions later, offering healthier development and costing the health care system less. Z-codes and other at-risk diagnosis codes allow for the implementation of evidence-based preventative services but are currently not financed in DC.[xxxv] Parent Cafes, mindfulness programs, and support groups are valuable resources to parents and caregivers and deserve sustained investment by DC and MCOs. In as much as the infant and young child are completely linked to their caregiver, parents or other important guardians in a child's life must be incorporated into the behavioral health care of infants and young children.

The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-5) do not correspond to the DC Medicaid billing system. A crosswalk[xxxvi] is needed for behavioral health professionals to provide clear and concise assessments and diagnoses that correlate to the billing system in the District. Once developed, the crosswalk can be disseminated and trainings offered to behavioral health providers. It is also critical that multisession assessments be supported in MCO billing where appropriate. Assessments of infant or young children, family dynamics, and certain conditions require more time for assessment than may be possible in one visit.

IECMH carries beyond the family unit and health care environment and into the learning system as well. Child care and early learning environments are valuable partners in capturing behavioral health concerns early. In doing so, the deeply rooted patterns of school failure in under-resourced communities can be stopped before they begin, thus improving educational opportunity and later economic prosperity. DC's Early Childhood Mental Health Consultation Project (Healthy Futures Program) and the Early Childhood Innovation Network's Early Childhood Mental Health Consultation for PreK3/4 (ECMHC) are two evidence-based models providing IECMH and other related behavioral health consultation to early learning environments.[xxxvii]

[xxxiv] *Other services include the Strengthening Family Coping Resources (SFCR).*
[xxxv] *See Chapter 4 for discussion of gap analysis and recommendations.*
[xxxvi] *A crosswalk is a tool that provides links between DC:0-5 diagnoses and the common state Medicaid agency DSM-5, ICD-10, and ICD-10 codes. The Zero to three national organization has developed one at https://www.zerotothree.org/resources/1540-crosswalk-from-dc-0-5-to-dsm-5-and-icd-10, in addition to many state crosswalks such as Colorado's at https://www.cbhc.org/wp-content/uploads/2021/08/DC0-5-Memo_FAQ_-Crosswalk.pdf.*
[xxxvii] *Healthy Futures program is funded by DBH, operates in childhood development centers as well as homes, and offers child- and family-centered consultation services to care providers and family members that promotes social emotional development, reduces challenging behaviors, and provides referrals for additional services. ECMHC is a project of the Early Childhood Innovation Network and provides on-site consultation to teachers and leaders at AppleTree Centers.*

9.8 Children Who Speak Languages Other Than English

Approximately 5% (26,400 people) of DC residents five years or older are classified as limited or non-English proficient (LEP/NEP).[441,442] According to 2012 data, the top four languages spoken by LEP/NEP children and adults in the District are Spanish, followed by Amharic/Ethiopian, French, and Chinese. Many LEP/NEP individuals are concentrated in Wards 1 and 4.[439] In DC, 7% of LEP/NEP individuals are children ages 5–17. Among children ages 3–17 in DC, roughly 7–10% live with LEP/NEP parents, and approximately 4% of children ages 0–17 live in households where no one 14 years or older speaks English proficiently.[442] Slightly less than half of LEP/NEP households in DC are classified as low income (< 100–200% of federal poverty level).[442]

LEP/NEP individuals have legal rights to access health services in their native language. In accordance with the Language Access Act of 2004, the District passed laws that any agency, department, or program that renders services to the public must provide language services to LEP/NEP persons who seek the services offered by the covered entity.[443] DBH has a policy to ensure that all DBH-certified agencies offer language accessible services.[444] The DC Office of Human Rights (OHR) oversees implementation of language access programs for all District agencies, including DBH.[445] OHR organizes its work into four areas: enforcement, compliance monitoring, technical assistance, and community engagement of these services.[444] DBH providers are required to establish and maintain a viable language access policy and services, which are offered at no cost to the LEP/NEP consumer. The DBH policy also stipulates that DBH providers are required to report quarterly on the number of LEP/NEP consumers served (and what languages services were provided in), the frequency with which LEP/NEP individuals come in contact with DBH providers, and the number and type of languages the agency staff speak.[444] In addition to oversight and enforcement by OHR, there is a Language Access Coordinator within DBH who oversees the development, implementation, and enforcement of many of the language access policies and plans within DBH and their contracted community providers. Informal complaints can be filed with the Language Access Coordinator. Formal complaints regarding language access issues are filed with the DC Office on Human Rights or in accordance with the DBH Consumer Grievance Procedures in 22A DCMR Chapter 3.[444]

There is a dearth of multilingual, child-serving behavioral health professionals within the District, especially those serving non-Spanish speaking populations. There are a limited number of agencies that specialize in treating specific populations, such as the Latinx community, although these agencies also suffer from workforce shortages and often have extended wait times for services. This system gap is even more prevalent when LEP/NEP families seek specific types of behavioral health services (e.g., psychiatric care) or when LEP/NEP families fall within multiple "special population" categories (e.g., autism services for a LEP/NEP children, counseling services for children 0–5 years from a LEP/NEP family, LEP/NEP new mothers experiencing perinatal mood or anxiety disorders, LEP/NEP children in the foster care system, etc.).

It is noteworthy that LEP/NEP children enrolled in Medicaid have limited access to multilingual child-serving behavioral health providers. According to the June 2021 version of the *Child and Adolescent Mental Health Resource Guide*, 76 agencies serving DC children offer mental health counseling in a language other than English; however, only 38 of those agencies (50%) accept some form of DC Medicaid.[296] While not necessarily representative, according to the website Psychology Today accessed in July 2021, 49 child and/or adolescent serving counselors near the DC metropolitan area speak a language other than English; however, only four counselors (8%) accept some form of DC Medicaid. Though those two directories may not include a fully comprehensive listing of all the child-serving multilingual providers in the District, they serve as a reasonable indicator showcasing the limited language appropriate services that are accessible to LEP/NEP children enrolled with DC Medicaid.

76 agencies serving DC children offer mental health counseling in a language other than English; however, only 38 of those agencies (50%) accept some form of DC Medicaid.[296]

In the absence of multilingual clinicians, there are a few different pathways that LEP/NEP consumers can access interpretation and translation assistance for behavioral health services at no cost. They can call the DBH Access Helpline and a staff member will connect them with live interpretation using a language translation phone line.[446] If the consumer is enrolled with a DC Medicaid MCO, they are entitled to free translation and interpretation through their insurance coverage. Each managed care plan has a language translation phone line that the consumer or family can contact.[447, 448, 449, 450] Through managed care benefits, consumers can arrange in-person interpretation services for set appointments, though those services must be scheduled with at least three to five days advance notice (depending on the MCO policy). DBH-certified agencies also should have access to telephonic language translation services so that they can triage or meet the needs of LEP/NEP consumers who seek services with a community mental health agency; in practice, that often does not work smoothly.

Even with translation resources available, it can be difficult and time consuming for LEP/NEP children, families, and individuals to access services via phone translation or in-person interpreters. The pathways for accessing translation services are not always clearly communicated to families and can be difficult to navigate, especially without the assistance of someone who has English proficiency. Often LEP/NEP individuals are directed to call a phone number that may have automated phone trees in the LEP/NEP individual's nonpreferred language, or the phone line may be answered by staff who do not speak the consumer's preferred language. In cases like that, the staff member is then tasked with identifying the consumer's spoken language and dialing in an interpreter who can translate, which can be a time-consuming and frustrating process. Hiring bilingual/multilingual staff can help to mitigate the barriers to arranging telephonic or in-person translation services. Additionally, it's important to consider cultural competency and varying levels of health literacy during the language translation process, because the norms and stigmas around accessing behavioral health services vary across cultures, which may pose an added level of challenge for LEP/NEP children and individuals seeking behavioral health services.

9.4 Recommendations

All recommendations from Chapter 5 apply to the populations referenced in this chapter. Some recommendations that are particularly important to emphasize for the identified special populations include the facilitation of integrated care, trauma-informed care, addressing social determinants of health, and promoting equitable access to care.

Additionally, as is recommended in Chapter 3, government leaders, MCOs, and behavioral health providers should strengthen their relationships with the community. This includes bringing in individuals that are representative of special populations into the decision-making about the District's behavioral health system for children.

For All Special Populations

1. Maximize appropriate information exchange among the behavioral health system, foster care system, juvenile justice system, school system, and the Homeless Management Information System.

Implementing Bodies: DHCF, DBH, DC Health, CFSA, DHS, DYRS, ICH, DCPS, OSSE
Timeline to Implementation: Long Term

Improved information-sharing among these different systems can enhance cross-sector collaboration and reduce system silos. Youth-serving agencies should collaboratively establish protocols for data-sharing, referrals, and consent for release of information, with clear guidance around HIPAA and FERPA laws.

The District's designated HIE—CRISP DC—can be leveraged as a technology to facilitate this information exchange in the following ways:

- **If other agencies' information systems were interoperable with CRISP, behavioral health professionals could benefit from data that provide a more comprehensive picture of their patients' history, which would facilitate more tailored care and referrals. Further, this interoperability will be beneficial when a child transfers to a new behavioral health provider, because comprehensive clinical information (behavioral health records from behavioral health professionals in community-based organizations, school, CFSA, etc.) can be easily transferred.**
- **If accessibility to appropriate health data in CRISP was expanded to other agencies, health data could be utilized in settings outside of health care. That would be beneficial to ensure whole-person care is delivered as children move between different systems and settings. Even now, expanded use of CRISP could allow a social worker in CFSA to follow up on children who were admitted or discharged from emergency departments or psychiatric residential treatment facilities through use of Encounter Notification Service. With some further work to ensure privacy and security protocols were aligned, communication and diagnostic/identification reciprocity between the health care sector, educational sector, and early intervention sector could make it easier for families who have a child with a classification of ASD in one system to receive acknowledgement in another system.**

Examples of Interagency Data Sharing in California	
Contra Costa County, California	**Alameda County, California**
Contra Costa County Health Services Division's Whole Person Care pilot integrates HMIS, behavioral health, public health nursing, and emergency medical services data systems into a central data warehouse. Some data from that warehouse is shared directly to providers through EHR patient charts. Data is also made available to program managers to inform reporting and strategic planning efforts. **Source: "Catalyzing Coordination: Technology's Role in California's Whole Person Care Pilots," California Health Care Foundation, April 2019.**	Alameda County's Social Health Information Exchange (SHIE) was made possible through data agreements across local health and homeless systems of care, binding all participating providers by HIPAA law. HIV and behavioral health data is only shared upon patient consent. Individuals' medical, behavioral health, housing, incarceration, crisis response, and social services data were collected and integrated into the SHIE central repository, which is made accessible across sectors. The SHIE system also notifies providers when a client is admitted into or released from the emergency room, inpatient care, or jail. Finally, SHIE data is used by the county for the purpose of equity-focused data analysis. **Source: "Breaking Down Silos: How to Share Data to Improve the Health of People Experiencing Homelessness," California Health Care Foundation, July 2021.**

Children With or At Risk for ASD

The Current Landscape of Behavioral Health Services for Children With Autism Spectrum Disorder Insured by Medicaid in Washington, D.C. by Children's National Hospital[xxxviii] outlines a more comprehensive list of recommendations that we fully endorse, but the following are highlighted as high priorities:

2. Ensure network adequacy for diagnostic and intervention services for ASD.

Implementing Bodies: DHCF, DBH, MCOs
Timeline to Implementation: Short Term

While MCOs are required to have network adequacy for ASD evaluations and intervention, there remain significant gaps in care. Additional information is needed to understand how DHCF is monitoring and ensuring network adequacy and why certain Medicaid MCOs are not accepted by different care providers. The District should ensure that all appropriately qualified providers are enrolled with all MCOs. In addition, DC should ensure there are behavioral health service providers available to care for children with co-occurring ASD and behavioral health issues, as this is common and requires intervention.

[xxxviii] *See pages 17–25 of the Current Landscape of Behavioral Health Services for Children with Autism Spectrum Disorder Insured by Medicaid in Washington, D.C. report.*

3. Identify and implement comprehensive policy solutions that ensure adequate access to the full array of services and providers needed for ASD diagnosis and treatment.

Implementing Body: DHCF
Timeline to Implementation: Medium Term

DC identified the need to develop comprehensive solutions for ASD services and providers during the Section 1115 Medicaid waiver process. In other states, approaches have included a Medicaid State Plan Amendment as recommended by CMS, systematically addressing training and workforce shortages and identifying innovative approaches through telehealth. The District should use upcoming planned changes to the public behavioral health system, including behavioral health services as covered benefits in the District's Medicaid managed care contracts, as an opportunity to work with families, providers, communities, and other stakeholders to determine and begin implementation of a core set of ASD policy changes. With the addition of a Neurobehavioral Benefit to DHCF's FY 22 budget, the District has taken steps to begin planning comprehensive ASD policy solutions and allowing for broader access to ABA services. We are supportive of that policy movement and encourage broad stakeholder engagement as implementation advances.

ASD policy reform is also needed for MHRS providers to allow this provider type to develop plans of care that address issues specific to ASD. In this manner, MHRS providers can facilitate better whole-person care for children with ASD and co-occurring behavioral health disorders, such as SED. Policy reform should include the addition of ASD diagnostic and treatment codes to MHRS. Additionally, as the current MHRS provider network is not experienced in delivering ASD-related services, further capacity development in terms of training and staffing will be needed.

4. Standardize insurance requirements for making a diagnosis of ASD across the MCOs and increase transparency and access to this information.

Implementing Bodies: DHCF, MCOs
Timeline to Implementation: Short Term

The different MCOs have varying or unclear standards for what documentation is required to substantiate an ASD diagnosis. These discrepancies make it difficult for providers to know what documentation is needed and for families to understand what to look for in an evaluator or in written evaluation results. Moreover, an ASD identification from a school-based evaluation that includes a DSM-5 diagnosis and corresponding comprehensive psychoeducational assessment should be considered sufficient for MCOs to initiate insurance-covered treatment services.

5. Secure funding to provide ongoing training and education on ASD for frontline care providers, including primary care providers, early intervention staff, school staff, and early childhood behavioral health professionals

Implementing Bodies: DBH, DHCF, DC Health, OSSE, DCPS
Timeline to Implementation: Short Term

Individuals in these roles frequently refer children with suspected or diagnosed ASD for specialty services. Parents and caregivers of children with ASD must also be educated about ASD and engaged as partners in their children's care. The District should also look to fund models that improve access to clinical expertise, such as ECHO Autism, which has been successful in other jurisdictions.

6. Support the implementation of universal, coordinated, and strategic developmental monitoring and screening practices across key agencies within the District.

Implementing Bodies: DBH, DHCF, MCOs
Timeline to Implementation: Short Term

Universal developmental monitoring/surveillance should be adopted by systematically integrating the CDC's "Learn the Signs. Act Early." materials across agencies in the District to promote increased awareness of developmental milestones across stakeholders. Routine universal ASD screening, and potentially two-stage screening, should be implemented in programs that target young children. Screening efforts should be coordinated with organizations that can provide technical assistance and support screening implementation while ensuring that identified children can be quickly seen for comprehensive ASD evaluations.

Children in Foster Care

7. Guarantee the timeliness of service connection and integrate warm handoff best practices between CFSA and DBH for behavioral health services for children in care.

Implementing Bodies: DBH, CFSA
Timeline to Implementation: Short Term

There needs to be a seamless transition from removal to assessment for behavioral health needs and to treatment. Whether all of those components happen in-house at CFSA or in collaboration with DBH, there must be capacity to serve this population. The system, as currently designed for children in care, requires multiple steps to initially connect a child to a behavioral health provider. The shortest amount of time to connect a child with a CFSA in-house therapist is 28 days, and that assumes they are screened, linked, and begin services on the first day the child comes into care. That is an unlikely scenario. As noted above, in FY 2020, 16% of children were not screened within 30 days of care (the exact screening time is not reported), and the average time to begin services with a CFSA in-house therapist is 28 days. Therefore, for those 16% of children, they are facing a two-plus month minimum delay on services. A child in care needing to access DBH services will be met with longer—but not substantially longer—delays, as discussed in Section 9.2.

Those delays in care can be detrimental to a child in care, especially when factoring in that removal from one's home can be traumatic in and of itself. Therefore, CFSA and DBH should explore ways to make connections to behavioral health services more timely for children in care and to minimize expected disruptions in care, including updating policies on initial evaluation of children's health that have not been updated since September 2011, well before the behavioral health redesign.[451] This effort will allow CFSA to better inform its policies around timely screening and connection to services based on feedback over the last three years. CFSA and DBH should also collaborate to establish an efficient and effective information-sharing system that will ensure children are not delayed in receiving services due to inaccessibility of behavioral health records or other information vital to a child's treatment.

Additionally, children coming into care have typically faced other adverse experiences and have behavioral health needs that a short-term solution like the OWB is not designed to meet. Therefore, CFSA should continue to offer in-house services but should integrate the warm handoff model between itself and DBH in every referral.[452] A warm handoff will allow the child to be involved in the transition from one behavioral health professional to another. This may ease the stress of having to endure another change. Children thrive from consistent relationships. While there is the importance of a quick connection, there is also a relational aspect in behavioral health services that can be appropriately addressed through a proper warm handoff. A child will not have to abruptly change a trusting, consistent relationship with an in-house CFSA therapist, which can be stressful in and of itself, but instead will be able to ease into a new long-term relationship with a DBH behavioral health professional.

8. Ensure there are clear pathways to accessing care for children in foster care residing in the District and Maryland.

Implementing Bodies: DBH, CFSA, DHCF
Timeline to Implementation: Short Term

DHCF has still not announced the timeline to transition the 10% of children and youth currently served by the Medicaid FFS program to the MCO program.[453] However, in considering the best way to go about this process, DHCF must ensure the behavioral health needs of children—and foster children in particular—are prioritized. The ability to readily access behavioral health services in DC and Maryland is crucial for this particularly vulnerable population.

In considering the transition from FFS to MCOs, there must be clear pathways to accessing care across the District as well as in Maryland, where 65% of DC foster children resided in FY 2020.[xxxix] Children placed in Maryland continue to be eligible for services in the District, but that is often impractical and inconvenient for many caregivers and families. Children need to be placed with services near where they are located. With the transition from the FFS program to managed care and the carve-in of behavioral health services into MCOs, children in Maryland will struggle to be connected with the appropriate behavioral services due to the lack of behavioral health organizations in Maryland that accept DC Medicaid. DHCF needs to take extra steps to ensure that DC foster children have access to behavioral health services in Maryland. The network adequacy time and distance standards need to be applied based on the child's outpatient home, not simply based on the District street address the family may have.

[xxxix] *According to the CFSA FY2020- FY 2021 Performance Oversight Responses, 451 of the 693 children in care with placed Nation Center for Children and Families in Maryland.*

9. Provide an augmented capitation payment for children in foster care to MCOs, to adequately support their increased needs.

Implementing Bodies: DBH, CFSA, DHCF
Timeline to Implementation: Short Term

Children in foster care are disproportionately more likely to have developmental, medical, and/or behavioral disorders than nonfoster Medicaid children.[454] Because foster children have higher levels of chronic health conditions, it is important that MCOs are paid higher capitation rates for this eligibility category to cover their necessarily higher costs. If the capitation rates are not higher, plans would have increased pressure to reduce health care utilization for foster children to remain profitable.[xl]

10. Continue to work on the implementation of evidence-based therapeutic foster care.

Implementing Body: CFSA
Timeline to Implementation: Short Term

In 2019, CFSA began a contract with a new provider to offer specialized therapeutic placements to children in care. There have been challenges with the new provider, including high staff turnover and inadequate staffing leading to a lack of communication, coordination, and challenges in providing therapeutic support and services.[455] Because this is a new program, there is an opportunity for CFSA to develop lessons learned as well as expectations. CFSA is and should continue to incorporate these lessons into more effective implementation of specialized therapeutic placement moving forward.

Additionally, CFSA has begun a pilot program, Professional Resource Parent Program (PRPP), to employ professional foster parents to further meet the need of therapeutic placements.[456] [457] Professional foster parents are full-time, salaried positions. They do not work outside the home and are trained and able to provide 24/7 services in a therapeutic home setting. Like therapeutic foster homes, professional foster parents receive specialized training and additional resources to support placement stability, including an in-house mental health services support team, in-house transportation services, and crisis intervention services available over the phone.

Both therapeutic foster homes and the PRPP allow a child with high behavioral health needs to heal and recover in a home setting instead of a residential or institutional setting. Providing therapeutic homes and professional foster parents is a good start. CFSA needs to continue these processes until there are sufficient resources to support foster care children with high behavioral needs with top tier services.

[xl] *According to Palmer et al (2017), Kentucky saw a decrease in outpatient utilization when children were transitioned to managed care; however, foster care children experienced less decrease, possibly due to the 28.9% enhanced capitation rate accounting for their higher need. See Medicaid Managed Care and the Health Care Utilization of Foster Children; Inquiry; 2017.*

11. Provide full transparency of specific data collection regarding medication monitoring, and publicly report these data regularly.

Implementing Bodies: DBH, CFSA
Timeline to Implementation: Long Term

Children in foster care have a documented higher rate of psychotropic medication use; however, transparency in this area is completely lacking. The District needs to adopt a framework that can provide effective oversight for the use of psychotropic medication by children and youth in foster care. To do so, the District must establish publicly available data that will allow medication utilization to be monitored among District foster care children and will provide a clear indication on any needed changes in policy or access to alternative treatments, where warranted. In developing an effective monitoring framework, the District may look to New Jersey, which uses existing data from its child welfare, Medicaid, and children's behavioral health entities, to gain a clear understanding of psychotropic medication use and psychosocial interventions.[458]

The District may also look to Texas, which in 2005 was the first state to develop a best practice guide, *Psychotropic Medication Parameters for Foster Children (Parameters)*, for oversight of psychotropic medications for children in foster care.[459] As part of the process, Texas' Health and Human Services Commission and Department of Family and Protective Services convened an advisory committee of child and family advocates, foster parents, providers, youth in foster care, and human services professionals to help guide its strategy concerning psychotropic medications. Since *Parameters*' release in 2005, the use of psychotropic medication has steadily declined.[459]

Children Who Experience Homelessness

12. Systematically identify children and youth using homeless shelters who are in need of behavioral health services.

Implementing Bodies: DHCF, DBH, DHS
Timeline to Implementation: Medium Term

While recent data describing the number of children and youth experiencing homelessness who were engaged through DBH outreach efforts is limited, available information suggests that only a small fraction of youth experiencing homelessness[460] are engaged through DBH's Homeless Outreach Program (HOP).[461] HOP is the only homeless shelter outreach program provided by DBH that is available for children experiencing homelessness.[462] High rates of intensive behavioral health service use, such as psychiatric hospitalizations, after spending time in homeless shelters suggest that homeless families and children should be systematically screened for behavioral health risks while engaging with homeless shelters to address and prevent need for later intensive services.[463] It may also be the case that shelters need to adopt strategies that mitigate exacerbation of behavioral health risk factors. It would be helpful to make publicly available current behavioral health screening data within District homeless shelters and to implement District-wide protocols within homeless shelters to ensure children who are experiencing homelessness are screened for behavioral health conditions.

DBH may consider partnering with DHCF and DHS to provide targeted outreach services for children in homeless shelters, including behavioral health assessment, providing service referrals as needed, and ensuring those services are Medicaid billable. It is important that there are behavioral health services tailored to meet the needs of LGBTQIA+ youth of color who experience homelessness. A similar approach, through which nurse care coordinators systematically visited homeless shelters to provide behavioral health screenings for children, was shown to be both feasible and necessary through a pilot study conducted in Jacksonville, Florida.[464] In this study, 33% of children over five years old who were screened using the Strengths and Difficulties Questionnaire (SDQ) were identified as needing behavioral health services, almost five times the rate of those screened by the SDQ within the general population.[464]

13. Increase participation in the Interagency Council on Homelessness (ICH) by DHCF and MCOs.

Implementing Bodies: DHCF, MCOs
Timeline to Implementation: Short Term

Given the increased behavioral health risk of children and youth experiencing homelessness, special attention should be taken with regards to their behavioral health service needs. Entities involved in their behavioral health care delivery, payment, and governance, including DHCF and MCOs, who are currently not represented within the ICH,[465] should ensure partnership and collaboration with the ICH. In addition to the ICH Medicaid work group's focus on developing and implementing a new Medicaid permanent supportive housing case management benefit, outcomes of this partnership should entail: increased service connectivity; improved homelessness prevention efforts for those using inpatient care; and improved targeting of available housing resources, such as through coordination of Medicaid services with housing supports.[466]

14. Systematically assess the housing status of crisis service users.

Implementing Bodies: DHCF, DBH, DC Health, MCOs
Timeline to Implementation: Short Term

Emergency and crisis response providers (such as ChAMPS, hospital EDs, etc.) should routinely assess the stability of the client's housing situations and connect children and families to appropriate housing resources in the same way they take into consideration other social risk factors. This can be achieved, for example, by requiring that crisis response providers use Certified EHR Technology—in which the core data set, the United States Core Data for Interoperability (USCDI), measures housing status.[467] Work is underway to implement Z-codes social determinants of health screening, following the work of the Gravity Project, in the DC Designated HIE, CRISP DC, could also be useful to support this work.

Based on stakeholder feedback, strategies to consider when assessing the housing situation of children:

- With appropriate supports and resources in place, housing assessment should be included as a standard part of care during triage in the ED.

- When assessing housing needs, the individual doing the assessment should be mindful of language, sensitivity, and stigma.
  - Ask caregivers about housing status separate from the child, because the child may not be aware of the situation.
  - Use language such as "stable living environment" or "housing instability" instead of "homelessness."
  - Questions could include: How many times in the past year have you moved? Are you concerned about where you will be living in the next month?

15. Collect data on youth homelessness beyond annual PIT prevalence estimates.

Implementing Body: DHS
Timeline to Implementation: Long Term

Collect real-time data on youth homelessness outcomes that can be used by relevant stakeholders, including homeless service providers, to measure and inform performance. Consider using youth homelessness outcome measures similar to those which the Seattle Human Services Department uses to inform quality-based payments to homeless services providers, including:

- Successful diversion from homelessness.[468]
- Milestones to success or specific actions taken by providers to address housing barriers, such as helping obtain identification needed to complete a housing application.[468]
- Obtainment of permanent housing.[468]
- Housing stability or whether an individual is still living in permanent housing three months after obtaining it.[468]
- Reentry into homelessness after obtaining housing.[468]
- Racial disparities demonstrated in the distribution of individuals experiencing homelessness.[468]

Given the transient nature of homelessness, this data should be collected frequently and made available in real time, ideally to the general public through an easy-to-understand data dashboard to maximize its utility to the community.[395]

16. Ensure that homeless shelter staff are adequately trained in cultural competency, anti-discrimination, anti-harassment, and trauma-informed approaches to protect the safety and well-being of LGBTQIA+ youth and children.

Implementing Bodies: DHS, Youth Sub-Committee on ICH
Timeline to Implementation: Short Term

A number of accounts on both local[413] and national[397, 398] levels suggest that homeless shelters are unsafe for LGBTQIA+ youth, especially those identifying as transgender.[397] A national survey revealed that nearly half of transgender individuals experiencing homelessness have reported leaving homeless shelters due to maltreatment, preferring to sleep on the streets than in a hostile or unsafe environment.[397] Further, traumatic experiences, such as harassment and peer victimization faced by LGBTQIA+ youth are strongly linked to later behavioral health outcomes.[399] As such, it is important that the District ensure adequate training for shelter staff on cultural competency, anti-discrimination, anti-harassment, and trauma-informed practices to better serve LGBTQIA+ youth and avoid increasing behavioral health risks. As described in Section 9.3, shelter staff should be enabled to enforce anti-harassment policies, and shelters should have safety measures incorporated into their structures.

Children Who Identify as LGBTQIA+

17. Support therapeutic interventions proven to be effective and appropriate for LGBTQIA+ youth populations, including culturally tailored treatment modalities.

Implementing Bodies: DBH, DHCF, DHS, OSSE, DCPS
Timeline to Implementation: Medium Term

As public health and behavioral science experts have noted, disproportionate exposure to stigma-related stress during childhood and adolescence is the most plausible explanation for behavioral health disparities in the LGBTQIA+ population.[469, 470] Given the role that these kinds of stressors play in the development of behavioral health concerns among many LGBTQIA+ youth, successful therapeutic interventions for this population must effectively address stigma-related stressors. Interventions tailored to the LGBTQIA+ population are purposefully designed to do this, leading many to call for their wider use.[471, 472] While there remains a need for studies comparing the efficacy of LGBTQIA+ tailored interventions to evidence-based, nontailored treatments,[473] existing evidence suggests that tailored treatments are very effective[473] and individuals identifying as LGBTQIA+ frequently prefer them,[474] helping to address barriers to treatment-seeking.[472]

For this reason, we recommend that DBH support behavioral health clinician training in evidence-based treatment modalities that are tailored to the needs of LGBTQIA+ youth, such as Transgender-Affirming Cognitive Behavior Therapy (TA-CBT) and Effective Skills to Empower Effective Men (ESTEEM).[414] Further, we encourage DBH to support evaluation services for gender-diverse and transgender youth because the standard of care for gender-affirming medical treatment requests requires careful assessment for medical treatment readiness.[419] We also encourage DHCF to ensure that these services are Medicaid billable.

Other evidence-based interventions that can address the behavioral health needs of LGBTQIA+ youth include the FAPrisk screening tool developed by the Family Acceptance Project, which has proven to be accurate in

predicting depression, suicide, and substance use risk in LGBTQ youth[409] and can be integrated into the workflow of health professionals serving youth to identify need for behavioral health services and inform service delivery and referral.[475] Health and social service agencies serving youth in DC should encourage service providers to use the FAPrisk to better identify LGBTQIA+ youth who are in need of behavioral healthcare service referral.

In instances where tailored interventions have not yet been developed, it is suggested that other evidence-based practices that have been proven effective within LGBTQIA+ youth and child populations be used in their place. For that reason, we suggest supporting the Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances Program treatment modality, which is the only known,[476] widely available intervention shown to be effective in significantly reducing substance use in the LGBTQIA+ youth and children through longitudinal data.[477]

18. Increase access to integrated behavioral health services for youth in gender transition.

Implementing Bodies: DBH, DHCF, MCOs,
Timeline to Implementation: Long Term

There is a need for increased integrated care services or interdisciplinary clinics for youth in gender transition to address and support the physical, social, emotional, and mental health needs of youth and their families. For example, it would be helpful to have an endocrinologist and behavioral health provider involved in appointments to increase multidisciplinary care for youth in gender transition. Some examples include Children's National's Gender Development Program (mentioned in Section 9.4) and the Youth Pride Clinic (mentioned in Section 9.4).

19. Improve District capacity to make data-informed decisions on behavioral health care for LGBTQIA+ youth.

Implementing Bodies: DBH, DHCF, DC Council
Timeline to Implementation: Medium Term

As the use of electronic health records and data-informed medical decision-making becomes more common, collection of sexual orientation and gender identity (SOGI) data is critical to eliminating health disparities experienced by LGBTQIA+ youth.[478] As such, it is imperative that the District's efforts to improve local behavioral health outcomes take into account the need for standardized, consistent collection and use of high-quality SOGI data in health care and social service settings by:

- Undertaking efforts to increase the use of Certified EHR Technology within health care systems, given that USCDI core data set embedded within these systems collects standardized SOGI data.[479]
- Involving LGBTQIA+ youth in data collection improvement efforts within the District, such as those taken by the ICH Youth Data and Performance Measures Work Group.
- Ensuring that service providers collect SOGI data in a culturally competent manner and encouraging the use of the National LGBTQIA+ Health Education Center (NLHEC) materials[480] to reference best practices.
- Implementing value-based care practices that reward providers for closing gaps in behavioral health outcomes for LGBTQIA+ youth.

20. Improve cultural competency of social and health care service delivery provided to LGBTQIA+ youth.

Implementing Bodies: CFSA, DYRS, CSS, DHS, DBS, OSSE, MPD, DCPS
Timeline to Implementation: Medium Term

Improving the cultural competency with which District services are provided serves to minimize the risk of LGBTQIA+ youth receiving discriminatory treatment that discourage use of needed supports, including behavioral health care. As such, youth-serving agencies in the District can improve cultural competency of service providers in the following ways:

- Ensure that youth-serving agency staff are trained in LGBTQIA+ cultural competency and nondiscrimination best practices as well as basic suicide prevention skills, such as those taught by the Question, Persuade, Refer gatekeeper training.[481]
- Ensure a culturally competent health care workforce, encouraging providers to use NLHEC as a free resource (using continuing medical education (CME) credits offered through NLHEC courses as incentives where appropriate) and the standards of care[xli] developed by WPATH, which specifically identify key competencies and roles of mental health professionals working with children or adolescents with gender dysphoria as well as considerations and guidelines for psychological assessment and intervention.
- Ensure that accurate information about LGBTQIA+ behavioral health issues are made available for youth and their families in youth-serving agency locations.[481]
- Establish a District-wide LGBTQIA+ cultural competence model to inform service delivery.[481]
- Facilitate opportunities for LGBTQIA+ youth in DC who are interested in behavioral health to enter the behavioral health workforce.[482]

Youth in the Juvenile Justice System

21. Increase access to affordable, high-quality behavioral health services and social service supports for justice-involved youth and their families.

Implementing Bodies: DYRS, DBH, MCO, CBOs/FROs, OSSE
Timeline to Implementation: Long Term

While the District has implemented a number of diversion programs that also address behavioral health, youth currently in DYRS custody need greater access to high-quality and timely behavioral health services. In discussion with stakeholders who have expertise with the District's juvenile justice system, they highlighted the following:

- There needs to be a greater number of child- and adolescent-specific providers who are trained to provide trauma-informed services, MST, youth-specific treatment for problem sex behaviors, and grief counseling services to youth in DYRS. There will need to be greater financial investment in technical assistance and training to increase the number of providers certified to provide these services.

[xli] *Please note that a new version is due out December 2021. "Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People," The World Professional Association for Transgender Health, 2012.*

- DBH and DYRS should work together to expand access to a number of services for justice-involved youth including co-occurring treatment services (MH/SUD) and residential SUD services when needed. In discussion with stakeholders, it was highlighted that when a youth in DYRS needs residential substance use treatment, the current option is a facility in Pennsylvania called Abraxas. Options for residential SUD treatment for justice-involved youth should be centrally located in the District and should be considered to allow for youth to remain in the District and near their families.
- DYRS should also use funds to contract with alternative therapy providers to better engage youth in treatment services, especially for youth who do not respond well to traditional forms of therapy. These services (e.g., pet and art therapy) should be widely available and not used as a form of reward.
- Develop a system to monitor and track timely development and implementation of appropriate treatment plans for youth at DYRS needing services. Treatment plans should incorporate all relevant data.
- A systematic process for collecting and reporting data on quality of behavioral health services should be implemented. This should include data on wait time to receive evaluation and treatment services, referrals, and types of services delivered. DYRS should also work with youth and their families to collect feedback on their experience of receiving these services.

22. Ensure continuity of behavioral health services and supports upon reentry into the community

Implementing Bodies: DBH, DYRS, and MCOs
Timeline to Implementation: Long Term

Reentry into the community should involve support with case management; navigating insurance requirements; and linkage to high-quality, community-based behavioral health programs. In particular, youth who were receiving services in DYRS and/or their families need to be assisted with enrolling in Medicaid and linking to appropriate services within the community prior to community reentry. For youth who meet criteria to have suspended Medicaid eligibility reinstated, the reinstatement process should be automatic. Youth and their families should also be included in the treatment planning process.

The family environment and stressors prior to the youth's reentry should also be addressed. That could include addressing behavioral health and social service needs of the family through connecting families to available resources and services, and helping them to navigate service requirements.

23. Implement training to individuals and organizations working with at-risk and justice involved youth.

Implementing Bodies: DBH, MPD, DCPS, OSSE, DC Health, CBOs
Timeline to Implementation: Long Term

Train school staff, police, and juvenile justice staff in working with youth with behavioral health challenges. Some examples include:

- Working with DCPS, MPD, and OSSE staff on how to interact in a way that supports recovery and de-escalation strategies.[483]
- Addressing biases and systemic racism through cultural competency, anti-racism, and implicit bias trainings, and linking those activities to long-term and structural adjustments that promote multicultural organizational success.
- Helping school staff to identify behavioral health challenges and appropriate resources, which in turn could help to reduce suspensions/expulsions and reduce the criminalization of Black youth.
- As outlined in *A Unified Vision for Transforming Mental Health and Substance Use Care*, training law enforcement officers in recognizing signs and symptoms of MH/SUD as well as in de-escalation models (e.g., Law Enforcement Assisted Diversion, and Mental Health First Aid).[207]

24. Increase peer support and mentoring opportunities for justice-involved youth.

Implementing Bodies: DBH, DCPS, CBOs
Timeline to Implementation: Long Term

Based on the findings of the CJCC's *Root Causes* report, it is recommended that the District pilot a community-based, cross-age peer mentoring program. This program would have high school students provide one-on-one or group mentoring to elementary and or middle school youth. The high school students would be supervised by program staff who would help maintain the structure of the program and provide guidance to the high school students. This type of program is rated as a "promising practice" by CrimeSolutions.gov, which is operated by the Department of Justice, and provides reliable resources on specific justice-related programs and practices to inform practitioners and policymakers. These mentoring programs are evidence-based, developmental models that promote psychosocial growth in both the mentors and mentees. Additionally, the programs can be tiered by allowing elementary mentees to participate through high school, progressing from mentees in elementary, mentors-in-training in middle school, and mentors in high school.[425]

25. Increase transition age youth-specific services and supports.

Implementing Bodies: DBH, DHC, MCOs
Timeline to Implementation: Long Term

As described in Section 9.6, DBH currently implements two evidence-based behavioral health treatments for transition age youth, one of which is not trauma-informed and the other misses the 22– to 25-year-old population. DBH and MCOs should explore new evidence-based behavioral health services specific to TAY that can be implemented in the District. New services developed and implemented should address social determinants of behavioral health and trauma and incorporate youth voice. DBH should also explore whether current evidence-based services for children and adults can be tailored to meet the specific needs of TAY. Furthermore, to increase services, DBH and the MCOs should ensure there are a sufficient number of community-based providers who are certified to provide TAY specific behavioral health support. To support increased services, there also needs to be sustainable funding opportunities.

To ensure continuity of care and seamless navigation of services, there should be dedicated care coordination or case management staff who help families transition from children's behavioral health services to TAY services, from TAY services to adult services, from pediatric primary care to adult primary care, and from school-based services to community-based services. That should also include warm handoffs and closed referral loops from the current provider, whom the individual has a relationship with, to the new provider.

26. Develop a system of care for TAY to ensure care continuity.

Implementing Bodies: DBH, CFSA, DCPS, DHS, CBO/FRO
Timeline to Implementation: Long Term

Secure sustainable funding to build a coordinated system of services across agencies and organizations in the District to meet TAY's specific needs. TAY need to be recognized as distinct from child- and adult-serving systems, with specific reimbursement mechanisms. Some strategies include:

- Identifying divisions within each agency that specifically address the issues of TAY.
- Similar to the development of ICH, developing a coalition or council specific to TAY. Many agencies are planning or implementing some services for this population already, but a coalition or council will ensure that it is a coordinated effort and increase communication between all of the relevant sectors impacting TAY.

27. Increase engagement of TAY in education, service planning, and delivery.

Implementing Bodies: DBH, CFSA, DCPS, DHS, CBO/FRO
Timeline to Implementation: Medium Term

To increase utilization of behavioral health supports, there has to be sufficient mechanisms in place to engage the TAY population and increase awareness of available services and resources. Additionally, to engage this population, providers and organizations must meet TAY where they are, recognizing that engagement and outreach for this population will look different from that of children and adult strategies. Some strategies to increase engagement include:

- Ensuring that information sharing, outreach, and engagement in services is conducted by trusted individuals such as peers with lived experience and at locations that are comfortable and easily accessible by TAY, as appropriate. For example, utilizing CBOs, churches, recreational centers, and other community supports that TAY frequent as TAY service hubs, in which a TAY can receive information and supports related to a number of their needs at one location (e.g., physical health, behavioral health supports housing, food, and employment supports).
- Creating comprehensive and easily accessible information in the form of a resource guide, memes, infographics, website, etc. that promotes all of the transitional services available to youth on local, state, and federal levels. Consult with the TAY committee and youth development leads as to the best ways to format, distribute, and display this guide, such as using social media platforms. Also, ensure there is dedicated staff to update these resources.
- Developing an education/promotion plan to highlight and spread awareness of TAY programs to youth, young adults, and families in the District. DBH has implemented a number of TAY services and programs of which residents may not be aware. Along these lines, the DBH webpage currently lists tabs for adult services and children, youth, and families. There needs to be an additional tab listing TAY-specific services and descriptions to make information more transparent and accessible to the public.
- Increasing engagement of youth in peer support and mentorship programs. See Chapter 6 recommendations.

Prenatal to Age Five

28. Include IECMH-specific MCO objectives that are measurable and supported with adequate financial incentives.

Implementing Bodies: DHCF, DBH
Timeline to Implementation: Short Term

This includes IECMH promotion and prevention requirements, and encouraging an IECMH-specific Performance Improvement Plan for each MCO. IECMH benefits the MCOs in addition to the Medicaid system and the community, by reducing intervention rates later or costlier treatments for behavioral health diagnoses not addressed at the preventative or early intervention stage. Value-Based, Alternative Payment Methodologies are discussed in more detail in Chapter 4, Financing.

29. Ensure coverage and adequate reimbursement rates for evidence-based dyadic and multigenerational models.

Implementing Bodies: DHCF, DBH
Timeline to Implementation: Short Term

Implement specific billing codes and enhanced rates for current covered services, such as PCIT and CPP. Ensure Medicaid coverage of additional evidence-based IECMH treatment, such as Attachment and Biobehavioral Catchup (ABC). DHCF and DBH have included review of CPP and PCIT rates in a Medicaid rate study begun as of late summer 2021 and are considering ABC, which we fully support. Flexibility in delivery of those services must be encouraged to allow for further advancement of culturally competent and trauma-informed care for this population, as well as contribution toward value-added services.

30. Ensure adequate financing for PMAD screening, prevention, and intervention across all settings and providers, regardless of the caregiver's health insurance status.

Implementing Body: DHCF
Timeline to Implementation: Short Term

Screening tools are ideally administered prenatally, at any postnatal visits for the mother, and additionally when parents are present for infant well-child visits throughout the first year and any ED and other specialized care received for the infant. Consider a psychiatry consultation program for pregnant and postpartum women, such as Massachusetts MCPAP for Moms.[484] Screenings are an important tool in identifying PMADs, and must be supported by prompt access to specialized treatment for perinatal behavioral health concerns that is readily available within the community, and culturally and linguistically representative of the population served.

31. Develop and disseminate a billing crosswalk for Medicaid behavioral health professionals across provider settings (DC 0:5 to DSM-V and/or ICD-10), along with training on use of that crosswalk. Policy guidance or clarification should also be issued regarding multisession assessment.

Implementing Bodies: DHCF, DBH
Timeline to Implementation: Short Term

Crosswalks are tools that providers can use to link diagnostic categories such as the DC:0-5 to a different diagnostic tool such as the DSM or ICD-10, often linked to state requirements for reimbursement. While ICD-10 may streamline all reimbursable activities for behavioral health, they are based in adult behavioral health diagnosis and, therefore, do not take a developmentally informed perspective of the unique issues for infant and early childhood mental health concerns and diagnoses. A simple crosswalk tool will allow for assessment using the age-appropriate diagnostic criteria and tools to detect disorders in this age group; more effective treatment planning; use of a common language for professionals across disciplines; and a consistent process for establishing medical necessity for reimbursement of services.

32. Continue and expand ECMHC programs with permanent and stable funding mechanisms to support needed services in child care centers and PreK3/4 classrooms.

Implementing Bodies: DBH, DHCF, OSSE, DCPS
Timeline to Implementation: Short Term to Medium Term

Currently, ECMHC is implemented in 57 child development centers and 18 home providers in the District through DBH's Healthy Futures program and in eight public charter preschools with the use of philanthropic funds.[372 485] Early childhood mental health consultation is a supportive service that builds teacher, staff, program, and schoolwide capacity to promote social-emotional development, improve challenging behaviors occurring in the child care or education settings, and provide support by embedding psychologists in early child care centers and education settings. This model provides many other benefits including addressing staff well-being through providing support and consultation to teachers and staff. The integrated, team-based approach to care helps reduce some of the burden placed on clinicians. It also promotes positive mental health of young children and their caregivers through providing upstream services, which can help to alleviate the need for acute clinical care later on in development. The District should explore opportunities for continued support and expansion of this program, which will also require an adequate and robust workforce to sustain this effort.

Children Who Speak Languages Other Than English

33. DBH should make its website more accessible to LEP/NEP individuals.

Implementing Bodies: DBH, OHR, DC Office of Disability Rights, D.C. Office for Deaf, Deafblind and Hard of Hearing
Timeline to Implementation: Short to Medium Term

Though DBH has historically scored exceptionally well in its implementation of language access programming by the OHR, it was noted in the most recently published report that DBH is lacking in language accessible materials listed on its webpage.[106] DBH should comply with OHR's recommendations to enhance the language accessibility of its website to LEP/NEP individuals by posting translated information. Additionally, DBH should include on its webpage all the places/pathways that families can access interpretation services—including via Access Helpline, MCOs, and through community agencies.

34. Expand the bilingual/multilingual behavioral health workforce.

Implementing Bodies: OHR, DBH, DHCF, MCOs, Community Based Agencies
Timeline: Long Term

DBH and community-based agencies should make reasonable efforts to hire both clinical (e.g., LCSW, LPC, psychologist, MD/DO, psychiatric NPs, etc.) and nonclinical staff (e.g., community support workers, care navigators, etc.) who are proficient in the languages spoken by District residents. The workforce should offer the full continuum of services to all beneficiaries, including children and families. Reasonable efforts should be made to hire a multilingual workforce from local communities. Additionally, reasonable efforts should be taken to offer these

services near or within the geographic regions of the District where the LEP/NEP communities reside (e.g., services for the Spanish-speaking population within Wards 1 and 4).

The District should invest in bilingual/multilingual behavioral health personnel. Provider organizations that demonstrate strong language capacity should be paid differential rates by the MCOs. That should incentivize provider organizations to offer language skills and training.

Workforce recruitment practices should be modified to hire and retain bilingual/multilingual personnel, and when possible and appropriate, bilingual/multilingual community members should be considered to fill workforce needs. Please reference Recommendation 1 in Chapter 6 for strategies that can be used to implement this.

35. Contract providers that can provide or translate behavioral health services for children in American Sign Language (ASL).

Implementing Body: DBH, DHCF
Timeline: Short to Medium Term

DBH currently contracts with Deaf REACH, an agency that provides ASL interpretation for adults. DBH should contract with an agency that can provide similar services for children (under 18 years). DBH can consider forming a partnership with VocoVision, an agency that has partnered with schools to offer mental and behavioral health support to children in ASL.

In addition, DBH and DHCF should mandate all MCOs contract with the following local resources that offer therapeutic services to children that speak ASL:

- Gallaudet University's Psychology Clinic (including all clinicians affiliated with the Parent Child Interaction Therapy Clinic)
- Deaf Counseling Center
- Kennedy Krieger Institute's Deafness-Related Evaluations and More (DREAM) Clinic

36. Improve data transparency about the language accessibility of services for LEP/NEP individuals.

Implementing Bodies: DHCF, DBH, OHR
Timeline: Short to Medium Term

The following strategies allow greater transparency about language accessibility, which can promote services delivery modifications to better meet the needs of children who speak languages other than English:

- According to the *2019–2023 DC Medicaid Managed Care Quality Strategy*, Medicaid enrollees may voluntarily disclose their primary language during enrollment and that information is shared with MCOs to ensure they provide culturally and linguistically appropriate services to members. Therefore, in line with CMS External Quality Review Protocols,[486] the District's independent external quality review organization should evaluate the linguistic appropriateness of MCO services and ensure it is reported on in their annual *MCO External Quality Review Annual Technical Report*. As mentioned in Recommendation 2 in Chapter 6, use of the CLAS framework[254] or similar standards can facilitate easier measurement of language accessibility.
- OHR should anonymously summarize and publish consumer complaint data on a quarterly basis. That data should be shared with DBH and DHCF leadership, as well as any named community-based provider as applicable, to strengthen the feedback loop between consumer experience and services being offered. The public should also have access to these data to inform decision making when seeking services and for advocacy purposes.

37. Managed care plans should ensure they have an adequate network of multilingual, child-serving providers and should have policies/guidelines for single-case agreements for LEP/NEP beneficiaries that require behavioral health services outside the MCOs standard network.

Implementing Bodies: MCOs, DHCF, DBH
Timeframe: Medium Term

When LEP/NEP consumers receive services from a bilingual (and culturally competent) clinician who is fluent in their preferred language, it helps to reduce the time of treatment, build trust between the clinician and client, and can increase treatment adherence and efficacy. When available, it is best practice to link LEP/NEP consumers with clinicians who are qualified to render services in the consumers' preferred language. MCOs should have policies and guidelines in place to ensure network adequacy for children who speak languages other than English.

Each MCO should have an identified process to request the establishment of a single-case agreement and/or enhanced payment contract when a beneficiary who speaks a language other than English requires a specialized service that is outside the MCO's standard network. It is noteworthy that there are many bilingual/multilingual clinicians in the District who are private-pay and/or operated through out-of-network benefits offered by commercial plans. This should be a special consideration as MCOs develop policies, specifically related to the potential of enhanced payment contracts.

38. Work with OHR to have DBH information included as part of the public awareness campaign for language services.

Implementing Bodies: OHR, DHCF, DBH, DC Health, OSSE, DCPS
Timeframe: Long Term

If a behavioral health awareness campaign is established, ensure that the webpage and materials are translated and posted in multiple languages (reference Recommendation 4 in Chapter 7: Information & Communication). The behavioral health awareness campaign should comply with the Migration Policy Institute best practices for multilingual websites. Guidelines include ensuring high-quality translation of materials, easily accessible, and culturally competent.

39. Create more bridge service opportunities like DC Health-supported Help Me Grow DC and DC MAP Partnership.

Implementing Bodies: DC Health, Help Me Grow, DC MAP, DBH
Timeline: Short, Medium, and Long Term

Until the multilingual workforce shortage can be addressed, the DC government should consider implementing more opportunities for bilingual providers to provide short-term bridge care for children and families. Currently, DC Health supports an expansion grant that partners DC MAP with Help Me Grow DC to employ a bilingual (English and Spanish) psychotherapist part-time who has expertise in early childhood and perinatal mental health. This expansion program offers families access to short-term services (typically one to six sessions) until they are linked with ongoing care in the community, which often can take six-plus months due to extended waiting lists. It is recommended that this expansion program between DC MAP and Help Me Grow DC is continued. Additionally, the DC government may consider creating additional expansion programs to provide short-term bridge services for other special populations with already limited service options that often have extended wait times (e.g., therapy for LEP/NEP LGBTQ+ youth).

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APPENDIX

Appendix A

Table A.1. The Governance & Leadership Roles of Selected Government Bodies in DC's Behavioral Health System for Children

Organization	Governance Role	Related Legislation/ Regulations*	Related Policies*
Centers for Medicare and Medicaid Services (CMS)	According to federal regulations, CMS must review and approve all contracts that states enter into with managed care organizations (MCOs), including contract provisions that incorporate standards for access to care. In addition, each state must submit to CMS its quality strategy, which includes these standards, and must certify that its MCOs have complied with its requirements for availability of services. Further, each state must submit to CMS regular reports describing the implementation and effectiveness of its quality.[xlii] Finally, CMS requires states to work with its Medicaid MCOs and Children's Health Insurance Program (CHIP) to ensure that the Mental Health Parity and Addiction Equity Act is applied to behavioral health services.[xliii]	Social Security Act § 1932[1] 42 CFR 438[xliv] 42 CFR 440 42 CFR 456 42 CFR 457[xlv, xlvi] 80 FR 19418	
Substance Abuse and Mental Health Services Administration	Leads public health efforts to advance the behavioral health of the nation through programs, policies, information and data, funding, and personnel. [xlvii]	Helping Families in Mental Health Crisis Act of 2013, H.R.3717[xlviii] 42 CFR 8[xlix] 42 CFR Part 2[l]	

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[xliii] *Centers for Medicare & Medicaid. Medicaid and Children's Health Insurance Programs; Mental Health Parity and Addiction Equity Act of 2008; the Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans. Federal Register; 2016. Accessed May 10, 2021. https://www.federalregister.gov/documents/2016/03/30/2016-06876/medicaid-and-childrens-health-insurance-programs-mental-health-parity-and-addiction-equity-act-of*
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[l] *SAMHSA's Legal Authority to Expand the Scope of the Part 2 Regulations. Epstein Becker & Green, P.C. Accessed May 10, 2021. https://abhw.org/wp-content/uploads/2019/10/Part-2-Legal-Memo.pdf*

Organization	Governance Role	Related Legislation/ Regulations*	Related Policies*
Administration for Children & Families	Promotes the economic and social well-being of families, children, individuals and communities with funding, strategic partnerships, guidance, training, and technical assistance.[li]	81 FR 61293 (45 CFR chapter undefined)[lii]	
Centers for Disease Control and Prevention (CDC)	Works toward eliminating diseases and ending epidemics through data analytics, lab capacity, and public health expertise.[liii]	Title 42 – Public Health	CDC Regulations
Department of Healthcare Finance (DHCF)	Administers the Medicaid program, programs for immigrant children, the State Child Health Insurance Program and Medical Charities (a locally funded program); DHCF also serves as the State Health IT Coordinator and leads health IT and health information exchange (HIE) policy for the District.	Title XIX of The Social Security Act DC Official Code Chapter 7D. Department of Health Care Finance. §§ 7-771.01 – 7-771.11	Medicaid State Plan Medicaid Managed Care Quality Strategy 2020 State Health Innovation Plan
DC Medical Care Advisory Committee (MCAC)	Reviews Medicaid's operations and offers advice for improvements directly to the DHCF leadership. The MCAC consists of no more than 15 voting members, with at least eight members being beneficiaries or beneficiary advocates and no more than seven members being health care providers (or representatives of providers). The MCAC also has four sub-committees through which nonmembers (including other nongovernmental organizations) can provide input.	Social Security Act § 1902 Code of Federal Regulations (42 CFR 431.12)	DC MCAC By-Laws and Procedures
DHCF Division of Program Integrity	Conducts audits and reviews of providers within DC's Medicaid program and investigates alleged violations of policies, procedures, rules, or laws.[liv]	Code of Federal Regulations (42 CFR 431.10, 42 CFR 447.202, 42 CFR 455, 42 CFR 438, 42 CFR 456, 42 CFR 1001) DC Official Code Chapter 8. Medicaid Provider Fraud Prevention. §§ 4-801 – 4-805	

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[liv] *About DHCF. Government of the District of Columbia. Accessed February 1, 2021. https://dhcf.dc.gov/page/about-dhcf*

Organization	Governance Role	Related Legislation/ Regulations*	Related Policies*
Office of Managed Care	Monitors MCO obligations in providing appropriate, timely, and quality care to managed care eligible persons.[lv]		Medicaid Managed Care Contracts
Department of Health (DC Health)	Works to improve perinatal, childhood, and adolescent health outcomes so every child in DC is healthy and able to thrive.[lvi]	DC Official Code Chapter 7A. Functions of the Department of Health, §§ 7-731 – 7-744.01	DC Health Systems Plan 2017
Health Regulation & Licensing Administration (HRLA)	Licenses and certifies health care facilities for compliance with state and federal health and safety standards and licenses health professionals.[lvii]		
Department of Behavioral Health (DBH)	Provides prevention, intervention, and treatment services and supports for children with mental and/or substance use disorders (including emergency psychiatric care and community-based outpatient and residential services).[lviii]	Department of Mental Health Establishment Amendment Act of 2001, DC Law 14-51 Department of Behavioral Health Establishment Act of 2013	DC DBH Strategic Plan 2019
Department of Behavioral Health Planning Council (BHPC)	Advises the DBH in identifying behavioral health needs in DC, planning and implementing person-centered behavioral health services, communicating to the public about DBH, as well as monitoring and evaluating the allocation and adequacy of mental health and substance abuse services in DC.[lix]	Mental Health Service Delivery Reform Act of 2001 State mental health planning council, 42 U.S. Code § 300x–3	DC BHPC Bylaws
Department of Human Services (DHS)	Provides youth homelessness services, as well as protection, intervention, and social services to help reduce risk and promote self-sufficiency in vulnerable families (including interim disability assistance, subsidized child care, Temporary Assistance for Needy Families and the Supplemental Nutrition Assistance Program).[lx]	Powers and duties of Department of Human Services, § 44–1302. DC Official Code Chapter 7A. Services for Homeless Individuals and Families, § 4-751.01 et seq.	

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[lvi] *Family Health Bureau. Government of the District of Columbia. Accessed February 1, 2021. https://dchealth.dc.gov/service/family-health-bureau*
[lvii] *Health Regulation and Licensing Administration. Government of the District of Columbia. Accessed February 1, 2021. https://dchealth.dc.gov/page/health-regulation-and-licensing-administration*
[lviii] *About DBH. Government of the District of Columbia. Accessed February 1, 2021. https://dbh.dc.gov/page/about-dbh*
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[lx] *Services. Government of the District of Columbia. Accessed February 1, 2021. https://dhs.dc.gov/services*

Organization	Governance Role	Related Legislation/ Regulations*	Related Policies*
Department of Disability Services	Responsible for the oversight and coordination of all services and supports provided to qualified persons with developmental disabilities in DC through its Developmental Disabilities Administration (DDA). The Youth in Transition Services Unit specifically coordinates activities that promote movement from school to post-school.[lxi]	DC Official Code Chapter 7C. Department on Disability Services (DDS) §§ 7-761.01 – 7-761.13 The Rehabilitation Act of 1973 (Rehab Act)	
Child and Family Services Agency (CFSA)	Investigates reports of known or suspected child abuse, assists families in overcoming difficulties that endanger their children, provides safe out-of-home care when a home presents danger, and re-establishes permanent homes for children.[lxii]	DC Official Code Part C. Child and Family Service Agency, § 4-1303 *et seq*	Initial Evaluation of Children's Health Policy Placement and Matching Policy Transition Services for Youth Policy Substance Abuse Treatment Policy Resource Parents Policy Resource Parents Training Policy Educational Services Policy All CFSA policies
Thrive by Five Coordinating Council	Works to measure progress of District and community-level initiatives focused on improving maternal and infant health outcomes (including behavioral health outcomes) and promoting healthy child development from birth to age 5.[lxiii]		Thrive by Five Coordinating Council Mayoral Order
District of Columbia Public Schools (DCPS)	DCPS is a system of neighborhood, matter-of-right schools with some selective school options, and it is required to serve all students in DC.[lxiv]	DC Official Code Chapter 1A. District of Columbia Public Schools § 38-171 *et seq.*	DC Public Schools' strategic plan for 2017-2022 DCPS District-Wide Bullying Prevention Policy

[lxi] *Services for People with Intellectual and Developmental Disabilities. Government of the District of Columbia. Accessed February 1, 2021. https://dds.dc.gov/service/services-people-idd*
[lxii] *Child and Family Services Agency. Government of the District of Columbia. Accessed February 1, 2021. https://dds.dc.gov/sites/default/files/dc/sites/oca/publication/attachments/CFSA_FY10PAR.pdf*
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[lxiv] *District of Columbia State Board of Education. Understanding the DC Public Education Landscape. Accessed February 1, 2021. https://sboe.dc.gov/sites/default/files/dc/sites/sboe/multimedia_content/public%20education%20governance%20%28web%29.pdf*

Organization	Governance Role	Related Legislation/ Regulations*	Related Policies*
Office of the State Superintendent of Education (OSSE)	OSSE serves as the District's liaison to the U.S. Department of Education and works closely with the District's traditional and public charter schools. Some of its key functions that can be linked to behavioral health: providing resources to assist the District's most vulnerable student populations, providing transportation to school for District children with special needs, and increasing health and physical education awareness.[lxv]	Public Education Reform Amendment Act (PERAA) Individuals with Disabilities Education Act (IDEA), 20 U.S.C. § 1400 (2004) The Youth Suicide Prevention and School Climate Survey Amendment Act of 2016, DC Law 21-0120.	OSSE Mental Health Guidelines 2018
State Early Childhood Development Coordinating Council (SECDCC)	Improve collaboration and coordination among entities carrying out federally funded and District-funded pre-K and other early childhood programs.[lxvi]	Pre-K Enhancement and Expansion Act of 2008, DC Law 24-9.	
Public Charter School Board	Provides oversight to public charter schools that are managed by independently run nonprofit organizations called local education agencies (LEAs).[lxvii]	District of Columbia School Reform Act of 1995	DC PCSB Policies
Metropolitan Police Department	Investigates child abuse and neglect, often through collaboration with CFSA; offers youth engagement through summer enrichment programs like the Jr. Police Academy, school year partnerships like the Youth Advisory Council, and clubhouse activities at the Metropolitan Police Boys and Girls Clubs,[lxviii, lxix]	*DC Official Code Chapter 1. Metropolitan Police §§ 5-101.01 – 5-133.21*	

[lxv] *About OSSE. Government of the District of Columbia. Accessed February 1, 2021. https://osse.dc.gov/page/about-osse*
[lxvi] *State Early Childhood Development Coordinating Council (SECDCC). Government of the District of Columbia. Accessed February 1, 2021. https://osse.dc.gov/service/state-early-childhood-development-coordinating-council-secdcc*
[lxvii] *Who We Are. Government of the District of Columbia. Accessed February 1, 2021. https://dcpcsb.org/about-us/who-we-are*
[lxviii] *Children's National Medical Center. Policy for the Identification and Reporting of Child Victimization. Accessed February 1, 2021. https://childrensnational.org/-/media/cnhs-site/files/departments/child_victim_model_project_child_victimization_policy.pdf?la=en&hash=6DFAA56C879F2ACFD42964C1B46D4774A21217F7*
[lxix] *Youth Outreach. Government of the District of Columbia. Accessed February 1, 2021. https://mpdc.dc.gov/page/youth-outreach*

Organization	Governance Role	Related Legislation/ Regulations*	Related Policies*
Department of Youth Rehabilitation Services (DYRS)	Responsible for the supervision, custody, and care of young people charged with a delinquent act in DC in one of the following circumstances: • Youth who are detained in a DYRS facility while awaiting adjudication.[lxx] • Youth who are committed to DYRS by a DC Family Court judge following adjudication.[lxxi] DYRS oversees DC YouthLink, a coalition of community-based organizations that deliver an array of services (including behavioral health services) for youth and families.[lxxii]	Department of Youth Rehabilitation Services Establishment Act of 2004 Omnibus Juvenile Justice Act of 2004	The DYRS Approach: Alcohol and Substance Abuse Treatment The DYRS Approach: DC YouthLink and Community-Based Rehabilitation
DC Council	The Council's central role as a legislative body is to make laws; however, its responsibilities also include oversight of multiple agencies. Specifically, Council committees review the performance of government programs and agencies to ensure they are serving their established purposes and operating under pertinent regulations and budget targets.[lxxiii]	DC Official Code Part A. The Council. §§ 1-204.01 – 1-204.13	Rules Of Organization And Procedure For The Council Of The District Of Columbia - Period 24.
DC Office of Administrative Hearings	The office decides cases involving Medicaid and other public benefits; public space; rent control; professional and business licenses; and building, health and fire code violations, among others.[lxxiv]	DC Official Code Chapter 18A. Office of Administrative Hearings. § 2-1831 *et seq.*	Office Of Administrative Hearings Rules Of Practice And Procedure
Advisory Neighborhood Commissions (ANC)	The ANC is a collection of locally elected representatives who advise the District and federal governments on matters affecting their neighborhoods, such as health services, budget, safety, planning, sanitation, social services, education, recreation, streets, and zoning. In addition to providing recommendations for improving city services, they monitor resident complaints and conduct neighborhood improvement plans. While the District and federal governments are not required to follow all ANC recommendations, they are required to give them great weight.[lxxv]	DC Official Code Part A. General. § 1-309 *et seq.*	

[lxx] *District of Columbia Government Child, Youth & Family Serving Agencies Washington, D.C., District Of Columbia. DC Support Link. Accessed February 13, 2021. https://washington.dc.networkofcare.org/mh/content.aspx?cid=3039*
[lxxi] *Youth Population Snapshot. Department of Youth Rehabilitation Services. Accessed May 6, 2021. https://dyrs.dc.gov/page/youth-snapshot*
[lxxii] *Department of Youth Rehabilitation Services. 2018 DYRS Annual Report; Accessed February 1, 2021. https://dyrs.dc.gov/sites/default/files/dc/sites/dyrs/page_content/attachments/DYRS2018_AnnualReport_WEB.pdf.*
[lxxiii] *About the Council. Council of the District of Columbia. Accessed February 1, 2021. https://dccouncil.us/about-the-council/*
[lxxiv] *Office of Administrative Hearings. Government of the District of Columbia. Accessed February 1, 2021. https://oah.dc.gov/*
[lxxv] *About ANCs. Government of the District of Columbia. Accessed February 13, 2021. https://anc.dc.gov/page/about-ancs*

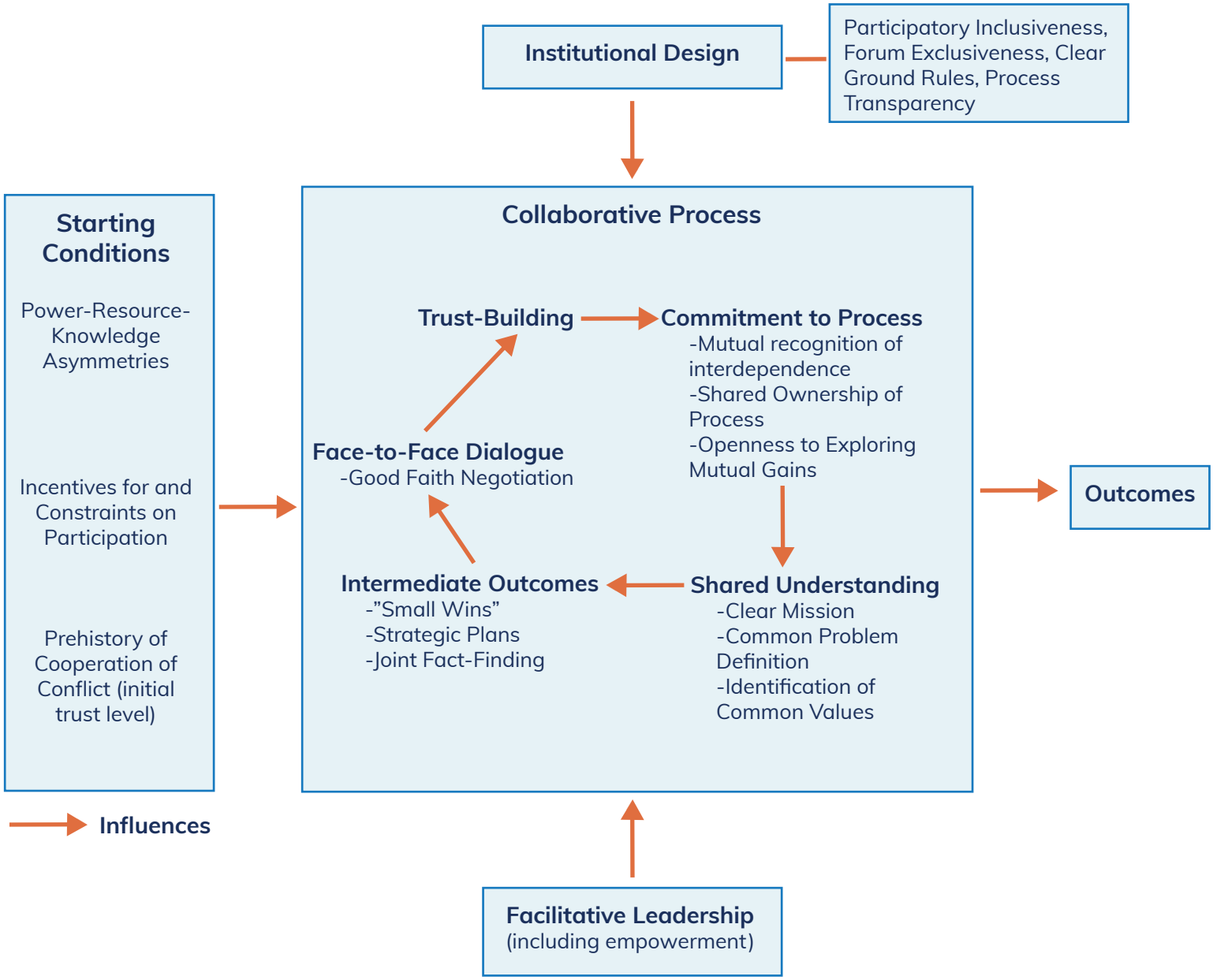
Organization	Governance Role	Related Legislation/ Regulations*	Related Policies*
DC Court of Appeals	The equivalent of a state supreme court, the DC Court of Appeals is authorized to review decisions made by the DC Superior court. It may also review contested case decisions made by the DC government and answer questions of law made by federal and state appellate courts.[lxxvi]	DC Official Code Part C. The Judiciary §§ 1-204.31 – 1-204.34	
DC Superior Court	The divisions of the Superior Court with strongest linkages to the behavioral health system for children are the Family Court Operations Division and the Family Court Social Services (CSS) Division. The former receives and processes cases such as child abuse and neglect, juvenile delinquency and mental health and habilitation, while the latter is the District's juvenile probation agency.[lxxvii]	DC Official Code Part C. The Judiciary §§ 1-204.31 – 1-204.34	

***Not a comprehensive list of legislation or policies related to the authority and responsibility of governmental bodies**

[lxxvi] *GW Law Library: Library Guides: District of Columbia (D.C.) Law: Courts. GW Law. Accessed February 13, 2021. https://law.gwu.libguides.com/DC/courts*

[lxxvii] *Superior Court of the District of Columbia. Superior Court of the District of Columbia 2018 Family Court Annual Report; 2018. Accessed November 11, 2021. https://www.dccourts.gov/sites/default/files/Family-Court-2018-Annual-Report.pdf*

Figure B.1. A Model of Collaborative Governance



Extracted from Ansell, C., & Gash, A. Collaborative Governance in theory and Practice. Journal of Public Administration Research and Theory, 18, 543-571. (2008). https://doi.org/10.1093/jopart/mum

Table C.1. Selected States' Successes and Challenges With Their Behavioral Health Carve-in

State	Behavioral Health Integration Approach	Successes	Challenges
Washington	Washington state uses a fully integrated managed care (FIMC) model, in which all populations receive both physical and behavioral health coverage through the managed care plan. In this system, MCOs may subcontract with managed behavioral health organizations (BHOs) to manage behavioral health coverage.[lxxviii] The transition to FIMC in Washington was phased by region from 2016 to 2020.[lxxix]	• Increased encounter data facilitated proactive patient engagement.[lxxx] • Significant improvements in a number of behavioral health outcomes.[lxxxi] • MCOs standardized claims processing, minimizing administrative burden.[lxxxii] • Early Warning System feedback loop and triage process addressed early implementation issues.[lxxxiii]	• Provider systems reconfigurations related to the transition to FIMC contributed to some delays in claim submissions.[lxxxiv]
New York	New York provides FIMC for the general population, as well as specialty plans (called a Health and Recovery Plan) for individuals with a serious mental illness (SMI) or substance use disorder (SUD).[lxxxv] MCOs may choose to subcontract with BHOs to manage behavioral health benefits.[lxxxvi] Individuals with SMI or SUD are able to opt into a nonspecialty plan if preferred.[lxxxvii] Implementation of New York's carve-in was phased by population and region and began in 2015.[lxxxviii]	• Real-time hospital utilization data collected through New York' electronic HIE has helped improve treatment for high-risk patients.[lxxxix] • Value-based purchase (VBP) arrangement pilots reported improved patient health outcomes and provider readiness to participate in future VBP initiatives.[xc] • Healthcare Effectiveness Data and Information Set (HEDIS) measure use has helped to inform provider whole-health initiatives.[xci]	• Provider workforce shortages have presented challenges in meeting demand associated with behavioral health system reform efforts.[xcii]

[lxxviii] *National Health Law Program. An Overview of Physical and Behavioral Health Integration; 2020. Accessed November 11, 2021. https://healthlaw.org/wp-content/uploads/2020/01/NHeLP-BH-Integration-FINAL.pdf*
[lxxix] *Logan K and Hamblin A. Behavioral Health Integration in Medi-Cal: A Blueprint for California. California Health Care Foundation and Well Being Trust; 2019. Accessed November 11, 2021. https://www.chcf.org/wp-content/uploads/2019/02/BehavioralHealthIntegrationBlueprint.pdf*
[lxxx] *Logan K, Conway M. Exploring the Impact of Integrated Medicaid Managed Care on Practice-Level Integration of Physical and Behavioral Health. Center for Health Care Strategies. July 2, 2019. Accessed November 11, 2021. https://www.chcs.org/resource/exploring-the-impact-of-integrated-medicaid-managed-care-on-practice-level-integration-of-physical-and-behavioral-health/*
[lxxxi] *Logan K and Hamblin A. Behavioral Health Integration in Medi-Cal: A Blueprint for California. California Health Care Foundation and Well Being Trust; 2019. Accessed November 11, 2021. https://www.chcf.org/wp-content/uploads/2019/02/BehavioralHealthIntegrationBlueprint.pdf*
[lxxxii] *Regional Health Alliance and Washington State Health Care Authority. Delivery of Whole-Person Care in Southwest Washington: Report on the First 90 Days of Fully Integrated Managed Care; 2016. Accessed November 11, 2021. https://www.hca.wa.gov/assets/program/early-adopter-report.pdf*
[lxxxiii] *Regional Health Alliance and Washington State Health Care Authority. Delivery of Whole-Person Care in Southwest Washington: Report on the First 90 Days of Fully Integrated Managed Care; 2016. Accessed November 11, 2021. https://www.hca.wa.gov/assets/program/early-adopter-report.pdf*
[lxxxiv] *Regional Health Alliance and Washington State Health Care Authority. Delivery of Whole-Person Care in Southwest Washington: Report on the First 90 Days of Fully Integrated Managed Care; 2016. Accessed November 11, 2021. https://www.hca.wa.gov/assets/program/early-adopter-report.pdf*
[lxxxv] *National Health Law Program. An Overview of Physical and Behavioral Health Integration; 2020. Accessed November 11, 2021. https://healthlaw.org/wp-content/uploads/2020/01/NHeLP-BH-Integration-FINAL.pdf*
[lxxxvi] *Soper, MH. Integrating Behavioral Health into Medicaid Managed Care: Design and Implementation Lessons from State Innovators. Center for Health Care Strategies; 2016. Accessed November 11, 2021. https://www.chcs.org/media/BH-Integration-Brief_041316.pdf*
[lxxxvii] *National Health Law Program. An Overview of Physical and Behavioral Health Integration; 2020. Accessed November 11, 2021. https://healthlaw.org/wp-content/uploads/2020/01/NHeLP-BH-Integration-FINAL.pdf*
[lxxxviii] *National Health Law Program. An Overview of Physical and Behavioral Health Integration; 2020. Accessed November 11, 2021. https://healthlaw.org/wp-content/uploads/2020/01/NHeLP-BH-Integration-FINAL.pdf*
[lxxxix] *Logan K and Hamblin A. Behavioral Health Integration in Medi-Cal: A Blueprint for California. California Health Care Foundation and Well Being Trust; 2019. Accessed November 11, 2021. https://www.chcf.org/wp-content/uploads/2019/02/BehavioralHealthIntegrationBlueprint.pdf*
[xc] *Logan K, Conway M. Exploring the Impact of Integrated Medicaid Managed Care on Practice-Level Integration of Physical and Behavioral Health. Center for Health Care Strategies. July 2, 2019. Accessed November 11, 2021. https://www.chcs.org/resource/exploring-the-impact-of-integrated-medicaid-managed-care-on-practice-level-integration-of-physical-and-behavioral-health/*
[xci] *Logan K, Conway M. Exploring the Impact of Integrated Medicaid Managed Care on Practice-Level Integration of Physical and Behavioral Health. Center for Health Care Strategies. July 2, 2019. Accessed November 11, 2021. https://www.chcs.org/resource/exploring-the-impact-of-integrated-medicaid-managed-care-on-practice-level-integration-of-physical-and-behavioral-health/*
[xcii] *Smyth, A. System Change and Service Providers: Opportunities and Challenges in Addressing Unmet Needs. Behavioral Health News, January 1, 2019. Accessed November 11, 2021. https://behavioralhealthnews.org/system-change-and-service-providers-opportunities-and-challenges-in-addressing-unmet-needs/*

State	Behavioral Health Integration Approach	Successes	Challenges
Arizona	Arizona has opted to integrate behavioral health services into managed care for the general population while contracting with specialty plans through regional behavioral health authorities (RBHAs) that cover both physical and behavioral health for individuals with SMI.[xcii, xciv] Arizona phased the implementation of its carve-in efforts by geography and population, beginning with individuals who have SMI.[xcv] The transition began in 2014 and lasted until 2018.[xcvi]	• Partnerships between RBHAs and BHOs to create data collection platforms led to improvements in care management capacity.[xcvii] • HIE use, including real-time hospital data alerts, helped inform high-risk patient care.[xcviii] • Significant increases were seen in provider participation in state HIE.[xcix]	• One MCO experienced issues with unpaid claims, credentialing errors, service reductions, and staff layoffs related to the transition.[c]

[xcii] *National Health Law Program. An Overview of Physical and Behavioral Health Integration; 2020. Accessed November 11, 2021. https://healthlaw.org/wp-content/uploads/2020/01/NHeLP-BH-Integration-FINAL.pdf*
[xciv] *Logan K and Hamblin A. Behavioral Health Integration in Medi-Cal: A Blueprint for California. California Health Care Foundation and Well Being Trust; 2019. Accessed November 11, 2021. https://www.chcf.org/wp-content/uploads/2019/02/BehavioralHealthIntegrationBlueprint.pdf*
[xcv] *Logan K and Hamblin A. Behavioral Health Integration in Medi-Cal: A Blueprint for California. California Health Care Foundation and Well Being Trust; 2019. Accessed November 11, 2021. https://www.chcf.org/wp-content/uploads/2019/02/BehavioralHealthIntegrationBlueprint.pdf*
[xcvi] *Logan K and Hamblin A. Behavioral Health Integration in Medi-Cal: A Blueprint for California. California Health Care Foundation and Well Being Trust; 2019. Accessed November 11, 2021. https://www.chcf.org/wp-content/uploads/2019/02/BehavioralHealthIntegrationBlueprint.pdf*
[xcvii] *Logan K, Conway M. Exploring the Impact of Integrated Medicaid Managed Care on Practice-Level Integration of Physical and Behavioral Health. Center for Health Care Strategies. July 2, 2019. Accessed November 11, 2021. https://www.chcs.org/resource/exploring-the-impact-of-integrated-medicaid-managed-care-on-practice-level-integration-of-physical-and-behavioral-health/*
[xcviii] *Logan K, Conway M. Exploring the Impact of Integrated Medicaid Managed Care on Practice-Level Integration of Physical and Behavioral Health. Center for Health Care Strategies. July 2, 2019. Accessed November 11, 2021. https://www.chcs.org/resource/exploring-the-impact-of-integrated-medicaid-managed-care-on-practice-level-integration-of-physical-and-behavioral-health/*
[xcix] *Logan K, Conway M. Exploring the Impact of Integrated Medicaid Managed Care on Practice-Level Integration of Physical and Behavioral Health. Center for Health Care Strategies. July 2, 2019. Accessed November 11, 2021. https://www.chcs.org/resource/exploring-the-impact-of-integrated-medicaid-managed-care-on-practice-level-integration-of-physical-and-behavioral-health/*
[c] *Smith AD, Edwards BC, and Frederick D. The Transition of Behavioral Health Services into Comprehensive Medicaid Managed Care: A Review of Selected States. National Council for Behavioral Health. June 2020. Access November 11, 2021. https://www.thenationalcouncil.org/wp-content/uploads/2020/07/Transition_of_BH_Services_into_Comprehensive_Medicaid_Managed_Care_Final_June_2020.pdf?daf=375ateTbd56*

Table D.1. Public Behavioral Health Programs for Children in DC

Program/ Managing Agency	Description of Services	Target Population	Service Utilization & Service Capacity	Points of Entry	Number of Providers
Mental Health Rehabilitation Services (MHRS) program/DBH	Child/youth MHRS include: 1) Diagnostic/ assessment 2) Medication/ somatic treatment 3) Counseling 4) Community support 5) Crisis/emergency 6) Community-based intervention[ci]	Children and youth age 0–22 with severe emotional disturbance (SED) or SMI diagnosis.	Number of children (0-20) served: • FY 2015 – 5060 • FY 2016 – 5512 • FY 2017 – 4807 • FY 2018 – 3821 • FY 2019 – 3692[cii] These numbers were not reported for FY 2020.	• Access Helpline • Contact a CSA directly • DC Jail or pretrial services[ciii] • Provider- or self-referral from Medicaid MCO/Fee-for-Service (FFS)[civ] • Referral from hospital staff, DYRS, CFSA, Child and Adolescent Mobile Psychiatric Service (ChAMPS), or School Based Health Providers (SBHP)[cv, cvi] • Once an individual is assigned and enrolled with a CSA, a diagnostic assessment is scheduled[cvii]	As of July 2019, there were 21 child/youth-serving MHRS providers. MHRS Providers include DBH-certified Core Service Agencies (CSAs) and subspecialty and specialty providers.

[ci] *State Plan for Medical Assistance Under Title XIX of the Social Security Act. Department of Health Care Finance. Government of the District of Columbia. 2015. Accessed November 11, 2021. https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/DHCFStatePlanAttach3-1bSup3_1_0.pdf*

[cii] *Department of Behavioral Health. Department of Behavioral Health FY19-20 Performance Oversight Questions; 2020. Accessed May 26, 2021. https://dccouncil.us/wp-content/uploads/2020/02/dbh.pdf*

[ciii] *Acosta J, Blanchard JC, Pollack CE, Benjamin-Johnson R, Adamson DM, Gresenz CR, and Saloner B. WORKING PAPER: Guide to the Behavioral Health Care System in the District of Columbia. District of Columbia Department of Mental Health; August 2010. Accessed November 11, 2021. https://www.rand.org/content/dam/rand/pubs/working_papers/2010/RAND_WR777.pdf*

[civ] *Wotring JR, O'Grady KA, Anthony BJ, Le LT, Rabinowitz LA, Yoon LS, and Rotto K. Behavioral Health for Children, Youth and Families in the District of Columbia: A Review of Prevalence, Service Utilization, Barriers, and Recommendations." Department of Behavioral Health; May 2014. Accessed November 11, 2021. https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/webpage.%20Children%20Youth%20and%20Families.%20Behavioral%20Health%20Report.pdf*

[cv] *Department of Behavioral Health. MHRS Bulletin: CSA Response to CFSA Initial Referrals. Government of the District of Columbia; 2013. Acessed November 11, 2021. https://dbh.dc.gov/sites/default/files/dc/sites/dslbd/publication/attachments/Bulletin%20%20%23%2096%20CSA%20Response%20to%20CFSA%20Initial%20Referrals.pdf*

[cvi] *Department of Behavioral Health. Department of Behavioral Health FY18-19 Performance Oversight Questions. Council of the District of Columbia; 2019. https://dccouncil.us/wp-content/uploads/2019/04/dbh.pdf*

[cvii] *Department of Behavioral Health. Department of Behavioral Health FY19-20 Performance Oversight Questions. Council of the District of Columbia; 2020. Accessed May 26, 2021. https://dccouncil.us/wp-content/uploads/2020/02/dbh.pdf*

Program/ Managing Agency	Description of Services	Target Population	Service Utilization & Service Capacity	Points of Entry	Number of Providers
Psychiatric Residential Treatment Facility (PRTF)/DBH	A nonhospital treatment center that provides inpatient services to Medicaid-eligible children under 21 years of age in agreement with a State Medicaid Agency[cviii]	Medicaid-eligible children and youth under age 21[cix]	Number of children/youth receiving treatment in a PRTF: • FY18 – 81 (44 new admissions)[cx] • FY19 – 81 (43 new admissions)[cxi] • FY20 – 97 (36 new admissions)[cxii]	DBH PRTF Placement Review Committee is responsible for certifying medical necessity for the PRTF level of care for placements or continued stays to be funded by Medicaid FFS. DHCF approves prior authorizations only if medical necessity has been confirmed by the DBH.[cxiii]	There are no PRTF providers in the District.
HealthCheck or Early and Periodic Screening, Diagnostic and Treatment (EPSDT)/ DHCF	DC HealthCheck offers services such as free check-ups, including developmental and behavioral assessments, and medically necessary care.[cxiv] It also offers provider trainings and fosters collaboration between sectors.[cxv]	Children from birth to 21 years enrolled in DC Medicaid[cxvi]	Number of children/youth eligible for EPSDT who received at least one initial or periodic screen • FY18 – 57,528[cxvii] • FY19 – 59,535[cxviii] Number of children/ youth eligible for EPSDT who were referred for corrective treatment • FY18 – 54,441[cxix] • FY19 – 38,273[cxx]	State Medicaid agencies are required to inform Medicaid-eligible youth and children under age 21 about EPSDT services and arrange for EPSDT service provision.[cxxi]	N/A

[cviii] *Wotring JR, O'Grady KA, Anthony BJ, Le LT, Rabinowitz LA, Yoon LS, and Rotto K. Behavioral Health for Children, Youth and Families in the District of Columbia: A Review of Prevalence, Service Utilization, Barriers, and Recommendations." Department of Behavioral Health; May 2014. Accessed November 11, 2021. https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/webpage.%20Children%20Youth%20and%20Families.%20Behavioral%20Health%20Report.pdf*
[cix] *Wotring JR, O'Grady KA, Anthony BJ, Le LT, Rabinowitz LA, Yoon LS, and Rotto K. Behavioral Health for Children, Youth and Families in the District of Columbia: A Review of Prevalence, Service Utilization, Barriers, and Recommendations." Department of Behavioral Health; May 2014. Accessed November 11, 2021. https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/webpage.%20Children%20Youth%20and%20Families.%20Behavioral%20Health%20Report.pdf*
[cx] *Department of Behavioral Health. Department of Behavioral Health FY18-19 Performance Oversight Questions. Council of the District of Columbia; 2019. Accessed November 11, 2021. https://dccouncil.us/wp-content/uploads/2019/04/dbh.pdf*
[cxi] *Department of Behavioral Health. Department of Behavioral Health FY19-20 Performance Oversight Questions. Council of the District of Columbia; 2020. Accessed May 26, 2021. https://dccouncil.us/wp-content/uploads/2020/02/dbh.pdf*
[cxii] *Department of Behavioral Health. Department of Behavioral Health FY20-21 Performance Oversight Questions. Council of the District of Columbia; 2021. Accessed November 11, 2021. https://dccouncil.us/wp-content/uploads/2021/06/dbh.pdf*
[cxiii] *Turnage, W. Responses to Fiscal Year 2018-2019 Performance Oversight Questions. Council of the District of Columbia; 2019. Accessed November 11, 2021. https://dccouncil.us/wp-content/uploads/2019/04/dhcf.pdf*
[cxiv] *Government of the District of Columbia. Health Check. 2020. Accessed November 11, 2021. https://www.dchealthyfamilies.com/Documents/DC1/HealthCheckBrochureEnglish.pdf*
[cxv] *McCourt School of Public Policy. "Helping Doctors Care for DC's Most Vulnerable." November 24, 2019. Accessed November 11, 2021. https://live-guwordpress-mccourt.pantheonsite.io/news/helping-doctors-care-for-dcs-most-vulnerable/*
[cxvi] *Government of the District of Columbia. Health Check. 2020. Accessed November 11, 2021. https://www.dchealthyfamilies.com/Documents/DC1/HealthCheckBrochureEnglish.pdf*
[cxvii] *Centers for Medicare and Medicaid. Annual EPSDT Participation Report—District of Columbia FY: 2018. U.S. Department of Health and Human Services; 2018. Accessed November 11, 2021. https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html*
[cxviii] *Centers for Medicare and Medicaid. Annual EPSDT Participation Report—District of Columbia FY: 2019. U.S. Department of Health and Human Services; 2019. Accessed November 11, 2021. https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html*
[cxix] *Centers for Medicare and Medicaid. Annual EPSDT Participation Report—District of Columbia FY: 2018. U.S. Department of Health and Human Services; 2018. Accessed November 11, 2021. https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html*
[cxx] *Centers for Medicare and Medicaid. Annual EPSDT Participation Report—District of Columbia FY: 2019. U.S. Department of Health and Human Services; 2019. Accessed November 11, 2021. https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html*
[cxxi] *Early and Periodic Screening, Diagnostic, and Treatment. Medicaid. Accessed May 26, 2021. https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html*

Program/ Managing Agency	Description of Services	Target Population	Service Utilization & Service Capacity	Points of Entry	Number of Providers
Parent Infant Early Childhood Enhancement (PIECE) Program/DBH	Individual, family, art therapy, play therapy, and parents' psychoeducational group. Evidence-based practices offered are: Child Parent Psychotherapy (CPP) and Parent Child Interaction Therapy (PCIT).	• Children ages 0–7, who present with social, emotional, and disruptive behaviors that cause impaired functioning. • Mothers who have been identified as experiencing mental health challenges that impact early attachment and parenting of their infant child.	Children served: • FY 18 – 215 (35 children receiving CPP and 23 children receiving PCIT) • FY 19 – 205 (24 children receiving CPP and 23 children receiving PCIT) • FY 20 – 296 (DBH did not report a breakdown between CPP and PCIT in FY 20).[cxxii] (Note: caseload capacity is 150 clients with each clinician carrying up to 25 cases.)[cxxiii]	• Referral from physician • Access Helpline[cxxiv]	N/A
Healthy Futures/DBH	Child and family-centered consultation services to care providers and family members that build their skills and capacity to promote social-emotional development, prevent escalation of challenging behaviors, and increase appropriate referrals for additional assessments and services.	Consultations provided to child development centers and home child care providers, as well as directly to children and families.	1,825 young children had access to consultation across the 61 Healthy Futures sites.[cxxv]	The point of entry is through the child development centers and home providers that offer Healthy Futures.	61 sites in FY 2019 (42 child development centers and 19 home providers)[cxxvi] Sites are located in every Ward with a concentration in Wards 4 and 8.

[cxxii] *Department of Behavioral Health. Department of Behavioral Health FY20-21 Performance Oversight Questions. Council of the District of Columbia; 2021. Accessed November 11, 2021. https://dccouncil.us/wp-content/uploads/2021/06/dbh.pdf*
[cxxiii] *Department of Behavioral Health. Department of Behavioral Health FY19-20 Performance Oversight Questions. Council of the District of Columbia; 2020. Accessed May 26, 2021. https://dccouncil.us/wp-content/uploads/2020/02/dbh.pdf*
[cxxiv] *Child & Adolescent Mental Health Resource Guide. HealthCheck Training & Resource Center. Accessed May 27, 2021. https://www.dchealthcheck.net/resources/healthcheck/mental-health-guide.html*
[cxxv] *Department of Behavioral Health. Department of Behavioral Health FY19-20 Performance Oversight Questions. Council of the District of Columbia; 2020. Accessed May 26, 2021. https://dccouncil.us/wp-content/uploads/2020/02/dbh.pdf*
[cxxvi] *Behavioral Health in the District of Columbia for Children, Youth, and Their Families: Understanding the Current System. Children's Law Center. 2019. Accessed November 11, 2021. https://childrenslawcenter.org/resources/behavioral-health-district-columbia-children-youth-families-understanding-current-system/*

Program/ Managing Agency	Description of Services	Target Population	Service Utilization & Service Capacity	Points of Entry	Number of Providers
Healthy Steps/ DC Health	An evidence-based national model pediatric primary care program that provides infants and toddlers with social-emotional and development support by integrating child development specialists into primary care and strengthening family engagement.[cxxvii]	Families with infants and toddlers[cxxviii]	In 2019, HealthySteps DC administered 350 parental behavioral health interventions and supported over 2,000 screenings to assess child development and behavioral health.[cxxix]	Families can access Healthy Steps at the applicable sites: • Unity Health Care – Minnesota Avenue Health Center • Unity Health Care – East of the River Health Center • MedStar Georgetown – Medstar Georgetown University Hospital (MGUH) Pediatrics/Kids • MedStar Georgetown – MedStar Medical Group at Fort Lincoln • Children's National – Children's Health Center at THEARC • Children's National – Children's Health Center Anacostia	There are two HealthySteps sites in the District, located in Ward 8.[cxxx] There are plans to expand to four additional sites at Unity Health Care and MedStar Georgetown.[cxxxi]
Primary Project/DBH	Screening and early intervention services to children identified with mild school adjustment issues in pre-kindergarten through third grade.	Children with mild school adjustment issues in pre-kindergarten through third grade	DBH did not report on Service Utilization & Service Capacity.	Accessible through the public schools and child development centers that provide this project	Certain public schools and child development centers (DBH did not report which schools.)

[cxxvii] *Valado T, Tracey J, Goldfinger J, and Briggs R. HealthySteps: Transforming the Promise of Pediatric Care. The Future of Children. 2019;29(1):99-122.*
[cxxviii] *Human Resources & Services Administration. District of Columbia - 2020 - III.E.2.c. State Action Plan - Child Health - Annual Report. Accessed May 27, 2021. https://mchb.tvisdata.hrsa.gov/Narratives/AnnualReport3/258318d0-8dbe-46fd-9a77-385b6753e1c7*
[cxxix] *Weerasingha-Cote T. Testimony Before the District of Columbia Council Committee on Health February 20, 2020. Accessed November 10, 2021. https://childrenslawcenter.org/resources/oversight-testimony-dc-health-0/*
[cxxx] *Our Sites: Find a HealthySteps Site Near You. HealthySteps. Accessed May 27, 2021. https://www.healthysteps.org/sites*
[cxxxi] *Our Sites: Find a HealthySteps Site Near You: Washington, DC. HealthySteps. Accessed November 11, 2021. https://www.healthysteps.org/who-we-are/the-healthysteps-network/healthysteps-practice-directory/?location=Washington+DC*

Program/ Managing Agency	Description of Services	Target Population	Service Utilization & Service Capacity	Points of Entry	Number of Providers
Adolescent Substance Abuse Treatment Expansion Program (ASTEP)/ DBH	Substance abuse assessment and treatment services using Adolescent Community Reinforcement Approach. Every adolescent accessing substance abuse treatment is screened for indicators of a mental health disorder using the Global Appraisal of Individual Needs.	Children under age 21 or up to 22 years of age with a SSA determination of disability, with an Axis I diagnosis of a substance use disorder, who meet insurance and income restrictions, and are a resident of DC at the time of treatment.[cxxxii]	In FY 20, 50 youth in foster care were referred for an assessment by an ASTEP provider.[cxxxiii] DBH does not report total numbers for Service Utilization & Service Capacity.	Adolescents in need of treatment may refer themselves to treatment, or they may be referred by a parent, guardian, doctor, teacher, social worker, mentor, or friend.	ASTEP network provider As of July 2019, 31 certified SUD providers include three child and youth outpatient providers, one child and youth residential provider, and one parent with children provider.
Child and Adolescent Mobile Psychiatric Service (ChAMPS)/ Catholic Charities of Washington Behavioral Health Services & DBH	1) Provides on-site crisis assessments to determine the mental health stability of a youth and their ability to remain safe in the community 2) Assists in the coordination of acute care assessments and hospitalizations when appropriate 3) Conducts post-crisis follow-up interventions up to 30 days after the initial crisis intervention to ensure linkage to DBH mental health providers for ongoing treatment, including longer-term mental health or substance use rehabilitative services	Children ages 6–17, as well as children ages 18–21 if they are in the care and custody of the DC Child and Family Services Agency.[cxxxiv]	In FY 19, 1,125 youth were served.[cxxxv] In FY 20, 710 youth were served.[cxxxvi] In FY 19, the average response time was 32 minutes, with the shortest response time at 31 minutes and the longest response time at 1 hour 35 minutes.[cxxxvii] In FY20, the average response time was 39 minutes. The longest response time was 2 hours, 39 minutes, and the shortest time was 1 minute.[cxxxviii]	Any parent or provider in any setting can initiate crisis emergency services for crisis situations.	The mobile team provides services where the child is located. It is available 24 hours, seven days a week.

[cxxxii] *Acosta J, Blanchard JC, Pollack CE, Benjamin-Johnson R, Adamson DM, Gresenz CR, and Saloner B. WORKING PAPER: Guide to the Behavioral Health Care System in the District of Columbia. District of Columbia Department of Mental Health; August 2010. Accessed November 11, 2021. https://www. rand.org/content/dam/rand/pubs/working_papers/2010/RAND_WR777.pdf*
[cxxxiii] *Donald, B. Performance Oversight Hearing Fiscal Year 2020-2021. Council of the District of Columbia; 2021. https://dccouncil.us/wp-content/uploads/2021/03/FY20-21_CFSA_POH_PreHearing_Responses_FINAL2.pdf*
[cxxxiv] *Millar, M and Rieke A. Re-Routing Behavioral Health Crisis Calls from Law Enforcement to the Health System. DC Health Matters Collaborative; 2021. Accessed November 11, 2021. https://www.dchealthmatters.org/content/sites/washingtondc/Re-Routing_Crisis_Response_white_paper_May_2021.pdf*
[cxxxv] *Department of Behavioral Health. Department of Behavioral Health FY19-20 Performance Oversight Questions. Council of the District of Columbia; 2020. Accessed May 26, 2021. https://dccouncil.us/wp-content/uploads/2020/02/dbh.pdf*
[cxxxvi] *Department of Behavioral Health. Department of Behavioral Health FY20-21 Performance Oversight Questions. Council of the District of Columbia; 2021. Accessed November 11, 2021. https://dccouncil.us/wp-content/uploads/2021/06/dbh.pdf*
[cxxxvii] *Department of Behavioral Health. Department of Behavioral Health FY19-20 Performance Oversight Questions. Council of the District of Columbia; 2020. Accessed May 26, 2021. https://dccouncil.us/wp-content/uploads/2020/02/dbh.pdf*
[cxxxviii] *Department of Behavioral Health. Department of Behavioral Health FY20-21 Performance Oversight Questions. Council of the District of Columbia; 2021. Accessed November 11, 2021. https://dccouncil.us/wp-content/uploads/2021/06/dbh.pdf*

Program/ Managing Agency	Description of Services	Target Population	Service Utilization & Service Capacity	Points of Entry	Number of Providers
School-Based Behavioral Health (SBBH) Program/ DBH	The program's goal is for all public schools and public charter schools to provide a full array of behavioral health supports at three tiers: • Tier 1 encompasses mental health promotion and prevention for all students; • Tier 2 includes focused interventions for students at risk of developing a behavioral health problem; and • Tier 3 is comprised of intensive support/ treatment for individual students who are experiencing a behavioral health problem. DBH identifies CBOs that, through funding from DBH, have the capacity to provide all tiers of services. DBH works with DCPS, OSSE, and the Public Charter School Board (PCSB) to match CBOs with individual schools. Once a school has been successfully matched with a CBO, a full-time CBO clinician is placed in the school to provide full-time behavioral health services.	Pre-K through grade 12 students in DC Public Schools and DC Public Charter Schools	As of 2021, there are 251 schools being served by SBBH programs[cxxxix] • 116 DCPS • 133 charter schools • 2 DYRS schools	The School Strengthening Tool and Work Plan guide the development and implementation of integrated and comprehensive behavioral health services, designed specifically for that school community.	251 public and public charter schools

[cxxxix] *Materials for Coordinating Council on School Behavioral Health October 18, 2021, Meeting. Access October 18, 2021. On file with the Children's Law Center.*

Program/ Managing Agency	Description of Services	Target Population	Service Utilization & Service Capacity	Points of Entry	Number of Providers
Strong Start DC Early Intervention Program (DC EIP)/ OSSE	Early intervention services and supports for children birth to three and their families who are District residents. Each eligible child and their family participate in the development of an Individualized Family Service Plan (IFSP) – for providing early intervention services.	Children under the age of 3 who have or are at risk of having developmental disabilities or delays All services are provided at no cost regardless of the family's income, insurance, and legal or employment status.	In FY 20, there were 1,890 referrals to DC EIP,[cxl] and 1,089 were found eligible as a result of referral.	Primary points of entry are from Clinics.[cxli] The other points of entry include: • CFSA • Child development centers • CBOs • Hospitals • Medicaid MCOs • Other • Other government agencies • Parent/family • Physician's offices	In FY 20, there were seven providers of DC EPI, DC EIP and MCO are the only source of payment options allowed by the program: • Coastal Healthcare • Kids in Motion • Milestone Therapeutic Services • National Therapy Center • Playwell • Strong Start • Little Feet and Hands
Early Stages/ DCPS	All children referred to Early Stages receive a developmental screening. If necessary, the child will receive a more in-depth evaluation and services. Early Stages can recommend specialized instruction, speech/ language therapy, physical therapy, occupational therapy, psychological services, and behavioral support services For eligible children, an Individualized Education Program (IEP) is developed Early Stages offers a variety of professional development workshops certified by OSSE.	Children between the ages of 2 years 8 months and 5 years 10 months	In FY 20, 2,827 children were screened. Of those, 605 (21.4%) were recommended for further evaluation.[cxlii]	Parents/caregivers can contact the center directly. A child care provider, teacher, doctor, or other professional may contact the center with a concern. (Early Stages then contacts parents/ caregivers to begin the process.)	Early Stages Centers (two available in DC)

[cxl] *Young, S. Response to Fiscal Year 2020 Performance Oversight Questions. Government of the District of Columbia, Offices of the State School Superintendent of Education. 2021. Accessed November 11, 2021. https://dccouncil.us/wp-content/uploads/2021/03/FY20-POH-Narrative-v7.2.pdf*
[cxli] *Young, S. Response to Fiscal Year 2020 Performance Oversight Questions. Government of the District of Columbia, Offices of the State School Superintendent of Education. 2021. Accessed November 11, 2021. https://dccouncil.us/wp-content/uploads/2021/03/FY20-POH-Narrative-v7.2.pdf*
[cxlii] *District of Columbia Public Schools. FY20 Performance Oversight Questions. 2021. Accessed November 11, 2021. https://dccouncil.us/wp-content/uploads/2021/03/DCPS-FY20-POH-Oversight-Responses_Final.pdf*

Program/ Managing Agency	Description of Services	Target Population	Service Utilization & Service Capacity	Points of Entry	Number of Providers
Parent & Adolescent Support Services (PASS)/DHS	Several evidence-based approaches to supporting families, including: • Strength-based intensive case management • Functional Family Therapy (FFT) in partnership with DBH • Transition to Independence Process in partnership with DBH All youth receiving PASS services have access to community support services such as mentoring, tutoring, and after-school programming.[cxliii]	Open to families with DC youth ages 10–17 who are committing status offenses Families are not eligible for PASS if they have an open case with CFSA or if the youth has an active case with CSS or DYRS.[cxliv]	As of January 31, 2021, PASS is serving 112 youth, which includes 71 youth receiving PASS Intensive Case Management (ICM), 17 youth receiving services from the PASS Crisis and Stabilization Team (PCAST), and 24 youth receiving therapeutic services from the PASS FFT team.[cxlv]	This is a voluntary program. Referrals can be made by using this PASS Referral form or by email, fax, or phone.[cxlvi]	Offered through DHS.
DC Mental Health Access in Pediatrics (MAP)/DBH	A team of mental health professionals (including psychiatrists, psychologists, social workers, and care coordinators) answer mental health-related inquiries about specific children (e.g., questions about appropriate community resources or medication), as well as provides education and technical assistance for primary care providers (PCPs) about identifying and addressing mental health issues in primary care.	PCPs	Since its inception, 358 PCPs have enrolled in DC MAP. Of that number, 123 remained active in FY 20. Since DC MAP started in May 2015 through December 2020, DC MAP has received a total of 4,066 consultation requests generated from primary care settings.[cxlvii]	N/A	See the Service Utilization & Service Capacity column. Note: As of November 2021, DC MAP's new vendor is Paving the Way.

[cxliii] *Department of Human Services, Parent and Adolescent Support (PASS) Intensive Case Management. Access November 11, 2021. https://dhs.dc.gov/service/parent-and-adolescent-support-pass-intensive-case-management*
[cxliv] *Committee on Human Services. 2021 Performance Oversight. Council of the District of Columbia. 2021. Accessed November 11, 2021. https://dc-council.us/wp-content/uploads/2021/02/DHS_2021-Performance-Oversight-Pre-Hearing-Responses.pdf*
[cxlv] *Committee on Human Services. 2021 Performance Oversight. Council of the District of Columbia. 2021. Accessed November 11, 2021. https://dc-council.us/wp-content/uploads/2021/02/DHS_2021-Performance-Oversight-Pre-Hearing-Responses.pdf*
[cxlvi] *Department of Human Services. Parent and Adolescent Support Services (PASS) Program Referral Form. Accessed November 12, 2021. https://dc-gov.seamlessdocs.com/f/PASSREFERRAL*
[cxlvii] *Department of Behavioral Health. Department of Behavioral Health FY20-21 Performance Oversight Questions. Council of the District of Columbia; 2021. Accessed November 11, 2021. https://dccouncil.us/wp-content/uploads/2021/06/dbh.pdf*

Program/ Managing Agency	Description of Services	Target Population	Service Utilization & Service Capacity	Points of Entry	Number of Providers
High Fidelity Wraparound/ DBH	Care coordination service and is a collaborative team-based care planning process where the family and the team implement, track, and adapt an individualized Plan of Care (POC) to achieve positive outcomes in the home, school, and community.[cxlviii]	A child or youth with complex emotional needs who are at-risk of out-of-home placement or juvenile involvement with the courts for the family[cxlix]	• FY18 – 53 youth referred (new entry) 50 youth served, • FY19 – 45 youth referred (new entry), and 63 youth served. • FY 20 – 41 youth referred (new entry), 93 total youth served.[cl] The average length of stay of youth and families enrolled in wraparound in FY 20 was 10 months.[cli]	Children and youth are currently referred by a DBH-certified Core Service Agency, the Juvenile Behavioral Diversion Program, the Office of the Attorney General, Here Opportunities Prepare You for Excellence (HOPE) Court or the child or youth's family. Once a referral is received, DBH's Wraparound Committee reviews the case presentation. Referral can be received through the program's website, wraparound.cftm@dc.gov or by calling the Access Helpline. Children and youth who are involved in multiple systems and are at risk of out-of-home placement are accepted into the program.[clii]	Children who meet the criteria for wraparound support are connected with DBH's contracted service provider, MBI Health Services (MBI).[cliii] The current contract was awarded to MBI for $1.1 million dollars, currently funded with local dollars.

[cxlviii] *Department of Behavioral Health. High Fidelity Wraparound Care Planning Process. 2014. Accessed November 11, 2021. https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/340.10-TL-260.pdf*
[cxlix] *Department of Behavioral Health. Department of Behavioral Health FY20-21 Performance Oversight Questions. Council of the District of Columbia; 2021. Accessed November 11, 2021. https://dccouncil.us/wp-content/uploads/2021/06/dbh.pdf*
[cl] *Department of Behavioral Health. Department of Behavioral Health FY20-21 Performance Oversight Questions. Council of the District of Columbia; 2021. Accessed November 11, 2021. https://dccouncil.us/wp-content/uploads/2021/06/dbh.pdf*
[cli] *Department of Behavioral Health. Department of Behavioral Health FY20-21 Performance Oversight Questions. Council of the District of Columbia; 2021. Accessed November 11, 2021. https://dccouncil.us/wp-content/uploads/2021/06/dbh.pdf*
[clii] *Department of Behavioral Health. Department of Behavioral Health FY20-21 Performance Oversight Questions. Council of the District of Columbia; 2021. Accessed November 11, 2021. https://dccouncil.us/wp-content/uploads/2021/06/dbh.pdf*
[cliii] *Department of Behavioral Health. Department of Behavioral Health FY20-21 Performance Oversight Questions. Council of the District of Columbia; 2021. Accessed November 11, 2021. https://dccouncil.us/wp-content/uploads/2021/06/dbh.pdf*

Program/ Managing Agency	Description of Services	Target Population	Service Utilization & Service Capacity	Points of Entry	Number of Providers
Access Helpline/ DBH	24-hour call service staffed by behavioral health professionals who respond to crisis calls and dispatch crisis services if needed; enroll individuals in the DBH system of care; assists with consumer transfers between providers, and provides authorization for specialty services. The Access Helpline also includes a "Warm Line" and is certified in suicide prevention. Language interpretation services are available.	District residents (any age).	FY 2020 – number of answered calls was 67,005.[cliv]	N/A	N/A
Help Me Grow DC/ DOH	Information line and integrated district-wide system providing perinatal support and early identification of developmental and behavioral concerns for children under the age of 5.[clv]	Children ages 0–5 living in DC	Not reported	Referrals may come from health care and service providers through a Help Me Grow referral form (paper or online), or a parent or caregiver may also self-refer by dialing 1-800-MOM-BABY.	N/A

[cliv] *Bazron, B. Mental Health and Substance Use Report on Expenditures and Services. District of Columbia Department of Behavioral Health. 2021. Accessed November 11, 2021. https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/MHEASURES%20January%202021.pdf*
[clv] *Child & Adolescent Mental Health Resource Guide. HealthCheck Training & Resource Center. Accessed May 27, 2021. https://www.dchealthcheck.net/resources/healthcheck/mental-health-guide.html*

Program/ Managing Agency	Description of Services	Target Population	Service Utilization & Service Capacity	Points of Entry	Number of Providers
DC Prevention Centers/ DBH	DC has four Prevention Centers that use education campaigns to prevent and delay the onset of alcohol, tobacco, and other drug use. The services provided by the centers include: • Community education: education on current, relevant drug use/access information • Community leadership: builds the prevention capacity of current and emerging leaders and identifies potential Community Prevention Networks for data-driven planning • Community change: working with the networks in action plan development and implementation	District children (anyone under age 21)	FY19 – prevention centers held 368 activities across the city reaching 33,511 adults and youth through planned prevention strategies.[clvi] During FY20, the DCPCs served approximately 9,950 District residents through their 225 activities. Specifically during the COVID-19 pandemic (March through September 2020), the DCPCs implemented 127 activities that reached 3,664 individuals.[clvii]	N/A	Four DC Prevention Centers that each serves two District wards: 1) Latin American Youth Center (Wards 1 & 2) 2) National Capital Coalition to Prevent Underage Drinking (Wards 3 & 4) 3) Sasha Bruce Youth Work, Inc. (Wards 5 & 6) 4) Bridging Resources In Communities (Wards 7 & 8).[clviii]
My DC Health Homes/ DHCF	Interdisciplinary teams coordinate a full array of health and social service needs, including primary and hospital health services, mental health care, SUD care, and long-term care services and support.	People with Medicaid who have: • Two or more chronic conditions • One chronic condition and are at risk for a second • One serious and persistent mental health condition	As of February 25, 2020, there are six My DC Health Homes providers, and a total of 1,251 beneficiaries are enrolled in the program.[clix]	N/A	CSAs, which have hired nurses, primary care liaisons, and others with social and health-related backgrounds

[clvi] *Department of Behavioral Health. Department of Behavioral Health FY19-20 Performance Oversight Questions. Council of the District of Columbia; 2020. Accessed May 26, 2021. https://dccouncil.us/wp-content/uploads/2020/02/dbh.pdf*
[clvii] *Department of Behavioral Health. Department of Behavioral Health FY20-21 Performance Oversight Questions. Council of the District of Columbia; 2021. Accessed November 11, 2021. https://dccouncil.us/wp-content/uploads/2021/06/dbh.pdf*
[clviii] *Prevention Services. Government of the District of Columbia. Accessed November 11, 2021. https://dbh.dc.gov/service/prevention-services*
[clix] *District of Columbia Health Care Finance. FY19-20 Performance Oversight Questions. Access November 18, 2021. On file with the Children's Law Center.*

Program/ Managing Agency	Description of Services	Target Population	Service Utilization & Service Capacity	Points of Entry	Number of Providers
Health Homes 2 or MyHealth GPS (MHGPS)/ DHCF	Multidisciplinary teams within the primary care setting coordinate care across medical, behavioral, and social service systems. Covered services include: • Care coordination • Comprehensive case management • Health promotion • Comprehensive transitional care, • Individual and family support services • Referrals to community and social support services	FFS and MCO beneficiaries with three or more chronic conditions (Note: Beneficiaries who are eligible for a program that provides case management services, such as the Elderly and Persons with Disabilities (EPD) Waiver, The Intellectual and Development Disabilities (IDD) Waiver or the Child and Adolescent supplemental security income (SSI), are not eligible for the MHGPS program).	As of June 2020, My Health GPS has served more than 5,000 enrollees.[clx]	N/A	As of June 2020, the My Health GPS program works with 10 providers: • Bread for the City • Children's National Health System • Community of Hope • Medical Home Development Group • Family and Medical Counseling Service • La Clinica del Pueblo • Mary's Center • Providence Health Services • Unity Health Care • Whitman-Walker Clinic

[clx] *Department of Health Care Finance. Letter about MyHealthGPS. Government of the District of Columbia. Accessed November 11, 2021. https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/ITA%20MHGPS%20Summary%20%289.30.2020%29.pdf*

Program/ Managing Agency	Description of Services	Target Population	Service Utilization & Service Capacity	Points of Entry	Number of Providers
Individualized Education Program (IEP)/ OSSE	A written statement for each child with a disability that is developed, reviewed, and revised in accordance with federal law. The IEP guides a special education student's learning. It describes the amount of time that the child will spend receiving special education services, any related services the child will receive, and academic/behavioral expectations.	Students between ages 3 and 22	As of October 7, 2020, 14,797 public and public charter students had an IEP.[clxi]	DCPS has a Child Find policy which includes public outreach, free and comprehensive screening, complete documentation of referrals, and timely evaluation. A child can be referred to an evaluation for an IEP by family, third-party, educational professionals, etc.[clxii]	The IEP team is a group of individuals including: • The parent(s) • At least one general education teacher • At least one special education teacher; • A representative of the LEA who is qualified to provide, or supervises the provision of, specially designed instruction • An individual who can interpret assessment results and the related instructional implications; • Other individuals, at the discretion of the parent or the LEA, who have knowledge or special expertise regarding the child, including related services personnel, if appropriate • The child, if appropriate

[clxi] *Office of the State Superintendent of Education. Organizational Structure. 2021. Accessed November 11, 2021. https://dccouncil.us/wp-content/uploads/2021/03/Binder1-1.pdf*
[clxii] *District of Columbia Public Schools. Child Find Guidelines. 2020. Accessed November 11, 2021. https://dcps.dc.gov/sites/default/files/dc/sites/dcps/page_content/attachments/ChildFindGuidelines-Version02-Final2-26-20.pdf*

Table E.1. DC Licensing Information for Selected Behavioral Health Professions[clxiii]

Board	License Type	Active Licenses Between October 2018 to February 2020
Medicine	Medicine and Surgery (MD, inclusive of psychiatrists)	10,919
Psychology	Psychologists	1,343
	Psychology Associate	114
Social Work	Graduate Social Worker	1,327
	Independent Social Worker	46
	Independent Clinical Social Worker	3,423
	Social Work Associate	62
Professional Counseling	Licensed Professional Counselor	1,223
	Licensed Graduate Professional Counselor	324
	Certified Addiction Counselor I	95
	Certified Addiction Counselor II	171
Marriage & Family Therapy	Licensed Marriage and Family Therapist	130

[clxiii] *DC Department of Health. DC Department of Health Performance Oversight Response to Question 80. 2020. Accessed November 11, 2021. https://dccouncil.us/wp-content/uploads/2020/02/doh.pdf*

Table E.2. Suggested Supervision Standards by Behavioral Health Profession[clxiv]

Profession	Suggested Supervisor-to-Staff Ratio Maximum	Suggested Weekly Supervision Minimum
Community Health Worker (CHW)	1:6[clxv]	There is no known national standard. However, research indicates that organizations generally report regular individual supervision time and team meetings for CHWs, at least biweekly.[clxvi]
Child Welfare Caseworker	1:5-7[clxvii]	• Two hours per week for new caseworkers.[clxviii] • While there are no known national quantifiable supervision standards for child welfare caseworkers, a survey conducted by the National Association of Social Workers found that nearly half of child welfare caseworkers meet with supervisors once a week or more.[clxix]
Social Worker	National standard not recommended.[clxx]	No known national standard.
Licensed Professional Counselor	No known national standard.	• Trainees: One hour of supervision is provided weekly, plus one additional hour if the trainee provides more than five hours of services, plus one additional hour for every additional five hours of services provided in a week.[clxxi] • Trained staff: One hour of supervision is provided weekly, plus one additional hour if the staff member provides more than 10 hours of services.[clxxii]
Certified Peer Support Specialist	1:8[clxxiii]	One hour per 20 hours of services is provided.[clxxiv]

[clxiv] *These rations are included to provide broad context for our vision for workforce adequacy but are not specific recommendations for District implementation.*
[clxv] *Brooks B, Davis S, Frank-Lightfoot L, Kulbok P, Shawanda P, and Sgarlata L. Building a Community Health Worker Program: The Key to Better Care, Better Outcomes & Lower Costs. American Hospital Association; 2018. Accessed November 11, 2021. https://www.aha.org/system/files/2018-10/chw-program-manual-2018-toolkit-final.pdf*
[clxvi] *Sinai Urban Health Institute. Best Practice Guidelines for Implementing and Evaluating Community Health Worker Programs in Health Care Settings. 2014. Accessed November 11, 2021. https://chwcentral.org/wp-content/uploads/2014/01/CHW-BPG-for-CHW-programs-in-health-care-settings.pdf*
[clxvii] *Salus, M. Supervising Child Protective Services Caseworker. U.S. Department of Health and Human Services. 2004. Accessed November 11, 2021. https://www.childwelfare.gov/pubpdfs/supercps.pdf*
[clxviii] *Salus, M. Supervising Child Protective Services Caseworker. U.S. Department of Health and Human Services. 2004. Accessed November 11, 2021. https://www.childwelfare.gov/pubpdfs/supercps.pdf*
[clxix] *National Association of Social Workers. "If You're Right for the Job, It's the Best Job in the World." 2004. Accessed November 11, 2021. https://www.socialworkers.org/LinkClick.aspx?fileticket=Mr2sd4diMUA%3D&portalid=0*
[clxx] *Association of Social Work Boards. Model Social Work Practice Act. 2013. Accessed November 11, 2021. https://www.aswb.org/wp-content/uploads/2013/10/Model_law.pdf*
[clxxi] *Board of Behavioral Services. Important Answers to Frequently Asked Questions. 2020. Accessed November 11, 2021. https://www.bbs.ca.gov/pdf/publications/mft_faq.pdf*
[clxxii] *Board of Behavioral Services. Important Answers to Frequently Asked Questions. 2020. Accessed November 11, 2021. https://www.bbs.ca.gov/pdf/publications/mft_faq.pdf*
[clxxiii] *Centers for Medicare and Medicaid Services. Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services. 2010. Accessed November 11, 2021. https://downloads.cms.gov/cmsgov/archived-downloads/MedicaidGenInfo/downloads/NC-10-004-Att.pdf*
[clxxiv] *Montana's Peer Network. Behavioral Health Peer Support Specialist Service Best Practices Guide 2020. 2020. Accessed November 11, 2021. https://mtpeernetwork.org/wp-content/uploads/2021/05/BHPSS-Services-Best-Practices-Guide-2020.pdf*

Profession	Suggested Supervisor-to-Staff Ratio Maximum	Suggested Weekly Supervision Minimum
Registered Behavior Analyst	1:10[clxxv]	Five percent of hours are spent providing services.[clxxvi]
Substance Abuse Counselor	No known national standard.	One hour per week[clxxvii]
School Psychologist	Faculty-to-student ratio in school psychology programs should be no greater than 1:12.[clxxviii]	One hour per week for the first three years of full-time employment, followed by periodic supervision, peer review, and professional development efforts.[clxxix]

[clxxv] *Kazemi E and Shapiro M. A Review of Board Standards Across Behavioral Health Professions: Where Does the BCBA Credential Stand?. Behavior Analysis in Practice. 2013;6(2):18-29.*
[clxxvi] *Gray, N. 10 Things Every RBT Should Know. TIIBA. 2020. Accessed November 11, 2021. https://www.tiiba.org/career-tips/10-things-every-rbt-should-know*
[clxxvii] *Substance Abuse and Mental Health Administration. Clinical Supervision and Professional Development of the Substance Abuse Counselor. US Department of Health and Human Services. 2014. Accessed November 11, 2021. https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4435.pdf*
[clxxviii] *National Association of School Psychologists. Proposed 2020 Graduate Preparation Standards. 2020. Accessed November 11, 2021. http://www.nasponline.org/assets/documents/Standards%20and%20Certification/Standards/Draft_2020_NASP_Grad_Prep_Standards.pdf*
[clxxix] *Fischetti B and Lines C. Views From the Field. The Clinical Supervisor. 2004;22(1):75-86.*

My Name is Colie Levar Long, and I was released from prison 10 months ago, after serving over 26 years for a crime I committed as a youth offender. I am speaking before this committee as a Georgetown employee, as I am currently a Program Associate at Georgetown University's Prisons and Justice Initiative. I'm speaking before this committee as a returning citizen, but most importantly, I'm speaking as a concerned citizen for those who currently do not have a voice in this matter.

I am home because of the Second Look Act, and the tireless work of my attorney Destiny Fullwood from the Second Look Project. This Safer Stronger DC Amendment Act that the mayor proposes will severely restrict the scope and undermine the purpose of the IRAA Bill and the Second Look Act. There is a disconnect between what the mayor wants in this Safer Stronger Amendment Act and the needs of our people living in the underserved communities of DC. Because there's no amount of legislation that can create safe communities if we don't have stable households.

There is no correlation between the slight increase in youth-related crimes and the sudden influx of many good men who made bad choices in their youth, learned the errors of their ways, and are coming home from prison to be positive contributors to their households. Through a vigorous vetting process, over 120 men whom all served over 20 years, were able to show a history of rehabilitation and win an opportunity to return to society. Based on a false narrative and a disregard for neuro-science, the Safer Stronger Amendment Act will singlehandedly reverse the IRAA and Second Look Act and take away the only opportunity my brothers have to come back home and help rebuild the communities they come from.

Bill 2023-061, "Safer Stronger Amendment Act of 2023."
The National Network for Returning Citizens

Courtney Stewart
Before the
Committee on The Judiciary & Public Safety
For
Council of the District of Columbia
Councilmember Brooke Pinto

Tuesday, June 27, 2023

Good afternoon to all in attendance.

Thank you chairperson Brooke Pinto, members of Council of The District of Columbia, and community members for being here today. In light of bill 2023-061, Safer Stronger Amendment Act of 2023, I came here today on behalf of the National Reentry Network for Returning Citizens to reiterate the importance of the Incarceration Reduction Amendment Act of 2016.

Introduced first in 2016, The Incarceration Reduction Amendment Act, known as IRAA, allows for incarcerated residents who committed serious crimes before their 18th birthday to petition the court to reevaluate their sentencing following at least 15 years of completion of the original sentence. Rather than taking a harsher punitive stance, the act allows for proper consideration of the individual's personal history. By allowing this, factors such as environment, personal growth, rehabilitation progress, and much more is taken into account when evaluating whether or not to change the original sentence. Since the original bill's passing, numerous additions have expanded who qualifies for review, as seen with both the Second look Amendment Act of 2019 and the Omnibus Public Safety and Justice Act of 2020.

IRAA has gone above and beyond in showing the importance of judicial review and consideration of all personal circumstances in sentencing. An adolescent does not have proper decision making skills in comparison to an adult, are extremely susceptible to fail to recognize all of the risks associated with crime, and to give into peer pressure and negative influence of others. Children who grow up surrounded by poverty, inequality, unstable families, drug usage, and so much more become psychologically traumatized in many cases from this exposure. These negative factors discussed that can influence criminal activity often impact children and adolescents far more seriously than a fully developed adult, thus it is unfair in many situations that mature adults who have taken strides to improve themselves are still serving time for a crime committed decades ago. IRAA has dozens of success stories, individuals are truly given a second chance at life again because of it.

Mayor Muriel Bowser's Safer Stronger Amendment Act of 2023 contains many instances of approaches that pose risks of harming our communities, especially in the case of juvenile justice.

A major component of the Safer Stronger Amendment is the emphasis on increased penalties for violent crimes that victimize or target vulnerable residents with physical or mental impairments as well as expanded protections for transit and for-hire vehicle employees, transit passengers, and people at rec centers[1].h

Crimes largely committed by juveniles in DC, are crucial for us to stop nonetheless, but are indicative of a much larger issue that is being ignored. We must invest in our communities more. Further creating punitive sentencing measures without any sort of increased community efforts and involvement will continue the detrimental cycle of over sentencing, and in this case it is our youth that may suffer the most. DC is ridden with social inequality, gentrification, and poverty in so many areas- committing to fixing these issues will also largely decrease the city's crime rates. Each day we continue to focus more and more on increasing penalties and deterrence based practices despite the ever so obvious cries of help from dozens of communities here. We cannot allow our constituents to keep suffering from these factors that we are well aware of.

We already see far too much opposition to resentencing appeals, and even though The Safer Stronger Amendment claims to honor increasing discretion in these instances, it is not enough. The U.S. The Attorney's office challenges individuals despite the protection provided by IRAA[2], and with increasing punitive measures will come more and more legal challenges that will deny individuals the chance of renewal at life.

Because incarceration changes one's life in so many ways through limiting employment, housing, and stability, we strongly support resentencing acts. The Safer Stronger Amendment Act poses too large of a risk to strip dozens of individuals of the chance of early release, and will complicate existing acts that favored judicial sentencing review for juvenile offenders. I stand before you today demanding that you truly consider the potential harm the Safer Stronger Amendment poses.

I sincerely am thankful for this opportunity to be heard by the Judiciary and Public Safety Council, and I also thank Councilmember Pinto for your time.

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[1] Mayor Bowser announces Safer Stronger Amendment Act of 2023 (Executive Office of The Mayor, 2023) https://mayor.dc.gov/release/mayor-bowser-announces-new-safer-stronger-dc-legislation

[2] Federal Prosecutors Have Opposed Every Request For Early Release Under A Local Law Aimed At Juvenile Offenders (DCist, 2019) https://dcist.com/story/19/05/23/federal-prosecutors-have-opposed-every-request-for-early-release-under-a-local-law-aimed-at-juvenile-offenders/

Council of the District of Columbia
Committee on the Judiciary and Public Safety
Brooke Pinto, Chair
Testimony of Craig Watson
Public Hearing
The Safer Stronger Amendment Act of 2023
Tuesday, June 27, 2023
Room 500
Wilson Building 1350 Pennsylvania Ave NW Washington DC

Good afternoon Chairwoman Pinto and members of the Committee,

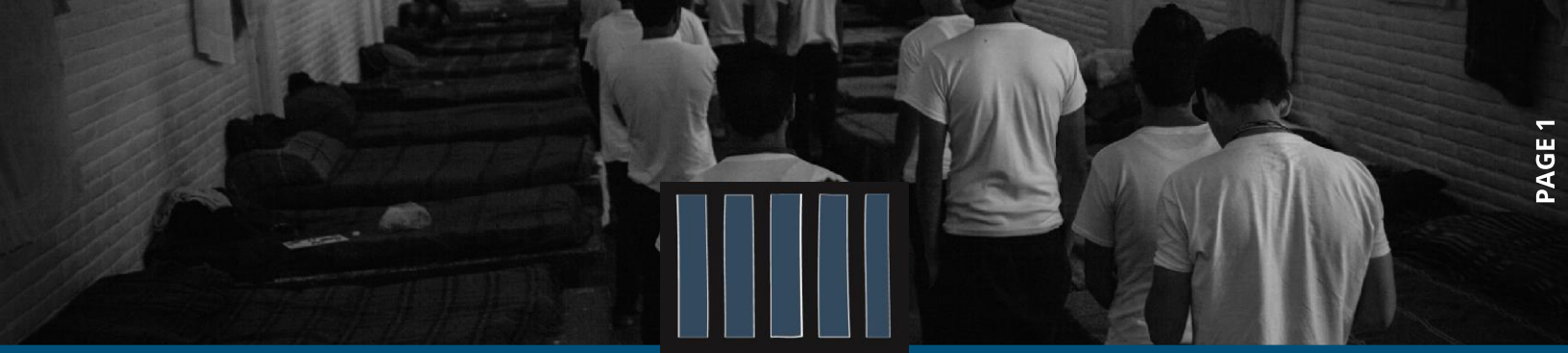
Thank you for this opportunity to testify. My name is Craig Watson and I am a recipient of the Incarceration Reduction Amendment Act. I am the Peer Support Specialist and Restorative Justice Facilitator for Free Minds.

I am here today to urge the Council to keep the IRAA and Second Look Act as they were originally passed. As a peer supporter for IRAA recipients, I have seen first-hand how much those that have come home are making our city safer and stronger and stopping the violence. We are a very close group and we know together we can bring change. We are committed to repairing the harm in our neighborhoods.

During my incarceration, I wrote a letter to the family of my victim, apologizing for the pain I caused them. I realized my words could not change anything, or take away their grief. I did not expect them to forgive me, I just wanted them to know that I was taking responsibility for what I did. The father of the victim wanted to visit me. When we met, we began talking and I broke down crying. He grabbed my hand, and he said, "I gotchu. I forgive you. And I love you." Before he left, he hugged me and promised me, "I'm gonna stay in contact with you no matter what happens." That meant so much to me. I've been home for almost 4 years now, and I still talk to the father every week. I want to make sure no father has to go through the loss he has endured. I want to bring healing to our city and stop the pain.

We at Free Minds have a community healing project in partnership with Network for Victim Recovery DC, which is centered on Restorative Justice practices where those who have caused and experienced harm can work together to understand and heal from each other's traumas and repair harm.

I believe a second opportunity should continue to be offered to everyone. Thank you very much for this opportunity to share.



JUVENILE JUSTICE ADVOCATES

July 10, 2023

Statement from Douglas Keillor
Founder & Executive Director, Juvenile Justice Advocates International
Council of the District of Columbia
Regarding B25-291, the Safer Strong Amendment Act of 2023

The District of Columbia has a higher rate of child incarceration than nearly any other jurisdiction in the world. The proposed Safer Stronger Amendment Act of 2023, B25-291 would increase D.C.'s incarcerated child population. Based on internationally recognized child rights principles, Juvenile Justice Advocates International urges the Council of the District of Columbia to reject the proposed changes and redouble efforts to divert children from the justice system to community-based alternatives and embark on a policy of decarcerating its youth justice system.

Child Incarceration as a Last Resort

Children should only be incarcerated as a last resort. Before placing children in pretrial detention. all alternatives should be carefully considered.[1] The United States has the highest rate of child incarceration in the world.[2] The District of Columbia has a higher rate of child incarceration than any other U.S. state and four times the U.S. national average.[3] Under the current law, D.C. is not using child incarceration as a last resort. The proposed changes would increase the use of pretrial detention with no requirement to first exhaust alternatives, violating the rights of more children.

Prosecutor's Burder to Show Need for Pretrial Detention

Under international principles, children should never automatically be subjected to pretrial detention. Rather, it is the prosecutor's burden to show that pretrial detention is necessary for the safety of the community and the integrity of the legal process, and that less restrictive alternatives are insufficient.[4] Otherwise, pretrial detention is converted into a punishment before trial and violates the principle of the presumption of innocence. The proposed changes expand the categories of charged offenses where the presumption is in favor of pretrial detention, subjecting more children to violations of their due process rights.

Pretrial Detention Conditions

Children deprived of liberty must be placed in facilities that can ensure their safety, provide for all of their needs and ensure activities that promote youth development and social reintegration. [5] Reports indicate that D.C.'s Youth Service Center is already at capacity and

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[1] Convention on the Rights of the Child [CRC], G.A. Res. 44/25, art. 37(b) & 40(3)(b), "Juvenile Justice and Human Rights in the Americas," Inter-American Commission on Human Rights, para 276; U.N. General Assembly, *United Nations Standard Minimum Rules for the Administration of Juvenile Justice ("Beijing Rules"),* para 11, 18, 19(1), U.N. Doc. A/Res/40/30 (Nov. 29, 1985) [hereinafter The Beijing Rules]; U.N. Comm. on the Rights of the Child, General Comment No. 24 on children's rights in the child justice system [hereinafter General Comment No. 24], U.N. Doc. CRC/C/GC/24 (September 18, 2019) paras 85-87.

[2] The United Nations Global Study on Children Deprived of Liberty, Manfred Nowak, November 2019, p. 262.

[3] Juvenile Justice State Profiles, Statistical Briefing Book, Office of Juvenile Justice & Delinquency Prevention.

[4] Convention on the Rights of the Child [CRC], G.A. Res. 44/25, art. 40(2)(b)(i), U.N. Doc. A/Res/44/25, (Nov. 20, 1989)[CRC].

[5] CRC art. 37(c); General Comment No. 24 para 95(b)-(c).

understaffed, resulting in a lack of necessary services for the children already detained there. Increasing the number of children deprived of liberty would only exacerbate these shortcomings and make the facility more unsafe for all children detained there, posing an unacceptable risk to these children.

The international community has recognized these rights for children deprived of liberty for over 30 years. Now is the time for the Council of the District of Columbia to insist that your children are protected with the same rights of millions of children around the world, rather than regress further by subjecting more children to incarceration. This is why Juvenile Justice Advocates International calls on the Council of the District of Columbia to reject the Safer Stronger Amendment Act of 2023, B25-291 and instead explore proven strategies to reduce child incarceration.

About Juvenile Justice Advocates International:

Juvenile Justice Advocates International is an internationally recognized leader in juvenile justice system reforms that improve respect for human rights of children in conflict with the law. JJAI's vision is that children should only be imprisoned as a last resort, in extreme circumstances, and for the shortest period of time possible. JJAI was founded in 2013 with offices in Mexico City and St. Paul, Minnesota. For inquiries contact **info@jjadvocates.org**

Douglas Keillor
douglas@jjadvocates.org
https://jjadvocates.org

Council of the District of Columbia
Committee on the Judiciary and Public Safety
Brooke Pinto, Chair
Testimony of Daniel Kinard
Public Hearing
The Safer Stronger Amendment Act of 2023
Tuesday, June 27, 2023
Room 500
Wilson Building 1350 Pennsylvania Ave NW Washington DC

Good afternoon Chairwoman Pinto and members of the Committee,

Thank you for this opportunity to testify. My name is Daniel Kinard and I am a recipient of the Incarceration Reduction Amendment Act. I am also a proud member of Free Minds Book Club & Writing Workshop. All IRAA petitioners and recipients are eligible to be in the Free Minds community of support and we unite together to bring peace to DC. We meet every week to be with each other , encourage each other and come up with ways to help the youth and the city we love. We work hard, we are fiercely committed to helping our neighbors and young people.
I am here today to urge the Council to keep the Incarceration Reduction Amendment Act and Second Look Amendment Act as they were originally passed. .

IRAA has given many of my peers including myself new hopes in life, the hopes of being a part of our family's lives and being productive members of our community. Many IRAA members have taken to the street again, to help combat the problem that many of us feel we contributed to in some way or another back in the 80's and 90's.

We are brothers and sisters, who are given a new chance, a new lease on life to do something greater for others. We are fighting against more incarceration and we stand together in lowering recidivism.

Many IRAA members have gone back to the D.C. jail, not as a returning inmate but to talk with our young brothers that are housed there.

We reach back into the federal Bureau of Prisons and give brothers there hope that they too can one day make it out of there, come home and make a difference in the lives of others.

Chairwoman Pinto, I would ask this of you and Councilmembers present today, if it's not broken why fix it? Granted, there are people here who dislike ideas like this all together; to those of you, I ask that you please try to find peace in your heart and help us stop the violence in D.C., our community.

Since coming home from prison, I've been working and giving back to my community as a mentor. I know that there are so many fellow IRAA brothers and sisters that have yet to be given the opportunity to contribute their talents and gifts to transform our

neighborhoods. They are needed here, so that they can be on the frontlines of creating community-driven solutions that will build a truly safer and stronger DC.

We can't bring back that which was lost, but we can stop more from being lost. Thank you for this opportunity to speak.

fwd.us

FWD.us Written Testimony on B25-0291, The Safer Stronger DC Amendment Act of 2023
Committee on the Judiciary and Public Safety Public Hearing
July 3, 2023

FWD.us is a bipartisan political organization that works to address the harms caused by our immigration and criminal justice systems. FWD.us was founded by leaders in the technology and business communities and believes that America's families, communities, and economy thrive when more individuals are able to achieve their full potential.

This written testimony is submitted by Dawit Getachew, D.C. Director for Criminal Justice Reform at FWD.us, to the Committee on the Judiciary and Public Safety of the D.C. Council following the hearing on June 27, 2023 on the Safer Stronger Amendment Act of 2023 (SSDC). Mr. Getachew, who lives in Ward 8, provided oral testimony at the hearing and this written testimony expands on the position of FWD.us.

FWD.us strongly opposes the SSDC because of decades of research showing that unnecessary pretrial detention and longer prison sentences increase taxpayer spending, hurt families and communities, and provide no public safety benefits. The SSDC moves the District's criminal justice system in the wrong direction and will make it harder for the D.C. Council to invest in evidence-based public safety solutions that would be more effective.

Specifically, we oppose the policy changes in the SSDC that would dramatically increase incarceration without making D.C. residents, or the communities hardest hit by mass incarceration and violent crime, any safer. The most harmful of the proposed policies are the changes that would:

1. Significantly increase pretrial detention for youth and adults;
2. Create new mandatory minimums and sentencing enhancements that undermine judicial discretion; and
3. Roll back D.C.'s successful Second Look law

D.C. leaders cannot afford to return to failed policies that created the current mass incarceration crisis. Instead, it's critical to support policies that do not increase incarceration and advance long term public safety in the District.

The Problem of Mass Incarceration in the District

Although the District has made strides in reducing its bloated prison and jail populations, nearly 4,000 D.C. residents are incarcerated in its jails and in federal prisons.[1] The District's incarceration rate of 590 people per 100,000 residents remains above the national average. The racial disparities in the District's criminal justice system also remain stubbornly high. Black residents are 21 times more likely to be imprisoned than white residents and 17 times more likely to be incarcerated in jail.[2]

These statistics and their corresponding harm are not lost on District voters, who strongly prefer investments in social services and treatment in the community to more incarceration. According to polling conducted by HIT Strategies in 2022, 81 percent of D.C. voters believe it is important to reduce the jail and prison population in the District, including 87% of Black voters.[3] Likely voters are also nearly twice as likely to say that hiring more social workers, funding vocational and job training, and funding treatment programs would make them feel "much safer" compared to sending more people to jail or prison.[4]

Any policy changes that would further increase incarceration or exacerbate racial disparities in the District would therefore only worsen the District's already high incarceration rate and stand in stark contrast to voters' preference for real public safety solutions.

Increasing Incarceration Will Not Increase Public Safety

Decades of research and evidence show that doubling down on more criminalization and incarceration will not advance public safety. To the contrary, incarceration actually increases the likelihood that people will be reincarcerated and directly contributes to the destabilization of communities, without improving public safety.[5]

A recent meta analysis that reviewed every study published comparing outcomes for people who received incarceration sanctions (jail or prison) to those who received non-incarceration sanctions such as probation found that putting people in jail or prison either has no impact on

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[1] D.C. Corrections Information Council, "CIC Bulletin" https://cic.dc.gov/sites/default/files/dc/sites/cic/release_content/attachments/CIC%20Bulletin%20-%20June%202023.pdf

[2] FWD.us analysis of D.C. Residents in Federal Bureau of Prisons Custody at the end of August 2022, available via the District of Columbia Justice Statistical Analysis Tool (DC JSAT) at https://www.dcjsat.net/FBOP.html, and Washington, D.C. population estimates from the U.S. Census Bureau, July 2022. Analysis was limited to individuals in secure institutions and does not account for D.C. residents in residential reentry confinement.

[3] HIT Strategies. "District Voters Overwhelmingly Support Revised Criminal Code Act." April 2022. Available: https://hitstrat.com/wp-content/uploads/2022/06/DC-Justice-Lab-Memo-District-Voters-Support-RCCA.pdf

[4] Ibid.

[5] Charles E. Loeffler1 and Daniel S. Nagin. "The Impact of Incarceration on Recidivism." Annual Review of Criminology. January 2022. Available: https://www.annualreviews.org/doi/10.1146/annurev-criminol-030920-112506

their likelihood of reoffending or makes them more likely to commit another crime.[6] On average, across all of the studies, they found that putting someone in jail or prison made them eight percentage points more likely to recidivate in the future.[7]

That is one of the reasons why 37 states were able to reduce their imprisonment rate and their crime rate simultaneously between 2009 and 2019.[8] In fact, crime fell faster in the states that reduced their imprisonment rate than in states that did not. Indeed, D.C. also experienced declines in both its incarceration rate and crime rate during this period. This shows that public safety and a fairer, smaller criminal justice system are not in conflict and are actually two sides of the same coin.

Since incarceration is one of the least effective and most expensive approaches to crime prevention, increasing incarceration undermines taxpayer investments in real public safety solutions and unnecessarily harms already disadvantaged communities. These effects have multi-generational negative impacts for the communities that are disproportionately harmed, especially Black communities. This harm extends beyond the people who are incarcerated, and their children and other family members also experience reduced financial stability, housing security, educational achievement, and physical and mental health outcomes.[9]

Increasing Pretrial Incarceration Hurts Families and Will Not Reduce Crime

The proposal to increase pretrial detention for youth and adults would have a devastating consequence for families and unravel the progress that the District has made over the years in reducing the number of people held in jail while awaiting trial. Pretrial releases are not connected to any increase in crime. In the last fiscal year, 93% of people who were released pretrial in D.C. were not rearrested in the District for any offense while awaiting trial. Only 1% of those released pretrial were re-arrested for a violent crime.[10]

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[6] Damon M. Petrich, Travis C. Pratt, Cheryl Lero Jonson, and Francis T. Cullen, "Custodial Sanctions and Reoffending: A Meta-Analytic Review," Crime and Justice, volume 50, 2021. Available: https://www.journals.uchicago.edu/doi/pdf/10.1086/715100

[7] Ibid.

[8] FWD.us. "Advancing Public Safety and Moving Justice Forward." Fall 2022. Available: https://www.fwd.us/wp-content/uploads/2022/09/Advancing-Public-Safety.pdf

[9] Brennan Center for Justice. "Conviction, Imprisonment, and Lost Earnings: How Involvement with the Criminal Justice System Deepens Inequality." September 2020. Available: https://www.brennancenter.org/our-work/research-reports/conviction-imprisonment-and-lost-earnings-how-involvement-criminal; Prison Policy Initiative. "Incarceration Shortens Life Expectancy." June 2017. Available: https://www.prisonpolicy.org/blog/2017/06/26/life_expectancy/; Ella Baker Center. "Who Pays? The True Cost of Incarceration on Families." September 2015. Available: https://ellabakercenter.org/who-pays-the-true-cost-of-incarceration-on-families/; Sundaresh, R., Yi, Y., Harvey, T. "Exposure to Family Member Incarceration and Adult Well-being in the United States," JAMA Network, May 2021, https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2780438

[10] Court Services and Offender Supervision Agency for the District of Columbia, "FY 2022 Agency Financial Report," Available: https://www.psa.gov/sites/default/files/FY%202022%20Agency%20Financial%20Report.pdf

Research shows that even short term incarceration can have far-reaching consequences, including loss of employment and housing, that cause families significant economic and social hardship. Overwhelming evidence makes clear that the proposed change would hurt public safety: holding people in pretrial detention (youth or adults) has been shown to increase, rather than decrease, the likelihood that a person is rearrested again.[11]

Similarly, expanding pretrial detention of children is not an effective public safety intervention. It goes against the goal of the youth justice system to rehabilitate and flies in the face of research showing incarceration leads to worse outcomes and increased risk of recidivism for kids.[12]

The bill significantly broadens the scope and purpose of D.C 's detention law enabling courts to detain children pre-adjudication for the purported purpose of protecting "the person or property of others or *of the child* from significant harm." However, data shows that incarceration will serve no such purpose. Additionally, children accused of committing a range of offenses would also be subject to a presumption of detention.

The notion of incarcerating children for their own safety is fundamentally flawed. Youth detention centers, which are primarily designed to isolate and punish, are inherently ill equipped to foster the nurturing and supportive environment that is crucial for healthy child development. Numerous studies have shown that confining children in secure detention facilities exposes children to physical and emotional harm that undermines a child's wellbeing and would actually increase the likelihood of recidivism.[13]

New Mandatory Minimum Penalties and Arbitrary Sentence Enhancements will not Improve Public Safety

The SSDC will also increase the number of people who will be sentenced to prison and the length of time they will be imprisoned, despite evidence that clearly shows that long sentences do not improve public safety.

Importantly, provisions that include mandatory minimum sentences and other enhancements to the District's already long sentences echo failed policies that were key drivers of mass incarceration in the District. These punitive policies have resulted in significant racial disparities in the criminal justice system and Black D.C. residents have borne the brunt of these harsh sentencing laws. The high rates of incarceration has had a domino effect leading to cycles of poverty, disenfranchisement and inequities that continues to impact communities even today.

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[11] Charles E. Loeffler and Daniel S. Nagin, "The Impact of Incarceration on Recidivism," Annual Review of Criminology 2022 5:1, 133-152. https://www.annualreviews.org/doi/abs/10.1146/annurev-criminol-030920-112506

[12] Petrich et al 2021.

[13] The Sentencing Project, "Why Youth Incarceration Fails: An Updated Review of the Evidence," March 1, 2023 https://www.sentencingproject.org/reports/why-youth-incarceration-fails-an-updated-review-of-the-evidence/

Indeed, the D.C. Council recognized the harmful and disproportionate impact of mandatory minimums on Black Washingtonians as outlined in its racial equity impact assessment (REIA) during consideration of the Revised Criminal Code Amendment Act (RCCA) last year.[14] The REIA noted that the "elimination of all mandatory minimum sentences will empower and protect the rights of crime victims in the District, who are disproportionately Black."[15]

Today there is a bipartisan understanding that mandatory minimums are a wasteful, one-size-fits-all approach that undermines judicial discretion and worsens racial disparities. Mandatory minimum sentences constrain judges, removing their ability to consider the individual circumstance of each case and individual. Mandatory minimums undermine the principle of fair and proportionate punishment and judicial discretion. States across the country, including conservative states like Louisiana and Mississippi, are rolling back or rejecting mandatory minimums. and it is regressive for D.C. to even consider adding new ones.

The proposals compound on the problems underlying the District's antiquated code by adding new penalties instead of comprehensively revising our current sentencing laws.

Rolling Back IRAA Would Undermine Public Safety

Third, the proposed changes to the District's Incarceration Reduction Amendment Act (IRAA) would undo a successful policy that has given more than 100 people a meaningful second chance to return to their communities, without compromising public safety.

The proposed change to IRAA purports to give judges more flexibility whether sentences should be modified but overlooks the fact that the existing law already offers broad discretion. After people have served at least 15 years, IRAA allows courts to alter a sentence upon finding that a petitioner wouldn't be a danger to others and that resentencing the individual would be in the interests of justice.[16] The bill also aims to more heavily weigh the nature of the crime in the judge's consideration. By amplifying the weight of the original offense–a factor that individuals cannot change–it would inevitably overshadow personal growth and rehabilitation demonstrated by individuals, factors that are far more relevant to a person's ability to successfully return to their communities without compromising public safety.

This successful law has led to over a hundred people successfully reintegrating back in their communities. Individuals who have been released under IRAA have remarkably low recidivism rates, underscoring the law's success in reducing incarceration and giving people a second chance. People who have been released under IRAA have been able to rebuild their lives and reconnect with their families. Many have become active leaders contributing to their

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[14] Council Office of Racial Equity, "Bill 24-0416 - Racial Equity Impact Assessment Revised Criminal Code Act of 2022," October, 2022. Available: https://lims.dccouncil.gov/downloads/LIMS/47954/Other/B24-0416-REIA_-_Bill_24-0416_-_Revised_Criminal_Code_Act_of_2022.pdf?Id=148223

[15] Ibid.

[16] D.C. Code §24-403.03

communities, including as credible messengers, and spearheading initiatives to reduce gun violence and promote peace across the city.[17]

D.C. Leaders Cannot Afford to Return to Failed Policies

In this moment, where our city has seen a troubling increase in gun violence and some serious offenses, it is critical for elected officials not to revert to failed policies that will only deepen harm to our communities. Instead, this moment must be met with data-driven solutions like the RCCA and investments in public health, infrastructure, and public safety.

By relying on more criminalization and incarceration instead of true public safety solutions, these proposals fall short of offering tangible public safety improvements for D.C residents and overshadow what's needed to build safe communities. We urge the Council to reject this bill and advance evidence-based policies that will reduce incarceration and make our communities safer.

[17] Will Lennon, Bolts, "Waiting for Second Look," March 17, 2022 Available: https://boltsmag.org/waiting-for-a-second-look/

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dcrealtors.org

July 11, 2023

Councilmember Brooke Pinto
Chair, Committee of Judiciary and Public Safety
1350 Pennsylvania Avenue NW, Suite 106

Dear Councilmember Pinto,

Thank you all for allowing the DC Association of REALTORS® (DCAR) the opportunity to express our support for the Safer Stronger Amendment Act of 2023. DCAR and our over 3,000 members are a voice for real estate professionals, small housing providers, homeowners, and renters who live and work in the District of Columbia.

DCAR has had the opportunity to review this bill, and we are happy to see the meaningful steps being taken to address the rising crime rates in DC. As REALTORS®, we see firsthand the impact that crime has on individuals, communities, and DC as a whole. Crime rates in the city are at an all-time high and could have serious impacts on property values in the future. This legislation will help address the concerning crime rates we are seeing and make DC a more attractive place for new residents to call home for generations to come.

While we are saddened to see that this legislation is necessary to discuss, the impacts of increased carjackings, assaults, robberies, and violent crimes are too significant to ignore. DCAR supports Mayor Bowser's proposal, and we encourage her office and the Council to continue exploring opportunities to bolster the District's education system, along with mental health and social services. It is important to equip law enforcement to keep us safe while also ensuring DC has the tools to support residents in ways that prevent paths to crime and incarceration.

DCAR appreciates you allowing us to share our association's perspective and looks forward to continuing to discuss this legislation. We are eager to answer any questions you may have on how this legislation will positively impact the District's real estate professionals and perspective residents.

Sincerely,

Scott W. Reiter

Scott Reiter
Chief Executive Officer
DC Association of REALTORS®

Tony Mancuso
2023 Board President
DC Association of REALTORS®

STONEBRIDGE

By Electronic Mail - judiciary@dccouncil.gov

June 26, 2023

Honorable Councilmember Brooke Pinto
Committee Chair
Judiciary & Public Safety Committee
District of Columbia City Council
1350 Pennsylvania Avenue, NW
Washington, DC 20004

Re: B25-291, the Safer Stronger Amendment Act of 2023

Dear Councilmember Pinto, Members of the Committee, and other Members of the Council:

I am writing in strong support of the Safer Stronger Amendment Act of 2023. Everyone who cares about our City is very concerned about public safety. Crime is a real issue. The fear of crime is an ever-present conversation today. Those of us who continue to invest in the District are being challenged by our customers – which include tenants, their employees and investors - with how the District will respond to its public safety realities. There is an expectation that action is needed to reverse the perception, and frankly the reality, of the real decline in public safety.

Many urban areas are facing similar crime issues. Locally though that provides no solace for our residents, workers and visitors. There is no one single action that will reverse the public safety issues facing the District. That said, it is essential to quickly, and with an enormous sense of purpose, to implement actions that will build the foundation of a safer city.

The Safer Stronger Amendment is a critical step in building this foundation. It would be recognition by our elected leaders that the voices of residents, visitors, business owners small and large, property owners and, frankly, everyone interested in a healthy City are being heard. That criminal behavior will not be tolerated. Our justice system must both deter criminal behavior as well as punish it. Our public safety team must have the right tools to enforce our laws and punish those who commit crimes. The Safer Stronger Amendment provides a commonsense approach to strengthen these tools.

While the victims, and their families, of crime are by far the most harmed by crime, there are also other implications. Visitors chose where they visit. Businesses decide where to locate. Investors can deploy their capital as they choose. The District is facing many economic head winds, but public safety is a critical factor.

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Now is the time for leadership to provide a clear message that crime is not acceptable and that the District will take the right actions to ensure a safe, livable and vibrant City. Quick passage by the City Council of the Safer Stronger Amendment Act of 2023 is an essential next step.

Very truly yours,

Douglas M. Firstenberg

cc: Chair and Members of the City Council
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June 27, 2023

Council of the District of Columbia
Committee on the Judiciary & Public Safety
1350 Pennsylvania Ave, NW
Washington, DC 20004
Re: Testimony of EPIC on Bill B25-0291

Dear Chairman Mendelson and Council Members:

EPIC writes and will testify in person to urge you not to enact Titles V and VI of the Safer Stronger Amendment Act of 2023, Bill B25-0291.[1] DC enacted electronic monitoring by GPS ankle bracelet as part of a system that does not use cash bail. In some cases, electronic monitoring may be appropriate. But the system requires careful safeguards and scrutiny from this Council to ensure that electronic monitoring does not swallow up the substantial benefits to public safety and public health derived from a cashless bail system. The proposed changes would require all DC supervisory agencies to turn over GPS data from ankle monitors to police without a warrant and to make that data admissible at trial. These changes undermine the purpose of electronic monitoring and erode privacy protections for everyone.

The Electronic Privacy Information Center (EPIC) is a public interest research center established in 1994 to focus public attention on emerging privacy and civil liberties issues.[2] EPIC has long advocated for strong privacy protections for location data.[3] EPIC regularly advocates for strong limits on — and meaningful oversight of — advanced surveillance technologies.[4]

Title V § (a) of the proposed bill would change the law to make GPS data from any form of electronic monitoring, pre-trial, civil commitment, and post-trial/probation admissible in "any judicial proceeding". Pretrial agency records, including historical location data, are not currently admissible at trial to preserve the role of these agencies in providing supportive services to people in the criminal justice system.[5] Title VI would amend the policy for all DC supervisory agencies, including the Department of Youth Rehabilitation Services, to turn over GPS data and other data collected from electronic monitoring without a warrant, effectively giving the Metropolitan Police Department unfettered access to extraordinarily sensitive data.

The District of Columbia currently tasks four different agencies with monitoring different groups of people through GPS surveillance. The Pretrial Services Agency (PSA) oversees around 9,000 people each day who have been arrested and granted conditional release with pretrial monitoring before their case is adjudicated. These people, who have not been convicted of any

[1] https://legiscan.com/DC/bill/B25-0291/2023.
[2] EPIC, *About EPIC*, https://epic.org/epic/about.html.
[3] *See* EPIC, *Location Tracking*, https://epic.org/issues/data-protection/location-tracking/.
[4] *See* EPIC, *Surveillance Oversight*, https://epic.org/issues/surveillance-oversight/.
[5] D.C. Code §23-1303(d).

crime, are evaluated for dangerousness using an algorithmic risk assessment. There are serious transparency concerns with the PSA, which does not publish data on how many people are assigned electronic monitoring as a part of supervised release, or what conditions are regularly required of defendants. The Department of Youth Rehabilitation Services imposes curfews and travel restrictions on children in the criminal justice system that are enforced using GPS ankle monitors.[6] The Social Services Division of the District of Columbia Superior Court, a branch of the DC Family Courts, also subjects children to electronic monitoring in its Delinquency Prevention Unit and as a part of routine case management.[7] Finally, the Court Supervision and Offender Services Agency monitors adults who have been released post-conviction before they serve a term in prison or after they are released on parole. None of these units provides the public with transparent information about how many people they surveil, or are clear about whether juveniles, defendants, or parolees must pay for their own electronic monitoring. No provision of the District of Columbia Code authorizes or prohibits agencies from charging for GPS monitoring services. [8]

Despite problems with transparency, DC's current model of pretrial support is working well. Changes to the way the agency supervises arrestees that blur the line between police and Pretrial Services risk disturbing a model program that has led the nation for three decades. Pre-trial recidivism rates in the DC are exceptionally low in a system that releases 93 percent of defendants before trial.[9] Only 5 percent of defendants are rearrested before trial and only 2 percent are re-arrested for violent crimes.[10] The proposed changes would have no positive impact on public safety because they consider only historical GPS data, useable for investigations but not emergency response. Lowering the barriers to surveilling and investigating people on electronic monitoring has several demonstrable negative impacts, and few, if any, benefits to the public.

A. The Council should not weaken protections around location data for anyone, including people on supervised release.

EPIC has written extensively about the extraordinary sensitivity of location data, how this data can reveal the most intimate parts of a person's life.[11] A history of a persons' movements can reveal your religious practices, medical and reproductive healthcare decisions, sexuality or gender

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[6] Dep't of Youth Rehabilitation Services, *Electronic Monitoring*, https://dyrs.dc.gov/service/electronic-monitoring.

[7] District of Columbia Courts, *Supervision Services*, https://www.dccourts.gov/superior-court/family-social-services/supervision-services; *Id*. Delinquency Prevention Unit, https://www.dccourts.gov/superior-court/family-social-services/delinquency-prevention-unit.

[8] Fines and Fees Justice Center, *Electronic Monitoring Fees: A 50-State Survey of the Costs Assessed to People on E-Supervision* at 11 (Sept. 2022), https://finesandfeesjusticecenter.org/content/uploads/2022/09/FFJC-Electronic-Monitoring-Fees-Survey-2022.pdf; Adult federal parolees in the DC area are required to pay the costs of their GPS ankle bracelets. U.S. Probation Office for the District of Columbia, *Supervision Orientation Handbook* at 16 (Nov. 2018), https://www.dcp.uscourts.gov/sites/dcp/files/Supervision_Orientation_Handbook.pdf.

[9] Pretrial Services Agency, *It's About Results, - Not Money* (Dec. 2022), https://www.psa.gov/sites/default/files/It%27s%20About%20Results%20Not%20Money-FINAL-12-2022.pdf.

[10] *Id*.

[11] *See* EPIC, *Location Tracking*, https://epic.org/issues/data-protection/location-tracking/.

identity any many more intimate details.[12] At a time when GPS surveillance is becoming increasingly common through smartphone app tracking and the expansion of electronic monitoring in the criminal justice and immigration systems, maintaining strong bulwarks against harmful surveillance and abuse is critical to protecting the public.

The landmark Supreme Court case *Carpenter v. United States* imposed just such a bulwark, ruling that the government must obtain a warrant before accessing historical geolocation data from cellular service providers.[13] Title VI would allow the Metropolitan Police Department an end-run around *Carpenter* for anyone under electronic monitoring, including vulnerable populations like children in the criminal justice system. While this change will certainly be harmful for people on pre-trial release, probation, etc., it also erodes hard-fought rules imposing limits on government surveillance.

Without careful oversight and legislative scrutiny, government surveillance systems tend to grow over time—expanding who the system monitors, how much it monitors people, and what that data can be used for. Scholars call this process mission creep, the slow expansion of what a law enforcement agency does with the ever-present temptation to use powerful surveillance technologies.[14] The Council should be careful to prevent mission creep in DC's supervised release system.

The Council can prevent mission creep by limiting police access to historical GPS data to the times that police can get a valid search warrant. That would reduce the entanglement between police investigations and social services agencies meant to support people in the criminal justice system. To be clear, this rule would not hamstring police. A warrant requirement is reasonable limit that serves to ensure police have probable cause to suspect a person of wrongdoing, helping to prevent abuses of power and unjustified surveillance. Maintaining separation between DC's supervisory agencies and police investigations can make those agencies more effective at their jobs while preventing police from conducting fishing expeditions and other unnecessary surveillance. Expert-recognized best practices for electronic monitoring include strictly limiting electronic monitoring and enacting strong data protection including warrant requirements for police searches[15]

B. The Council should not introduce perverse incentives into the pre-trial release system.

The proposed rules also introduce inappropriate incentives into the pre-trial release system by giving prosecutors a potential new source of evidence. DC's cashless bail system works better than a cash bail system because it simplifies and improves the way judges make decisions on pretrial release. When considering releasing someone from jail, both prosecutors and judges should only

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[12] Jennifer Valentino-Devries et al., *Your Apps Know Where You Were Last Night, and They're Not Keeping It Secret*, N.Y. Times (Dec. 10, 2018), https://www.nytimes.com/interactive/2018/12/10/business/location-data-privacy-apps.html.
[13] EPIC, *Carpenter v. United States*, https://epic.org/documents/carpenter-v-united-states-2/.
[14] *See e.g.* Jennifer Granick et al., *Mission Creep and Wiretap Act Super Warrants: A Cautionary Tale*, 52 Loy. L. A. L. Rev. 431 (2018-2019).
[15] ACLU, Rethinking Electronic Monitoring: A Harm Reduction Guide (2022), https://www.aclu.org/report/rethinking-electronic-monitoring-harm-reduction-guide.

consider the risks to that person and to the community.[16] But allowing police and prosecutors easy access to GPS data, and making that data automatically admissible at trial, distorts that decision-making process by giving prosecutors an incentive to request electronic monitoring in virtually every case. From a prosecutor's perspective, requesting electronic monitoring under the proposed regime would have virtually no risks and many possible benefits. From this perspective, if the police do not obtain any evidence from the ankle bracelet, there is no harm done. But if they do get potentially incriminatory evidence, that evidence may be difficult to rebut and automatically admissible.

EPIC's recent study on risk assessments in DC found that despite years of improvements, DC's pretrial risk assessment tool continues to exhibit racial biases, meaning that electronic monitoring is already disproportionately harmful to Black and Brown communities.[17] Adding more perverse incentives to a system that is already biased will not improve outcomes. The potential to generate new evidence is not an appropriate consideration for conditions on a person's freedom. Rather, the question should be: does the defendant pose an unacceptable risk to the community unless they are subjected to 24/7 GPS surveillance? If the answer is no, that defendant should not be forced to wear an ankle monitor.

C. The Council should be taking steps to reduce the burden of electronic monitoring, not increase it.

While EPIC recognizes that there may be some instances where electronic monitoring is appropriate, the substantial weight of the evidence shows that electronic monitoring can be deeply harmful to people in similar ways to incarceration. The Council should not add an additional layer of surveillance—and stress—onto an already vulnerable population. One of the most comprehensive studies on ankle monitoring from George Washington University found that electronic monitoring restrict people's movements, limits their privacy, undermines their family and social relations, jeopardizes employment and housing, and subjects people to arbitrary rules that are unevenly enforced.[18]

Electronic monitoring creates high levels of stress from constant surveillance and frequently glitchy technology, leading to anxiety, depression, and higher risks of suicide.[19] People wearing

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[16] Nicole Zayas Manzano, *The High Price of Cash Bail*, American Bar Assn. (Apr. 12, 2023), https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/economic-issues-in-criminal-justice/the-high-price-of-cash-bail/ ("Americans can both strengthen the justice system and avoid the costly consequences of current law by (1) requiring that judges make decisions about pretrial release and detention based on evidence and due process rather than money as a proxy for who goes home; (2) ensuring that pretrial detention is the rare, limited exception, as the U.S. Supreme Court has emphasized; and (3) investing in solutions that address people's basic needs as they return to their communities while their cases are pending.").

[17] Tom McBrien, Ben Winters, Enid Zhao, and Virginia Eubanks, *Screened and Scored in the District of Columbia* at 15, EPIC (Nov. 2022), https://epic.org/wp-content/uploads/2022/11/EPIC-Screened-in-DC-Report.pdf.

[18] Kate Weisburd, *Electronic Prisons: The Operation of Ankle Monitoring in the Criminal Legal System*, George Washington University Law School (2021), https://issuu.com/gwlawpubs/docs/electronic-prisons-report?fr=sOGI5NDcxODg3.

[19] James Kilgore, Emmett Sanders, and Kate Weisburd, *The Case Against E-carceration*, The Inquest (Jul. 30, 2021), https://inquest.org/the-case-against-e-carceration/; Bail for Immigration Detainees, Medical Justice, and Public Law Project, Every Move You Make: The Human Cost of GPS Tagging in the Immigration

ankle monitors must worry about system errors flagging them as violating conditions of release, leading to police or social services interacting with the monitored person or their family.[20] And the available evidence shows that electronic monitoring does not increase rates of court appearances or reduce re-arrest rates.[21]

Adding an additional layer of surveillance on to a system that already creates stress will exacerbate the worst impacts of electronic monitoring. Enacting Titles V and VI would not just impact people under supervised release, it will also increase surveillance of their friends, family, and associates. A GPS record of one person's movements can also serve as evidence for the person driving with them in a car, or living with them, like a parent or sibling. This is especially harmful for children currently on electronic monitoring, who may worry about triggering searches and arrests of family members. These are overwhelmingly likely to be children in poor and marginalized communities who are already bearing the brunt of a criminal justice system that disproportionately targets them.[22]

Reducing barriers to accessing historical GPS data also magnifies the documented risk of abuse. Rogue police officers across the country have been caught using police databases, including databases of location data for inappropriate and dangerous uses including stalking and harassment.[23] The risk of abuse certainly exists in the Metropolitan Police Department. Earlier this year, an officer in the MPD's intelligence branch was charged with leaking confidential information to convicted Proud Boys leader Enrique Tarrio.[24] Enforcing a warrant requirement for this extraordinarily sensitive data, data that is often collected from children, would substantially reduce the risk of abuse.

System (Oct. 2022), https://hubble-live-assets.s3.amazonaws.com/biduk/file_asset/file/692/GPS_Tagging_Report_Final__1_.pdf (finding "the potential for significant psychological harm" from mandatory electronic monitoring for immigration detainees);

[20] Chicago Community Bond Fund, Punishment Is Not a "Service": The Injustice of Pretrial Conditions in Cook County (Oct. 24, 2017), (see pages 2, 6, 11, and 14 for case studies on the stress and tangible harms of electronic monitoring), https://perma.cc/BRN8-HGZ7; ACLU, *Rethinking Electronic Monitoring* at 7-9.

[21] Chicago Appleseed Center for Fair Courts & Chicago Council of Lawyers, 10 Facts About Pretrial Electronic Monitoring in Cook County (Sept. 2021), https://www.chicagoappleseed.org/wp-content/uploads/2021/11/202109_10-Facts-EM-Cook-County-EM-FINAL-updated.pdf, (finding no statistically significant difference between people released on personal recognizance and electronic monitoring in 2016-18).

[22] ACLU, *Rethinking Electronic Monitoring* at 7-8 (reporting that electronic monitoring is disproportionately assigned to, and disproportionately impacts, Black and Brown communities).

[23] Joseph Cox, *US Marshal Charged for Using Cop Phone Location Tool to Track People He Knew*, Vice (Jun. 14, 2022), https://www.vice.com/en/article/k7bqew/us-marshal-securus-phone-location-tracked; Sadie Gurman, *AP: Across US, police officers abuse confidential databases*, Associated Press (Sept. 18, 2016), https://apnews.com/article/699236946e3140659fff8a2362e16f43 (finding more than 350 instances of police officers abusing access to sensitive law enforcement databases); *Officer fired after using database to look up ex-girlfriends, prospective dates, officials say*, Associated Press (Aug. 4, 2021), https://www.nbcnews.com/news/us-news/officer-fired-after-using-database-look-ex-girlfriends-prospective-dates-n1275952;

[24] Jaclyn Diaz, A D.C. police lieutenant is accused of tipping off a leader of the Proud Boys, NPR (May 19, 2023), https://www.npr.org/2023/05/19/1177111254/washington-dc-lieutenant-charged-proud-boys-enrique-tarrio.

Conclusion

To avoid re-creating the harms of a cash bail system that overly incarcerated the poor and marginalized populations, the Council should be vigilant in cabining electronic monitoring to cases strictly necessary and reducing the impacts of electronic monitoring as much as possible. But the proposed legislation would do the opposite, subjecting people to more surveillance with demonstrated negative impacts on mental health, relationships, and access to work. And expanding warrantless access to location data normalizes a level of surveillance that both courts and the public finds unacceptable. We urge the Council to protect citizens by declining to enact changes to electronic monitoring through Titles V and VI of the Safer Stronger Amendment Act of 2023.

Thank you for the opportunity to testify, please reach out with any questions to EPIC Counsel Jake Wiener at wiener@epic.org.

Sincerely,

Jake Wiener
Jake Wiener
EPIC Counsel

Your Honor,

I hope this letter finds you in good health and high spirits. My name is Rosalie Ngatchou, and I am writing to express my sincere concern about the issue of gun violence in Washington D.C. and the urgent need for enhanced public safety measures to address this pressing matter.

As a resident of Washington D.C., I have witnessed firsthand the devastating impact that gun violence has had on our community. It not only takes innocent lives but also leaves an indelible mark on the families, friends, and neighborhoods affected by these senseless acts. Unfortunately, I am acquainted with individuals who have experienced the tragic consequences of gun violence, which has only deepened my conviction to advocate for stronger measures aimed at reducing such incidents.

It is evident that gun violence has far-reaching implications that extend beyond individual victims. It permeates our society, instilling fear and undermining the fabric of our community. The trauma inflicted upon survivors, the loss experienced by families, and the lasting emotional and psychological scars borne by witnesses are all haunting reminders of the urgent need for decisive action.

Washington D.C. has already taken steps to address gun violence, but we must recognize that more can be done to ensure public safety and protect our citizens. I firmly believe that a comprehensive approach is necessary, encompassing stricter regulations on firearm acquisition, more robust background checks, and measures to curb the illicit gun market. It is imperative that we prioritize initiatives that promote responsible gun ownership while also providing support for mental health services and community programs aimed at preventing violence before it occurs.

Additionally, investment in education and awareness campaigns regarding gun safety and responsible firearm storage should be a fundamental component of our strategy. By equipping our community with knowledge and resources, we can empower individuals to play an active role in preventing gun-related accidents and tragedies.

Your Honor, I urge you to consider the profound impact of gun violence on our society and to lend your support to initiatives that prioritize public safety. By strengthening our laws and implementing comprehensive measures, we can foster an environment where our residents can thrive without the constant threat of gun violence.

In conclusion, I would like to express my gratitude for your attention to this critical issue. I trust in the wisdom and impartiality of the court to champion the cause of public safety and to make decisions that will positively impact the lives of countless individuals in Washington D.C. Together, we can create a safer and more secure community for future generations.

Thank you for your time and consideration.

Sincerely,

Rosalie Ngatchou 6/27/23

Dear DC council

I am writing to address the issue of public safety in the District of Columbia. I am writing on behalf of the Renaissance Center team to talk to you about the importance of having a safer environment in the District. As you might be aware, the number of gun violence in the District of Columbia has risen up. The city has passed over 200 homicides about half a year through 2023.

As a young woman, it is terrifying to be out in the city myself. In April 2023, a lady in an uber was shot by a stray bullet. Since then, my level of anxiety when I go to school or to work or any other daily activities outside of my house has increased. Anytime I step out of my house is a chance I take to lose my life. Our kids should not go to school scared to have a gun shot when they come back from school or even while they are at school. We should not be teaching our kids how to hide under the table at a young age, they should be having fun on their field and feel at peace having fun, just like it was 10 years ago or so.

Additionally, last year, one of our colleagues got shot to gun violence in the city. According to criminal law DCI the gun pen possession penalty is "one year in jail and a maximum possible fine of $2500 of both". On the other hand, Hawaii is one of the cities with the lowest gun violence rate in the country. DC can help a lot from Hawaii. The violence rate in Hawaii is low due to some laws that DC can also implement. Firearms in Hawaii need to be registered for "a license with a strong background check on criminal, mental and drug or domestic violence records". This is one way to increase public safety in the city by increasing the penalties for gun possession. The result of these regulations is to help create a society where our citizens can better live more freely and peacefully.

Sincerely

Ingrid Tchamo 6/27/23

To whom it may concern,

Under the tenure of Mayor Muriel Bowser, the city of Washington DC has made significant strides in improving public safety. Her administration has focused on implementing policies and programs aimed at reducing crime, enhancing community policing, and expanding access to social services.

One of the key initiatives introduced by Mayor Bowser is the implementation of a data-driven approach to public safety. This involves the use of crime data analysis to identify crime hotspots and deploy law enforcement resources accordingly. In addition, her administration has invested heavily in technology and equipment to support law enforcement activities, such as body-worn cameras for police officers.

Mayor Bowser has also emphasized community policing, with the deployment of more police officers to neighborhoods and increased collaboration between law enforcement agencies and community organizations. This has resulted in improved relationships between the police and the community, as well as increased trust and cooperation.

The city has also established various programs aimed at reducing crime and providing support to those affected by it. This includes the Office of Neighborhood Safety and Engagement, which provides a range of services such as conflict mediation, community outreach, and job training to reduce violent crime in high-risk neighborhoods. The city also offers victim services, such as trauma centers, counseling services, and emergency financial assistance.

However, it is important to acknowledge that despite the progress made, challenges in public safety persist. Incidents of crime, like the one I mentioned where my colleague was shot due to a delay in moving his car, this have increased across the city, resulting in immense suffering and loss for many families. Reinforcing public safety measures will be crucial to support families in the district and address this issue.

Mayor Bowser and her administration should continue their efforts to strengthen public safety by implementing additional strategies, such as:

Deploying more officers to areas with high crime rates and focusing on proactive policing to prevent crimes before they occur. Encouraging open dialogue and collaboration between law enforcement, community organizations, and residents to build trust, gather intelligence, and develop effective crime prevention strategies. Continuously investing in advanced technology, surveillance systems, and training for law enforcement officers to improve response times and investigative capabilities.

By focusing on these measures and building upon the progress already made, Mayor Bowser and her administration can continue working towards a safer and more secure Washington DC for all its residents.

Best Regards

EMMANUEL AGBOOLA

6/26/23

Sabrina Mimms
DC. Resident

Title: A Call for Peace and Security: Ensuring Public Safety in Washington, D.C.

Ladies and gentlemen,

Today, I stand before you as a proud resident of Washington, D.C., a city filled with dedicated citizens who contribute to the fabric of our society and pay our taxes dutifully. We deserve the assurance of safety in our daily lives and the communities we call home.

When we step out onto the streets, we should not have to live in fear of senseless violence. I firmly believe that the possession of guns should be limited to trained professionals, such as the police and security officers, who are entrusted to use them only in the most dire circumstances and never against the public.

Guns, in their very essence, evoke fear. The sheer force and destructive power they possess can inflict irreparable harm upon human flesh. We should not have to bear the burden of worrying about whether someone nearby is carrying a firearm. We deserve the comfort of knowing that our fellow citizens can be trusted, whether we are in a restaurant, a club, a gala, a soccer game, or a simple brunch.

I express my sincere gratitude to Mayor Bowser for organizing the Public Safety Walk and Media, and for lending an ear to the concerns and voices of the people. By actively addressing public safety issues, she has shown her commitment to ensuring our voices are heard, and our well-being is safeguarded in our neighborhoods and environments.

It is time to put an end to the culture of fear that grips our communities in Washington, D.C. We need a season of peace—a long-lasting season of peace that permeates every street and every interaction. We yearn for a Washington, D.C. where violence holds no sway over the lives of its inhabitants, where safety and security are the norm, and where we can relish in the simple joys of life without trepidation.

To achieve this vision, let us consider practical solutions. Implementing security checkpoints in neighborhoods can help detect and deter the presence of illegal firearms. Strengthening patrols in these areas will create a visible presence of law enforcement, dissuading potential threats and reassuring the community.

Furthermore, workshops and community discussions can play a vital role in addressing the root causes of violence. By bringing together residents and local leaders, we can identify obstacles to peace and brainstorm strategies to create a harmonious environment for all.

We must be vigilant and advocate for the enactment of laws that promote public safety and curtail the dangers that threaten our beloved city. It is time to prioritize the well-being of our residents and visitors alike.

In conclusion, let us raise our collective voice for peace and security in Washington, D.C. We deserve to enjoy our time in the city—relishing in food, drinks, and the company of loved ones—without the specter of violence looming over us. Together, let us embark on a journey towards a safer and more secure District of Columbia, where trust, respect, and public safety prevail.

Thank you, and may we all experience a blessed and secure day ahead.

6/27/2023

Supplemental Testimony of Elisabeth Olds

SAVRAA Independent Expert Consultant

Hearing on the Safer Stronger Amendment Act of 2023, B25-291

Council of the District of Columbia, Committee on the Judiciary and Public Safety

Tuesday, June 27, 2023

Submitted July 11, 2023

Thank you for considering this testimony and for the opportunity to testify before the committee on June 27, 2023. I am providing this testimony in my capacity as the Independent Expert Consultant contracted under District law[1] to ensure that the Sexual Assault Victims Rights Amendment Act of 2019 (SAVRAA) is enacted legally and transparently, and to make related recommendations regarding policy changes needed to ensure best practices. The Safer Stronger Amendment Act of 2023's provision allowing DNA upon arrest is a significant improvement in the District's ability to fight crime while simultaneously limiting the footprint of law enforcement.

DNA testing is critical to solving sexual assault and other crimes. Obtaining offender DNA evidence is the goal of the more than 520 Physical Evidence Recovery Kits (PERK)s conducted each year during SANE exams provided to youth and adults. However, because disproportionately few defendants are ever convicted of sexual assault relative to the number of assaults committed and reported, the DNA upon conviction statute currently in place in the District is extremely limited in terms of ensuring serial offenders are identified and stopped.

The use of DNA profiles to solve crimes has produced dramatic advances in criminal justice and public safety and has led to the identification and prosecution of career criminals, serial rapists and murderers who would otherwise have eluded capture. Like all other states and the federal government, the District collects DNA for upload to CODIS from offenders after conviction for certain enumerated offenses. While

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[1] DC Code § 4-561.05.

collecting profiles upon conviction is a useful tool for law enforcement, it overlooks a critical opportunity to solve existing cases and prevent future crimes that most states have recently addressed in their approach to DNA collection. Thirty-one states and the Federal government allow DNA collection upon arrest rather than waiting for the uncertain possibility of conviction. The success of this practice in apprehending serial offenders and solving sometimes decades old violent crimes from sexual assault to homicide as well as its potential for preventing future serious crimes is remarkable. The District is an outlier in that the DC Code only permits DNA collection after conviction. Conversely, DNA collection upon arrest instead of conviction is currently allowed by thirty-one states and the federal government. Generally, these laws all address which crimes qualify for collection; whether probable cause hearings are required before testing, and whether analysis can begin immediately after arrest or if charges must be filed first; expungement procedures to determine the conditions under which a profile is removed from the database; and whether juveniles are subject to testing. A survey of the thirty states summarized by the National Conference of State Legislatures revealed the following:

- Twenty of the thirty-one DNA upon arrest states collect a buccal swab at booking when fingerprints and photos are taken.
- Thirteen states require a probable cause hearing to be held, or an arrest based on a warrant obtained illustrating probable cause, before a sample can be collected and/or analyzed. Of these thirteen states that require probable cause, seven collect the sample at arrest but do not analyze the swab until after a probable cause hearing has been held.
- Eight states apply the collection law to juveniles as well.
- 29 states collect DNA for some, or all felonies and 8 states also include certain misdemeanors, usually sexual assault crimes.
- The constitutionality of these laws has also been definitively tested. In Maryland v. King (2013), the US Supreme Court ruled that DNA collection at the time of arrest was no different than taking fingerprints as it was merely a tool to definitively identify a suspect: "When officers make an arrest supported by probable cause to hold for a serious offense and bring the suspect to the station to be detained in custody, taking

and analyzing a cheek swab of the arrestee's DNA is, like fingerprinting and photographing, a legitimate police booking procedure that is reasonable under the Fourth Amendment."[2]

In addition to probable cause, an additional protection exists such that if a case is dropped, dismissed, or lost at trial, the defendant's profile is removed from CODIS. States have different procedures for expunging profiles. Either the suspect must petition the state to remove it, or the state is automatically responsible for removing it from CODIS.

The constitutionality of this scenario has also been tested. In this scenario, provided the original DNA profile was legally obtained, any hits generated in CODIS while the profile is there constitute legally admissible evidence of the suspect's involvement in those crimes. It is also extremely important to note that while so called arrestee laws are a useful tool for law enforcement, the expansion of state and national databases that they create also accrues to the benefit of the falsely accused and convicted. In some states, such as Louisiana, DNA is being used to free prisoners, some of whom have spent the better part of their lives in prison for crimes they did not commit.[3] These databases ensure a more objective method of crime solving.

From a public safety perspective, the benefits of DNA upon arrest are hard to overstate. Three interrelated factors illustrate the benefits of DNA collection at the time of arrest as opposed to waiting until conviction. First, only 1% of criminals commit 63% of all violent crimes, meaning that a large proportion of hits will lead back to a small number of individuals who are committing most serious violent crimes.[4] The potential for multiple crimes to be solved by accessing one DNA profile is therefore significant. Second, the flow of a case through the criminal justice process means that most cases never actually enter the system and those that do are progressively filtered out until a

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[2] Maryland v. King (2013) 133 S. Ct. at 1967.

[3] Hennessy-Fiske, Molly. "DNA evidence exonerates 300th prisoner nationwide," Los Angeles Times, October 1, 2012. https://www.latimes.com/archives/la-xpm-2012-oct-01-la-na-dna-evidence-20121001-story.html.

[4] Falk, Ö., Wallinius, M., Lundström, S. et al. The 1 % of the population accountable for 63 % of all violent crime convictions. Soc Psychiatry Psychiatr Epidemiol 49, 559–571 (2014). https://doi.org/10.1007/s00127-013-0783-y.

final few reach the conviction and sentencing phase.[5] Third, serial or career criminals do not usually start with the most severe crime in their repertoire, nor do they remain faithful to one type of crime. Having the opportunity to identify repeat offenders earlier in their career solves cold cases, but also allows us to prevent the multiple future crimes they would likely commit. When viewed through the lens of sexual assault, these factors ring particularly true. Because disproportionately few defendants are ever convicted of sexual assault relative to the number of assaults committed and reported, even as compared to conviction rates for other crimes, the DNA upon conviction statute is extremely limited in terms of ensuring serial offenders are caught.

This limitation becomes particularly apparent when we consider the recidivism rate for sexual assault and other violent offenders. Disparities in studies of recidivism rates are often related whether it is defined as re-conviction only, and how long offenders are tracked after the initial crime. Even when researchers use criteria such as arrest or police reports, undercounting though that is given the low rate of reporting for sexual assaults, the length of time that an offender is tracked is key. The longer a researcher tracks adult sex offenders and the more accurate the study in terms of actual re-offense versus re-arrest or re-conviction, the higher the rates of recidivism.

Based on this standard, the sexual recidivism rate for sexual assault offenders, meaning they committed another sexual assault crime, after 10 years is approximately 20%, and after 15 years, it increases to approximately twenty-four percent (24%). Another study that looked at 5-year follow up recidivism rates found a rate of 14% for sexual recidivism, 25% for violent recidivism, and a 37% likelihood of any recidivism, meaning committing any type of crime. For felony level sex offenders, specifically those convicted of rape or its legal equivalent, the recidivism rates found in almost every study since 1985 is 39% for committing another sexual assault over 25 years, and a 75% recidivism rate for other types of violent crime.[6] New York State also conducted a study in 2002 that yielded similar results indicating that there was no particular crime type that

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[5] Seigel, J. and Narveson, S. "Why Arrestee DNA Legislation Can Save Indiana Taxpayers Over $60 Million Per Year," (January 2009). Page 5. http://dnasaves.org/files/IN_DNA_Cost_Savings_Study.pdf.
[6] Roger Przybylski, Recidivism of Adult Sexual Offenders," SOMAPI Research Brief, US Department of Justice, Office of Justice Programs, July 2015. Note: This is a summary of this research. If it is useful, I am happy to summarize points in the primary research in a separate research summary.

was predictive and that those who commit sexual assault also have long careers committing other non-sexual violent crimes.[7] This data illustrates that non-sexual violent crime and sexual assault crimes are inseparable in terms of strategies for pursuing serial offenders.

Significant research has been conducted on the benefits of using DNA profiles in property crime offenders, specifically burglary. In the Urban Institute's DNA Field Study, which examined the use of DNA profiling to solve property crimes,100 of such offenders were profiled in Denver upon arrest. Not only did researchers find that this cohort of offenders committed an average of 240 burglaries per year, but the property crime rate in Denver dropped by 26% after they were caught through DNA profiling.[8] Similarly, a review of New York's first 1,000 hits after they expanded their DNA database showed that the vast majority were linked to crimes like homicide and rape, and 82 percent of these offenders were already in the databank as a result of a prior conviction for a "lesser" crime such as burglary or drugs. In a Florida study, 52 percent of database hits against murder and sexual assault cases matched individuals who had prior convictions for burglary.[9] The Urban Institute's DNA Field Study also showed that DNA Profiling made a positive difference in the success of investigations and prosecution, increasing their efficacy by 50%.[10]

As discussed above, the recidivism rates rise significantly if researchers do not base their conclusions on convictions alone. An offender may be arrested for multiple low-level offenses and convicted of those, or arrested for felony level offenses and not convicted, leaving their DNA out of the system, and allowing them to continue their careers of repeated violent crime. The best illustration of this gap is through criminal

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[7] Bruce Frederick, James A. Gilmer, and David van Alstyne Bureau of Research and Evaluation, Expanding the Offender Index of the New York State DNA Data Bank, Office of Justice Systems Analysis, Policy Research Report, New York State Division of Criminal Justice Services, 2002.
[8] Zedlewski, E. and Murphy M., DNA Analysis for "Minor" Crimes: A Major Benefit for Law Enforcement. NIJ Journal, Issue No. 253. https://www.nij.gov/journals/253/pages/dna_analysis.aspx#noteReferrer7
[9] Zedlewski, E. and Murphy M., DNA Analysis for "Minor" Crimes: A Major Benefit for Law Enforcement. NIJ Journal, Issue No. 253. https://www.nij.gov/journals/253/pages/dna_analysis.aspx#noteReferrer7
[10] John K. Roman, Shannon Reid, et. al. The DNA Field Experiment: Cost-Effectiveness Analysis of the Use of DNA in the Investigation of High-Volume Crimes, The Urban Institute, Justice Policy Center, April 2008. https://www.urban.org/sites/default/files/publication/31856/411697-The-DNA-Field- Experiment.PDF.

history timeline analysis that shows the points at which DNA could have been profiled were the arrestee law in place rather than the conviction law model.

Some jurisdictions conducted analyses both before implementation and after to illustrate the success and the vital public safety function that this legal change serves. Chicago conducted an analysis of the timelines of eight offenders who had accumulated 21 felony arrests, only 7 of which were for violent crimes, before finally being identified as having committed multiple violent crimes through CODIS matches with crime scene and victim generated DNA profiles. They found that these eight offenders had committed multiple violent crimes, including sexual assault and murder, that could have been instantly solved had their DNA been in the database sooner. When added together, had Illinois had a DNA upon arrest law instead of one that mandated collection upon conviction, 60 violent crimes could have been prevented, including 53 murders and rapes (22 murders, 30 rapes, attempted rapes, and aggravated kidnapping). By waiting until these eight were convicted or in some cases not convicted at all to get a DNA sample, the opportunity to prevent these crimes was lost. The District has multiple such case examples in which DNA upon arrest would have identified a serial offender. In fact, quite recently a case was closed because a sexual assault was committed, and it led to the closing of 12 burglaries committed by the same perpetrator before committing sexual assault. In another case, a serial offender committed a home invasion sexual assault in 2004 and the case was eventually closed through DNA, but the same crime had already occurred in 2002 in the same neighborhood. When that case was closed, detectives were able to also close an additional 17 cases spanning many years.

In Maryland, when considering legislation to expand DNA collection to arrestees, a study was conducted to assess the impact of DNA collection upon arrest vs. upon conviction. In a review of criminal histories of three convicted offenders, Maryland found that 20 crimes could have been prevented if those offenders' DNA had been taken when they were arrested the first time. Indiana looked at both the criminal justice and public safety aspect of DNA upon arrest vs. upon conviction, as well as the cost savings to the state of preventing future crime and prosecuting criminals earlier in their careers. They found that because of the recidivism rates of offenders, each conviction prevents

seven to eight future crimes, and could significantly reduce the burden to taxpayers at the same time. Finally, in 2003, Virginia began taking DNA samples from arrestees for violent crimes and some sexual assaults. Between 2003 and 2009, Virginia has obtained 559 hits to its Arrestee Database, eighty-nine of which were associated with sexual assault cases. There are numerous individual cases in which a rape and/or murder could have been prevented had the offender's DNA been available to solve a previous crime. These cases are heartbreaking not only because of the traumatic losses that they are in and of themselves, but because they so clearly could have been avoided.

Capacity and Resources Required to Implement DNA Collection Upon Arrest

Although the DNA Analysis Backlog Elimination Act of 2000 requires that offender profiles obtained after conviction are sent directly to the FBI for analysis and upload to CODIS, District law could govern the implementation of DNA collection upon arrest and analyze those samples at the Department of Forensic Sciences (DFS) and maintain them in a separate part of the District's DNA database that currently indexes forensic profiles. These would be uploaded to CODIS according to the existing CODIS rules and certifications that are strictly maintained by the District already for the forensic profiles. The workload would be significant and would require an addition to the Forensic Biology Unit of at least six analysts and a CODIS expert to maintain the database itself. Much like Indiana's findings, while this would be a significant expense, the ability to apprehend repeat offenders early on would likely more than pay for itself over time.

As illustrated above, the benefits to the criminal justice process of arrestee or DNA upon arrest laws is abundantly clear, both in terms of solving cold cases and particularly regarding serial sex offenders and other career violent criminals. In 2021, the most recent year for which data is published, the District received 182 hits from 389 entries into CODIS.[11] This number of hits could increase at least ten-fold if the District enacts an arrestee statute that mirrors other states' efforts. The statute could mirror Maryland's which requires that a case be charged before analysis of

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[11]Department of Forensic Sciences Annual Report 2021, page 18. https://dfs.dc.gov/sites/default/files/dc/sites/dfs/publication/attachments/DFS%20Annual%20Report%202021.pdf.

the sample can be conducted, but this would be a step beyond the standard of probable cause is required by the Supreme Court in Maryland v. King to avoid unreasonable searches. To avoid placing the burden on someone who is no longer subject to the criminal justice system, expungement should be the responsibility of the District. Finally, juveniles aged 16 and over should be included for violent crimes, consistent with the District's law regarding the age at which a minor can be charged as an adult.

From the perspective of sexual assault advocacy and of the intent of SAVRAA, the most important use of this expanded database would be to identify serial sex offenders and solve cold cases in the hopes of preventing future assaults. The Metropolitan Police Department's Sexual Assault Cold Case Unit employs two of the District's most capable and dedicated detectives. As they attempt to solve decades-old sexual assault crimes, sometimes with little and piecemeal evidence including forensic samples tested with outdated methods or ruled out due to the technological limitations of the day, they need as many tools as possible to ensure that victims receive the justice they originally sought by reporting, and that offenders who have been offending since then and possibly earlier and have never been identified can finally be stopped from harming anyone else.

The larger purpose for the District would be to bring its criminal justice practices in line with neighboring jurisdictions and most states in the country to prevent violent crimes from happening in the first place rather than having to react and expend resources after the worst has happened.

I would like to thank the Mayor for this important step forward and respectfully suggest that it would be made significantly stronger by expanding those eligible for DNA collection upon arrest to all those currently eligible for DNA collection upon conviction under District law. The examples above illustrate that non-sexual violent crime and sexual assault crimes are inseparable in terms of strategies for pursuing serial offenders.

Written Testimony of M. Elizabeth Bowman, PhD, LICSW

Safer Stronger DC Legislation

Main points

1. Fully support creating felony penalties for strangulation
2. Increasing reimbursement for private camera program seems promising
3. Support increasing access to petitions for early release

Narrative

I am completing this testimony not in my official capacities and my statements are not a reflection of the political stances of my organizations. As a survivor of domestic violence and human trafficking, I believe that stricter penalties and monitoring of individuals who strangle their romantic partners and/or children will reduce deaths related to domestic violence. Research has shown that a majority of mass shootings in the United States can be attributed to family annihilators which are typically men who kill their partners and children, most often after long term domestic violence in the home. I believe that it is important to not only increase to the level of felony charges in the case of strangulation but create and mandate rehabilitation efforts mandated by the court which focus on healing abusers and their own trauma. Perpetrators and abusers are often victims of abuse themselves. Therefore, as a community we must ensure that they receive treatment, not just punishment- which is not effective at strengthening our DC communities. Early intervention efforts should ensure that juveniles are treated carefully and supported early in their communities, including both juvenile justice and child welfare systems.

I do not feel that I have enough information about the private camera program to fully support this action, however, it seems like a promising place to start if DC city cameras are not able to be effectively maintained and utilized to reduce crime.

Similar to my position on rehabilitative efforts for perpetrators of domestic violence, I agree that petitions for early release should be accessible and that attorney support should be available to those who have been convicted of crimes. Particularly, those who were sentenced as juveniles (second look/IRAA) and those who have shown marked improvements in behavior/mental health/etc. while incarcerated. We need assets to our community, not more incarceration of fathers, mothers, and community members. Community supports may not always be sufficient to stop crime, however, imprisonment merely displaces the person committing the crime, rather than helping them to grow and thus become assets to their communities.

D.C. Council
Committee on the Judiciary and Public Safety
Hearing on B25-0291 - Safer Stronger Amendment Act of 2023

June 27, 2023

Emily Cassometus
Director of Government & External Affairs

Chairwoman Pinto and members of the Committee, DC Justice Lab opposes B25-0291. First, this bill would not have the impact the mayor claims. Second, the language drafted presents serious constitutional, privacy, and other concerns. Third, this bill does nothing to invest in evidence-based violence prevention and intervention. I urge you to drop Mayor Bowser's crime bill, refuse to capitulate to Congress, and use your power to actually make DC safer.

This Crime Bill Would Not Make DC Safer or Stronger

This crime bill almost entirely focuses on increasing penalties for people convicted of crimes. The National Institute of Justice itself makes clear that "increasing the severity of punishment does little to deter crime" and that, in fact, incarceration likely makes people more likely to engage in future crime.

If longer sentences don't prevent crime, what does? If the response to behavior is immediate and fair, it is far more likely to help someone change their actions than simply making punishment more severe. Analysis of the cost and benefits of prevention and intervention programs have shown for decades that we see safer communities by increasing investments in front-end solutions. This crime bill does not do that. The mayor acknowledges that it is her "responsibility to make this system work for DC," yet, this bill does nothing to increase the certainty of accountability in any form for people who commit acts of violence.

This crime bill does not invest in accountability beyond prison, like restorative justice, treatment, or community supervision, which survivors of crime prefer at a rate of 3 to 1. This crime bill does not seek to increase the quality of Metropolitan Police Department's investigations or arrests, which contributes to the US Attorney for DC declining to prosecute nearly 70% of arrests. This crime bill certainly does not make the law easier for judges, lawyers, victims, or people committing offenses to understand and apply, like the bill you already voted in favor of, the Revised Criminal Code Act of 2021 (RCCA), did. Instead, this crime bill only doubles down on on failed "tough on crime" policies like mandatory minimums and geographic enhancement zones that have not increased safety, but have led to the mass incarceration of Black people in DC.

The mayor herself cannot even say what effect these proposed changes would have. As instructed by the Office of the Deputy Mayor for Public Safety (DMPSJ), we submitted a set of 12 questions about the crime bill's impact on May 26, followed by 11 more questions on June 5. DMPSJ has not sent a single response with data that would show how many youth or adult cases would be handled differently under any provision of this bill, or how proposed changes would increase safety.

This Crime Bill Would Make DC's Bottom-Ranked Criminal Code Even Worse

DC's Criminal Code is one of the worst in the nation, earning only 2.7 out of 20 possible points. The Criminal Code Reform Commission (CCRC) was created to overhaul the code, making the law more clear, consistent, and constitutionally sound.

As you well know, the CCRC delivered its recommendations to the Council in the form of the RCCA, a revised version of which this Committee approved and the full Council passed on first vote, second vote, and to override the mayor's veto. Despite this, the federal government ultimately interfered with DC's autonomy and prevented the RCCA from becoming law. The CCRC's work is still mission-critical to making a fair and effective criminal code in DC and must be picked back up immediately.

This crime bill would only make the code more confusing, less consistent, and less constitutional. For instance, many other witnesses have explained in depth today, the pre-trial detention and DNA sample collection titles raise concerns under the 4th and 5th Amendments. The strangulation title still relies on proving assault, which is never defined in DC's Code. Maximum sentences, mandatory minimums, and sentence enhancements are applied seemingly at random with no evidence of effectiveness. It is also a waste of time - this work has already been done, and done better, in the RCCA.

Rather than using piecemeal efforts that will only compound 100 years of mess, you must pass a new version of the RCCA to make the DC Code understandable, enforceable, and effective moving forward. The Council, mayor, and president should quickly come to an agreement on the three outstanding points of contention in the RCCA - the timeline for expanding jury trials to misdemeanors, expanding second-look sentencing, and the maximum penalties for a small number of offenses - and finally complete the project of modernizing DC's criminal code.

This Crime Bill Would Not Prevent or Address State or Interpersonal Violence

Even at their very best, the measures in this crime bill are nothing but bandaids, and will be so small in effect that we should be ashamed to consider trading away people's civil rights and freedom in the hopes of an outcome. We need leaders with solutions, not scare tactics. We need lawmakers who pursue violence prevention and healing programs that are designed to serve Black people, who make up 96% of both victims and suspects of shootings in DC.

What could we be doing to increase safety? The executive and the legislature should be working together to scale up DC's violence prevention efforts to the levels that are needed to make a significant difference. That includes evaluations of and investments in in violence interrupter programs, school-based mental health services, and trauma-informed care. We need the ability to look across all human services, policing, or correctional investments and see what is and is not working, then share that information broadly to build consensus on what else is needed.

Laws like the Second Chance Act must be funded and implemented so that people who are most at risk of violence have more access to jobs and housing. Laws like the Comprehensive Policing and Justice Act and the Corrections Oversight Improvement Omnibus Act must be fully funded to prevent abuse and strengthen systems of accountability for violence carried out by law enforcement and corrections officers. This Committee must conduct intense oversight of the agencies tasked with keeping us safe to ensure they fulfill their missions.

DC Justice Lab asks that you scrap this bill to focus your efforts on things that will make DC safer, freer, and more equal; pass a revised RCCA and fund and conduct thorough oversight of violence prevention and intervention programming now.

Attachment A:

Questions DCJL Submitted to DMPSJ on Safer Stronger Amendment Act of 2023

Submitted via email May 26, 2023:

1. Where in the D.C. Code is Title VI of the bill intended to be inserted?
2. Where in the D.C. Code is Title IV of the bill intended to be inserted?
3. How many people under 18, charged as juveniles or charged as adults at DC Superior Court since January 1, 2018, were charged with committing a "dangerous crime" or a "crime of violence" but not charged with a dangerous crime or a crime of violence while armed?
4. How many people under 18, charged as juveniles or charged as adults at DC Superior Court since January 1, 2018, were charged with any felony offense under Chapter 27 of Title 22 (Prostitution, Pandering)?
5. How many people under 18, charged as juveniles or charged as adults at DC Superior Court since January 1, 2018, were charged with any felony offense under Chapter 9 of Title 48 (Controlled Substances)?
6. How many people under 18, charged as juveniles or charged as adults at DC Superior Court since January 1, 2018, were charged with burglary?
7. How many people under 18, charged as juveniles or charged as adults at DC Superior Court since January 1, 2018, were charged with arson?
8. How many people under 18 and how many adults have been arrested on Department of Parks and Recreation property since January 1, 2018?
9. How many people charged as adults with a crime of violence since January 1, 2018, had a previous conviction of a crime of violence? Of these, how many were detained pretrial by a DC Superior Court judge?
10. How many times since January 1, 2018, have CSOSA, DYRS, CSS, and PSA each refused a request from MPD to share location and identification data collected from any detection device that a person is required to wear?
11. How many private security camera system rebates have been issued since September 22, 2015? How many of these cameras have had footage reviewed by MPD?
12. How many people have been granted release under IRAA? How many of those people have been rearrested? How many of those people have been convicted of misdemeanors? Of those, how many were convicted of a dangerous crime or

crime of violence? How many of those people have been convicted of felonies? Of those, how many were convicted of a dangerous crime or crime of violence?

Submitted via email June 5, 2023:

1. Since January 1, 2018, how many people under 18, charged as juveniles or charged as adults at DC Superior Court, were charged with committing a “dangerous crime” or a “crime of violence” against a vulnerable adult? How many of them had responsibility under civil law for the health, welfare, or supervision of the vulnerable adult?
2. From January 1, 2018 to present, how many people accused of a “crime of violence” who have previously been convicted of a “crime of violence” were released pre-trial each year by DC Superior Court judges? List the number of each of the most serious past convictions and most serious current charges by charge category.
3. Of the people released pre-trial to PSA’s supervision from January 1, 2018 to current, who were facing charges for a crime of violence and were previously convicted of a “crime of violence", what percent were rearrested while under PSA supervision? What percent failed to appear for court?
4. How many instances over a year is GPS data shared with MPD from CSOSA? DYRS? CSS? PSA?
5. Of the “crime of violence” cases cleared by MPD since January 1, 2018, what percentages of cases were cleared with assistance from footage from cameras registered to the Private Security Camera System Incentive Program?
6. What percentage of investigations conducted by MPD requested footage from cameras registered to the Private Security Camera System Incentive Program?
7. What is the total dollar amount given in rebates on the Private Security Camera System Incentive Program in Fiscal Years 2018, 2019, 2020, 2021, and 2022?
8. Please detail the specific expertise of the Metropolitan Police Department on sentencing guidelines.
9. How many businesses are currently participating in the Private Security Camera System Incentive Program? How many households are participating?
10. How does the Mayor currently use information provided by the Criminal Justice Coordinating Council?
11. How will the new information gathered under the Safer Stronger bill and EO 2023-061 be used?

Testimony of
Apartment and Office Building Association of Metropolitan Washington
On
B25-0291, the "Safer Stronger Amendment Act of 2023"
Council of the District of Columbia
The Committee of Judiciary & Public Safety Public Hearing
Tuesday, June 27, 2023

Good afternoon, Chairwoman Pinto and the members of the Committee on the Judiciary & Public Safety, my name is Eric J. Jones, MSF and I am the VP of Government Affairs, DC – Commercial for the Apartment & Office Building Association of Metropolitan Washington also known as AOBA. Since 1974, AOBA has served as the leading membership organization representing commercial office buildings and multi-family residential real estate in the Washington, D.C. area. In the District, AOBA's membership represents just shy of 108,000 apartment units and more than 76.6 million square feet of commercial space. I am here today as an advocate, a fourth-generation Washingtonian, and a Ward 4 resident to provide testimony on B25-0291, the "Safer Stronger Amendment Act of 2023".

As an organization, AOBA is fully committed to the long-term growth and sustainability of a vibrant commercial and residential community within DC's downtown core and throughout all 8 wards. This objective not only coincides with Mayor Bowser's vision as laid out in her recently released Downtown Action Plan, but it also coincides with the many goals and objectives highlighted by members of this legislative body during the recent FY2024 Budget process. To achieve these goals, we know that there are a few things that must happen:

1. The city must attract and retain businesses in high-rent areas to ensure that the District's commercial real estate portfolio continues to provide the taxable income required to operate our city,
2. The District must regain its standing as a preferred location to invest in development (commercial, multifamily, institutional, and mixed-use),
3. The District must continue to expand the current housing stock and provide quality communities for residents throughout the income ladder,
4. Provide quality educational opportunities for District residents, which help to train them for the jobs of now and the future.

The Problem

Since the city started its official transition from the COVID-19 Public Health Emergency a little over a year ago, the one issue that has impacted our entire city has been an increase in crime. While MPD figures show that last year was not as bad as many may think statistically, numbers for this year show a different story. In May, the Metropolitan Police Department (MPD) stated that violent crime, which includes robbery, assault with a dangerous weapon, sex abuse, and homicide are up by 13% over 2022. Additionally, violent crimes with a gun are up by 6% from last year. [1]

While the conversations around crime usually focus on residents and how to make them feel safe, rarely does the conversation touch on the direct and indirect impacts of these increases in crime. This includes the loss of local businesses, a reduction in jobs, as well as a decrease in corporate, income, real estate, and sales tax revenue. Additionally, it puts greater downward pressure on the District to provide items such as Emergency Rental Assistance (ERAP), Health Insurance, Housing Vouchers, SNAP Benefits & Unemployment Insurance, etc. Unfortunately, since the beginning of 2022, businesses have left the city in alarming numbers and many of them have noted crime as a contributing factor.[2]

Additionally, a spring 2022 study by the Urban Institute titled" Economic Costs of Gun Violence in Washington, DC" uses data based on the local market to highlight how our communities are impacted.[3] Some of the key findings include decreased homeownership rates and property values in the year(s) following an increase in violent crime, with even higher percentages when you focus on gun-related crime, including homicides. Additionally, the study also shows that these crimes have a direct negative impact on retail and business services, including a reduction in the number of retail & business services and the loss of the jobs associated with it. This is doubly troubling when you consider that many in our underserved populations are the first to lose benefits and are also the same individuals who are usually employed in these industries.

The Legislation and Its Impact

As previously stated, this legislation alone is not a magic bullet, that will drastically change our crime stats, but it does help begin to turn the tide. Of particular interest to our members are a few key points within the legislation:

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[1] Dil, Cuneyt. "Gun violence and homicides increase in D.C." Axios D.C., May 16, 2023. https://www.axios.com/local/washington-dc/2023/05/16/crime-gun-violence-homicide-statistics

[2] Fox 5 DC Digital Team *"Crime concerns in DC prompt restaurant departures"* WTTG Washington, DC, January 27, 2023. https://www.fox5dc.com/news/crime-concerns-in-dc-prompt-restaurant-departures

[3] Emily Tiry, Arielle Jackson & Paige S. Thompson. "Economic Costs of Gun Violence in Washington, DC" Urban Institute, 2022 https://www.urban.org/sites/default/files/2022-05/Economic%20Costs%20of%20Gun%20Violence%20in%20Washington%20DC.pdf

1. **Enhancing penalties for violent crimes that victimize or target vulnerable residents with physical or mental impairments as well as expanded protections for transit and for-hire employees, transit passengers, and people at rec centers –** *this section is helpful because it will provide additional protections for those most vulnerable and who many times are afraid to speak up due to a lack of support from our government.*
2. **Increasing penalties for illegal gun possession –** *giving residents, business owners, and customers a level of comfort that those perpetrating the most violent crimes will face stiff penalties will go a long way to bolstering consumer and resident confidence, which will lead to more community engagement and investment.*
3. **Ensuring the voices of victims and the community receive proper consideration during the early release petition process –** *one of the main factors discouraging individuals from speaking up against violent offenders is a fear that they will get out of jail or not be prosecuted. By making the early release process stricter, the city will encourage more citizens to speak up and speak out against crime.*
4. **Providing greater discretion for the Courts to determine who should be held pre-trial, including defendants previously convicted of a violent crime while they await trial for a subsequent alleged crime –** *unfortunately, many criminals have been able to slip through the cracks and offend repeatedly because they know they won't be held prior to their trial. This change will hold repeat offenders in pre-trial detention, which will provide a bit more comfort among residents that criminals won't have the ability to retaliate immediately against witnesses or alleged victims.*
5. **Requiring supervisory agencies to provide MPD with location and identification data collected from any detection device necessary in conducting criminal law enforcement investigations –** *this commonsense approach will encourage government agencies to work together to help locate criminals, share potential evidence, and ultimately make our communities safer.*

While nothing outlined above will be possible without additional steps such as additional training and investments in our public safety infrastructure, we believe they are the right step. Creating a clearer criminal code, while providing additional tools for prosecutors to use in gaining convictions, and enacting enhanced protections for the community will contribute to neighbors, both new and old feeling an increased level of safety. These actions in the long term will foster more comradery among neighbors and allow our city to flourish.

Conclusion

In closing, I thank you for allowing me the time to testify before you today and we at AOBA look forward to our continued partnership(s) as we continue to mold the District into a place that garners additional rounds of economic, emotional, and social investment.

June 19, 2023

To Whom It May Concern,

My name is Eric Weaver; I am the Chairman for National Association for the Advancement of Returning Citizens **NAARC**

In these tough economic times, many Returning Citizens have turned to NAARC for help in meeting basic needs, and the opportunity for a smoother transition back into the community. NAARC's mission is to improve the quality of life for Returning Citizens, their families, and communities, through strategic management and advocacy.

I want to add my voice to this hearing about IRRA. It’s very concerning that there is a discussion about altering the laws that pertain to this population. Researchers have already provided their findings on the development of the mind for this population. (no need to discuss that). What I have seen since the passing of this law and the release of the people that have benefitted from it, has been nothing short of amazing! Most of them have been active in the community, giving back to the city that they once took away from. There are very few that have reoffended. With that being said, this is one of the laws that you can say you got right! It’s also motivation for people who may soon qualify for this. It’s bad enough for people to go to jail with an undeveloped mind and be charged as an adult. But to have no hope makes it worst. I myself served 22 years of incarceration. I went to jail at 17 years old. IRRA was not available at the time. But I believe I show as well that giving another opportunity we can return to society and be productive citizens. The modifications to IRRA are unjust and unwarranted. These guys are doing an amazing job in the community. We need more of them out here

Sincerely, Eric Weaver

Chairman of NAARC

June 26, 2023

Chair Brooke Pinto
Committee on the Judiciary and Public Safety, Council of the District of Columbia
1350 Pennsylvania Avenue NW, Suite 106
Washington, DC 20004

Dear Chair Pinto and members of the Committee on the Judiciary and Public Safety:

I write to express FAMM's opposition to B25-291 and urge the Council to reject it. This bill would create mandatory minimum sentences for certain gun possession offenses and undermine the intent of the Incarceration Reduction Amendment Act (IRAA). The proposed bill will not achieve the goal of reducing gun violence in Washington, DC, but will lead to unnecessary and excessive incarceration that wastes taxpayer resources and does not increase public safety.

FAMM (which originally stood for Families Against Mandatory Minimums) is a national, nonprofit, nonpartisan sentencing and prison reform advocacy organization. For more than 30 years, we have advocated sentences that are fair, individualized, protect public safety, and preserve families. We are not against prisons or punishment. We are against one-size-fits-all and excessive sentences that produce absurd and unfair results, diminish respect for the justice system, ignore rehabilitation, and increase prison costs for taxpayers without making them safer.

FAMM appreciates the seriousness of gun crime and violence in Washington, DC, and agrees that those using and carrying illegal guns should be held accountable – and that may warrant prison time. Nonetheless, we oppose the proposed two-year mandatory minimum prison sentences for possessing or selling a stolen gun or ammunition and possessing with intent to distribute an illegal gun. All the evidence shows that mandatory minimum sentences do not actually reduce or deter crime or gun possession or use, but do lead to unnecessary, arbitrary, and costly over-incarceration.

No one has presented data or evidence that current sentences for illegal possession and sale of weapons and ammunition are inappropriate or too lenient. There is also no evidence that our current sentences for gun crimes are deterring or reducing gun possession or gun violence in the District. Decades of study and data show that it is the certainty of apprehension, not the length of sentence, that deters crime.[1] Other states and the federal government have created similar mandatory minimum gun sentences in the hope that they would reduce homicides and gun possession and violence. Studies of these efforts showed that the mandatory minimum sentences had no impact on and could not be causally connected to reductions in violent and gun crime.[2]

[1] National Academy of Sciences, The Growth of Incarceration in the United States: Exploring Causes and Consequences, Chap. 5 (2014), https://nap.nationalacademies.org/read/18613/chapter/5#82.
[2] See, e.g., Stephen Raphael and Jens Ludwig, Prison Sentence Enhancements: The Case of Project Exile, https://gspp.berkeley.edu/assets/uploads/research/pdf/Exile_chapter_2003.pdf.

Mandatory minimum sentences do not work and produce unjust and unintended consequences. A better response would be investing more in tools like community violence prevention, more street lighting, hiring more homicide detectives to close cases, and more forensic testing to produce evidence that can lead to convictions. All of these tools actually increase the certainty of apprehension, lead to convictions, and remove people using guns from the streets. Solving more crimes, not indiscriminately locking people up for possessing illegal guns or ammunition, actually deters and reduces crime.

We also oppose B25-291 because of its proposed changes to the Incarceration Reduction Amendment Act. The Council's intent and purpose for IRAA is in its name: to reduce unnecessary incarceration. The Council's choices in how it wrote IRAA were intentional and evidence-based. Young people have undeveloped brains that make them more impulsive and less able to appreciate the consequences of their actions. Young people also mature and become dramatically less likely to reoffend as they age. Based on this evidence, the Council recognized that excessive incarceration of youthful offenders was unjust, cost-ineffective, and does not increase public safety – and, importantly, that this is true regardless of the nature of the original offense or the victim, community, or prosecutor's opinions on the sufficiency of the sentence. The Council intentionally required courts to reduce sentences if the IRAA public safety criteria are met, and it decided that 15 years was enough retribution for this group of offenders. The Council reasonably decided that there are certain populations who should be released solely because they safely can be after a certain period of time in prison.

For that reason, the Council explicitly said that courts "shall" reduce sentences for people under age 25 at the time of the offense who have served 15 years in prison and do not pose a present danger to the public. The proposed change to "may" weakens IRAA and makes the law less likely to achieve its purpose of reducing unnecessary incarceration of people who committed crimes as children and are not a public safety risk today. No one is made safer when we keep people in prison past the point at which they are a danger to others. Denying IRAA relief to those who meet its criteria stops them from coming home and becoming employees, breadwinners, taxpayers, parents, partners, and caretakers. This further destabilizes communities and families.

The bill's addition of requirements that the court consider the nature of the offense raise concerns that courts would then automatically deny applicants based solely on the facts of the crime, instead of performing the full IRAA inquiry required by law. The Council previously considered and rejected the addition of this criterion. When the Council created IRAA, it was aware that many of the applicants' crimes would be serious or even horrific. Despite this, the Council chose to prioritize rehabilitation and evidence about youthful offenders in the court's review. In passing IRAA, the Council decided that when it comes to resentencing youthful offenders, rehabilitation and public safety trump retribution. Allowing courts to deny applicants based solely on the nature of the offense would allow retribution to trump rehabilitation and public safety. This undermines IRAA's clear intent and purpose.

As written, IRAA is evidence-based and increases public safety. The proposed changes increase the likelihood of keeping rehabilitated people in prison unnecessarily, contrary to IRAA's name and goal. In fact, even with the "shall" in current law, judges can and do deny relief to those they find do not merit it. We have been presented with no evidence that IRAA is being abused by

courts or leading to increased crime. Those who have been granted IRAA relief are overwhelmingly leading productive lives. For these reasons, we ask the Council to stand by its original intent in passing IRAA and reject B25-291.

Thank you for considering our views on this legislation.

Molly Gill
Vice President of Policy

B25-291 Safer Stronger Amendment Act of 2023
Testimony from Public Witness, Goli Fassihian
June 27th 2023, 12pm

Good afternoon Council Member Pinto.

My name is Goli Fassihian, and I am a resident of Ward 4 where I have lived with my husband and son since 2015. I am a native of the DMV and have always called this area home.

I am here today to testify in support of Bill 25-291, the Safer Stronger Amendment Act of 2023. The Act represents much needed reform to improve public safety in the District. Over the past year, residents have seen a significant rise in violent crimes, particularly gun violence. In our neighborhood alone, we have experienced five shootings, probably more, in less than two months - one of which resulted in a murder and another causing two nearby schools to go into lockdown. Frankly, it's been easy to lose track of the numbers given the frequency.

On May 29th around 3pm, my 6 year-old son and nanny were almost victims of a drive-by shooting. They happened to be on the corner of 9th and Delafield, literally yards, if not feet, away from a car as it turned the corner, firing gunshots. The two were walking home from the bus after a visit to the Natural History Museum - and, just happened to be in the wrong place at the wrong time.

Had our nanny not acted quickly to push our son and herself to the ground as the shots were fired from the car, they would have been shot and murdered. They were the only ones on the street and it was unclear who or what the shooter was targeting.

Our block - and neighborhood more generally - are full of families with young children who deserve to feel safe walking to school and daycare. They deserve to feel safe playing outdoors. This is not a "nice to have" amenity - this is a requirement. Our children should not be in the crosshairs of gangs and drug dealers speeding through our street spaying gun fire.

Things have gone from bad to worse in Ward 4. For example, neighbors who have two young children and have lived on our block for nearly 11 years, noted that the neighborhood has experienced more shootings and gun fire incidents within our one block radius this year alone than they remember from the past decade.

The public data doesn't paint an accurate picture either, underreporting the frequency of gun fire we hear on a weekly, and often, daily basis.

We believe not enough is being done to control the increasing gang and gun violence affecting residents. Many of us are talking about selling our homes and leaving. This is not a solution. But, as parents with young children, our family's safety and well-being is our number one priority.

I urge the Council to approve B25-291. It's common sense legislation and a necessary first step for public safety and protecting our neighborhoods from senseless violence and death. While much more needs to be done to address the complexities and social determinants that contribute to the rise of violent crimes, B25-291 is a necessary first step. It will help penalize violent crimes and possession of illegal firearms. And, it will incentivize residents to buy security cameras to assist the police department in solving such crimes.

Thank you for your time and the opportunity to testify. I am happy to answer any questions you may have.

My name is Fernando Gomez-Prada and I live in Cleveland Park. I am writing in support of Mayor Bowser's desire to find ways to promote safety across the District and help give residents like me even greater peace of mind.

Washington, DC has so much to offer, and I have enjoyed being able to continue discovering new great parts of the District since I moved here two years ago. I recently retired after a long career in finance, but I had been looking for ways to stay involved in the community while also helping pay the bills. That was when I discovered delivering with DoorDash, which has helped me remain financially independent and taken me into all kinds of new neighborhoods when I'm dropping off orders.

Thankfully, I know that DoorDash takes safety seriously, and I feel supported even when I'm in parts of the District I'm less familiar with. Peace of mind while dashing is essential, and I know that I can easily get help if I ever need it from their support team. We all benefit from feeling safer in all of the neighborhoods across the District.

This isn't an issue that only I think is important — public safety is top of mind for so many people in our community. I'm glad that it's getting the necessary attention from leaders like Mayor Bowser to make Washington, DC even safer.

Sincerely,
Fernando Gomez-Prada

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Safer Stronger Amendment Testimony
Dr. Brooks' Remarks

(Revised June 27, 2023)

Members of the D.C. Committee on Judiciary and Safety, Councilwoman and others:

I am expressing my support for the Safer, Stronger Amendment. As the founder, president, and CEO of SRB Communications, a boutique, minority-owned business located at 15th & K Street in Washington, D.C., for nearly 31 years, I have witnessed the city's growth and significance as a hub for influential leaders and a diverse workforce. With long-standing clients such as utility companies, government agencies, higher education institutions and national nonprofits, we must have a centralized office to gather. I lead a team of 12 employees **who commute to D.C. regularly** to serve our clients.

However, **I am deeply concerned** about the future of our city due to the rise in crime. Hijacking and other criminal activities **have become increasingly prevalent**, creating an atmosphere of fear and uncertainty when navigating through D.C. While **it is essential to nurture our children**, it is equally important to teach them what is right and wrong and **ensure that they face the consequences of their actions**.

Personally, **I have made the difficult decision** to refrain from using public transportation. Before the pandemic, I relied on public transportation regularly to reach my destinations. However, in my last experience, within the last six months, **I witnessed first-hand** domestic violence, encountered multiple altercations, and feared for my own safety – especially as a Black woman in her 60s.

Consequently, I now drive from my home daily. Even though I park in a parking lot, **I am constantly anxious** about the possibility of my car

being targeted for carjacking. Imagine leaving after a long day of work to find yourself stranded with your car stolen.

My staff and I often park a block or more away from the office – usually having to walk through alleyways. On multiple occasions, I had to befriend a homeless man to walk me to my car to ensure I get there without being attacked or robbed. **It is quite distressing** to consider the safety of the young women I employ. **Being able to get home safely** should be the least of their concern. **Ensuring the safety of my team is paramount to maintaining their productivity and delivering the best results for our clients.**

What's happening in our city is a tragedy. I'm afraid that all our business progress over the past 30+ years **will be ruined** if we don't do something about this crime wave. Other businesses **might not want to be here anymore**, people **might move away** and others might not even consider living here in the first place.

That's why **I'm pleading to you** to take action. **Approve the Safer, Stronger legislation.** Doing so **will strengthen our commitment** to reclaiming the safety and security of our beloved city. **Let us work together to reverse the tide of this crime wave** and create a Washington, DC, that remains an inspiration, attracts businesses, and fosters a diverse and thriving workforce.

Thank you for your attention to this matter of utmost importance.

Hello Ms. Benjamin,

I have recently moved to DC and use public transportation daily for my commute to and from work. An incident in the past month during my commute has caused me to be concerned with the safety for myself and other passengers. A passenger was going around on the waiting pad, getting in people's faces and yelling profanity and harmful actions he wanted to do to these passengers and to myself.

Thanks.

Council of the District of Columbia
Committee on the Judiciary and Public Safety
Brooke Pinto, Chair
Testimony of Gene Downing
Public Hearing
The Safer Stronger Amendment Act of 2023
Tuesday, June 27, 2023
Room 500
Wilson Building 1350 Pennsylvania Ave NW Washington DC

Thank you Council members for the chance to speak today. My name is Gene Downing, and I am the Co-Chair of Thrive Under 25, Community Outreach Specialist at Free Minds Book Club & Writing Workshop, and the Galena Yorktown Fellow at the Council for Court Excellence. I am also a recipient of IRAA.

At the tender age of 19 years old, I was sentenced to 82 years to life. Though I had no clue as to when or if I'd ever be released, I dedicated myself to education, mentoring others, and the overall betterment of myself. After 21 years in prison, I was granted release on November 12, 2021 due to IRAA and was given a second chance at life. Being home for only 18 months, I made sure to take advantage of all that I had learned in prison and the opportunities that were presented once released. There are so many others like me who have taken advantage of this second chance and are doing incredible things in our community. None of what we are doing now would be possible without hope. First it was that innate sense of hope that we all had which kept us on the right path despite the uncertainty of release. Then came IRAA, which gave us an even greater sense of hope because of the possibility of actually being given a chance to pursue all the endeavors we aspired to embark on.

As you will hear from others who will testify today, those who were released because of IRRA are now in the community as positive influences and many variations of violence interrupters; some even work in the DC government. Because we had hope, we stayed the course, when it was so easy to succumb to the pitfalls of prison. We made it on the other side of the wall and showed that redemption is real. There are so many men and women like me who are still incarcerated and deserve the same opportunities that I had. The only thing that's driving them is hope. If this bill is passed and IRAA is changed, it will steal the hope from those who have yet to get the second chance at life they so deserve. In my not so humble opinion, at this very moment, IRAA should be celebrated, not attacked. Thank you so much for your time.

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June 27th, 2023

Testimony of DC Police Union for B25-291, the Safer Stronger Amendment Act of 2023

Good morning members of the Committee. I appreciate the opportunity to testify before you today. As the Chairman of the D.C. Police Union, I speak on behalf of approximately 3,000 sworn police officers, detectives, and sergeants who serve our community as members of the Metropolitan Police Department (MPD). Having served as a D.C. police officer for eighteen years, I take immense pride in serving this city.

Today, I would like to draw your attention to two critical issues: the alarming decline in staffing levels within the MPD and the escalating violent crime rates in the District.

Crime rates in the District are now surpassing levels not seen in twenty years. Homicides have reached 111, putting us on pace for the third year in a row surpassing 200 murders. This year 65 juveniles have been shot, a 100% increase from this time last year. There have been 412 carjackings this year, a 78% increase over last year. Violent crime is up 23%, and crime overall is up 28%.

Since the implementation of the *Comprehensive Policing and Justice Amendment Act of 2021* (CPJAA), the MPD has lost over 1,200 police officers while only hiring 700, resulting in a net loss of over 500 officers. This decline has led to longer response times, fewer officers patrolling our neighborhoods, and a severe public safety crisis in the District. The MPD is now using more than one million hours of overtime to try to make up for these losses. It's worth noting that one million hours is equivalent to nearly 500 FTEs.

Today's hearing focuses on the "*Safer Stronger Amendment Act of 2023*," which aims to address the gaps in the District's public safety ecosystem necessary for reducing crime in D.C. While we broadly support the proposed changes in the Mayor's proposal, we believe it is essential for the Committee to address the primary cause of MPD officer resignations, namely the removal of collective bargaining rights for union members and the elimination of due process for the hard-working men and women of the MPD.

The CPJAA has undermined morale, eroded the rights of MPD employees, and contributed to the unwanted departure of police officers from the MPD. We have done everything we possibly could to warn the Council of these consequences, unfortunately, we have been ignored. This bill, which is now law, was a 46-page bill with 26 subtitles that made sweeping changes to policing and law enforcement. We are here testifying today to ask that just *four* of those 26 subtitles be amended.

Because of time limitations here today, we have sent the specifics of that request to your office under separate cover and attached them to our written testimony for this hearing.

I must emphasize the gravity of the situation. We are witnessing a historic exodus of MPD police officers, not retirements. These officers are leaving for alternative employment opportunities because they no longer wish to work in an environment where their workplace protections have been stripped away, and the fairness and equitability that was such a highly valued principle within MPD, no longer exists.

The D.C. Police Union respectfully urges the Committee to incorporate Councilmember Gray's "*Police Officer Recruitment and Retention Act of 2023*," along with additional amendments we have sent separately into the "Safer Stronger Amendment Act of 2023":

Adopting this legislation is imperative, as it addresses the urgent need to strengthen our MPD staffing numbers, something critically necessary to reduce exacerbating our crime problems as well as reducing tens of millions in spending on mandatory overtime.

Once again, I am grateful for allowing me to testify before this Committee. I stand for any questions or concerns you may have.

Greggory Pemberton
Chairman
D.C. Police Union

Attachment: Proposal for Amendments to B25-291 – *The Safer Stronger Amendment Act of 2023*

PROPOSED AMENDMENTS TO INSERT A NEW TITLE XII INTO BILL 25-291, THE "SAFER STRONGER AMENDMENT ACT OF 2023" AT COMMITTEE MARK-UP

Short title: to amend the District of Columbia Police and Firemen's Salary Act of 1958 to authorize the Mayor to fund recruitment and retention incentives for the Fraternal Order of Police Metropolitan Police Department ("MPD") Labor Committee (Compensation Unit 3) that will allow the District of Columbia to increase staffing at MPD until it reaches 4,200 sworn officers; to repeal Subtitle L, Subtitle M, Subtitle N, and Subtitle X of the Comprehensive Policing and Justice Reform Amendment Act of 2022 and restore previous statutory language, in order to treat MPD officers equitably with other organized labor unions, so as to not discriminate against officers in a manner that places them at risk and discourages them from serving in the District.

TITLE XII. POLICE OFFICER RECRUITMENT AND RETENTION

SUBTITLE A. METROPOLITAN POLICE DEPARTMENT WORKFORCE INVESTMENT

Sec. 1201. The District of Columbia Police and Firemen's Salary Act of 1958, approved August 1, 1958 (72 Stat. 480; D.C. Official Code § 5-541.01 *et seq.*), is amended by adding a new section 501(a) to read as follows:

"Sec. 501a. MPD Workforce Investment Fund.

"(a) There is established as a special fund, in the Workforce Investment Agency (UP0), the MPD Workforce Investment Fund ("Fund"), which shall be administered by Office of the Chief Financial Officer in accordance with subsections (d) and (e) of this section.

"(b) The Council authorizes the Mayor to use the money in the Fund as follows:

"(1) To provide any sworn officer of the Fraternal Order of Police MPD Labor Committee (Compensation Unit 3) who is eligible to retire, but who continues working for an additional 5 years after October 1, 2023, one-time additional compensation, at the end of the 5th year, equal to the salary for regular pay earned by that officer in the 5th year; provided that the employee was eligible to begin accruing the five years prior to October 1, 2028; and

"(2) Fund any other negotiated recruitment and retention incentives for the sworn officers of the Fraternal Order of Police MPD Labor Committee (Compensation Unit 3).

"(c) As the number of MPD sworn officers increases, a higher proportion of the additional officers shall be deployed to neighborhoods experiencing higher levels of violent crime.".

"(d) Upon the District reaching 4,200 sworn MPD officers, the Mayor shall not use the Fund to offer recruitment of retention incentives to any new police officers, but is authorized to continue to disburse previously agreed upon incentive payments.

"(e) Money deposited into the Fund shall be transferred by the Chief Financial Officer to the Metropolitan Police Department only in accordance with subsection (b).

"(f) The Mayor shall be authorized to disburse or designate funds in the Fund, without further Council approval, since all funds in the Workforce Investment Fund can be expended without approved budget authority, so long as funds are certified by the Chief Financial Officer and are being used for a statutorily approved workforce investment purpose.

"(g)(1) The money deposited into the Fund, shall not revert to the unassigned fund balance of the General Fund of the District of Columbia at the end of a fiscal year, or at any other time.

"(2) Subject to authorization in an approved budget and financial plan, any funds appropriated in the Fund shall be continually available without regard to fiscal year limitation.".

SUBTITLE B. METROPOLITAN POLICE DEPARTMENT COLLECTIVE BARGAINING AND LABOR RIGHTS RESTORATION AMENDMENTS

Sec. 1211. The District of Columbia Government Comprehensive Merit Personnel Act of 1978, effective March 3, 1979 (D.C. Law 2-139; D.C. Official Code § 1-601.01 et seq.), is

amended as follows:

(a) Section 801(d) (D.C. Official Code 1-608.01(d)) is amended to read as follows:

"(d) The Mayor may issue separate rules and regulations concerning the personnel system affecting members of the uniform services of the Metropolitan Police Department ("MPD") and Fire and Emergency Medical Services Department ("FEMS") which may provide for a probationary period of at least 1 year. Other such separate rules and regulations may only be issued to carry out provisions of this chapter which accord such member of the uniform services of MPD and FEMS separate treatment under this chapter. Such separate rules and regulations are not a bar to collective bargaining during the negotiation process between the Mayor and the recognized labor organizations for MPD and FEMS, but shall be within the parameters of § 1-617.08.".

(b) Section 1708 (D.C. Official Code § 1-617.08) is amended by striking subsection (c) in its entirety.

Sec. 1212. Section 502 of the Omnibus Public Safety Agency Reform Amendment Act of 2004, effective September 30, 2004 (D.C. Law 15-194; D.C. Official Code § 5-1031), is amended as follows:

(a) A new subsection (a-1) is added to read as follows:

"(a-1)(1) Except as provided in subsection (b) of this section, no corrective or adverse action against any sworn member or civilian employee of the Metropolitan Police Department shall be commenced more than 90 days, not including Saturdays, Sundays, or legal holidays, after the date that the Metropolitan Police Department had notice of the act or occurrence allegedly constituting cause.

(2) For the purposes of paragraph (1) of this subsection, the Metropolitan Police Department has notice of the act or occurrence allegedly constituting cause on the date that the Metropolitan Police Department generates an internal investigation system tracking number for the act or occurrence.”.

(b) Subsection (b) is amended to read as follows:

“(b) If the act or occurrence allegedly constituting cause is the subject of a criminal investigation by the Metropolitan Police Department or any law enforcement or prosecuting agency with jurisdiction within the United States, the Office of the United States Attorney for the District of Columbia, or the Office of the Attorney General, or is the subject of an investigation by the Office of the Inspector General, the Office of the District of Columbia Auditor, or the Office of Police Complaints, the 90-day period for commencing a corrective or adverse action under subsection (a) or (a-1) of this section shall be tolled until the conclusion of the investigation.”.

(c) Strike subsection (c) in its entirety.

Sec. 1213. Section 6-A1001.5 of Chapter 10 of Title 6 of the District of Columbia Municipal Regulations is amended by striking the phrase “reduce or increase the penalty” and inserting the phrase “reduce the penalty” in its place.

Sec. 1214. The Comprehensive Policing and Justice Reform Amendment Act of 2022, effective April 21, 2023 (D.C. Law 24-345; D.C. Official Code § 5–351.01), is amended by striking:

(a) Subtitle N, which includes section 119, in its entirety; and

(b) Subtitle X, which includes sections 134 and 135, in its entirety.

Republic

By Electronic Mail
judiciary@dccouncil.gov
BPinto@dccouncil.gov

June 22, 2023

Honorable Councilmember Brooke Pinto
Committee Chair
Judiciary & Public Safety Committee
District of Columbia City Council
1350 Pennsylvania Avenue, NW
Washington, DC 20004

Re: B25-291, the Safer Stronger Amendment Act of 2023

Dear Councilmember Pinto, Members of the Committee, and other Members of the Council:

I am writing to support the Safer Stronger Amendment Act of 2023. I do so for all the compelling reasons which many have cited to you regarding the proposed Act. I could repeat them, but I will restrain myself from restating those facts and justifications which others have expressed.

As legislators, you all have roles which are both functional and symbolic. You have opportunities to lead and obligations to respond, as well as react. In this case, the reality of the challenges before us in communities and urban environment is being shaped in ways that require actions which few of us are comfortable with.

Crime, the fear of crime, and the view that no one is listening to those fundamental concerns for personal and family safety is the perception of a vast majority of District residents. It is pointless and counterproductive to deny that reality.

The public is crying out for an acknowledgement of both the unacceptability of criminal behavior and acts, and the clear statement of our collective intolerance for hurtful and criminal actions. The public expects that the laws, law enforcement and the administration of justice be effective and clear on that.

The perception of the risks of experiencing crime and a perceived climate of related permissibility have consequences well beyond how the District's residents feel. The District of Columbia is our Nation's Capitol and we are at the center of the National Capitol Region. With that comes opportunities and responsibilities. We operate in a national and international environment where our actions are viewed far beyond the edges of our city and its communities.

By Electronic Mail

Our economy depends on choices made by others. The District operates in a competitive environment where people can decide whether and how often to come into the District or do business here. Investment and capital have choices where to deploy resources.

The actions of the Judiciary & Public Safety Committee and the Council, as a whole, need to make it clear that the Legislative branch has a unambiguous intolerance for clearly hurtful crime. It should not divert from that message by quibbling about the degree of punishment for heinous acts. It should act quickly and decisively so that the message is clear to the residents, those that might perpetrate crimes, and those that enforce and protect us.

Moreover, we need to become a model for the nation in many ways, one of which is in saying that we do not find the behaviors which B25-291 enumerates in any way tolerable. We should not divert from that message by quibbling about such unacceptable acts.

I hope that the Committee, and the Council, as a whole, swiftly confirm that this is the best approach and decisively act to pass the legislation as drafted. To do otherwise is both counterproductive and would send the wrong message to the community, to would-be perpetrators of crimes, and to those well beyond the District's borders.

Respectfully,

Steven Grigg

cc: Chair and Members of the City Council
PMendelson@dccouncil.gov
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GREATER WASHINGTON HISPANIC CHAMBER OF COMMERCE

COUNCIL OF THE DISTRICT OF COLUMBIA
Committee on The Judiciary And Public Safety

Tuesday, June 27, 2023
12:00 pm

Location
Virtual Meeting Platform

Good morning members of the Committee on the Judiciary and Public Safety, Councilmember Brooke Pinto. My name is Nicole Quiroga, *President and CEO of the Greater Washington Hispanic Chamber of Commerce* and I am written testimony on behalf of the Mayor's Office on Latino Affairs.

GWHCC in partnership with the Mayor's Office on Latino Affairs, known as MOLA, has engaged, educated and facilitated the economic development, growth and assistance of individuals, families, and small businesses with economic hardships since before the COVID-19 pandemic. To ensure the accomplish of its mission, the chamber has collaborated with community-based organizations, federal and local government entities to extend MOLA's services among the Hispanic community and other minorities in the District of Columbia.

B25-291, the Safer Stronger Amendment Act of 2023, includes a series of amendments aimed at improving public safety in the District.

These changes include:
• Increasing penalties for certain crimes, including violent crimes against individuals with physical or mental impairments, transit and for-hire vehicle workers, transit passengers, and people at public parks and recreation centers. The bill also creates a felony offense of strangulation.
• Increasing penalties for possession of illegal firearms.
• Making it easier for adults and youths who have been charged with certain dangerous or violent crimes to be held prior to adjudication. The bill would also allow youths who have been charged to be held prior to adjudication for their own protection.
• Eliminating caps on reimbursements under the Private Security Camera System Incentive Program, which helps residents and business owners buy security cameras that can assist the Metropolitan Police Department in solving crimes.
• Directing pretrial services agencies to provide GPS location data for individuals under supervision to MPD upon request; and making GPS data admissible in criminal proceedings.
• Directing MPD to collect DNA samples from individuals who have been charged with first-degree sexual assault.
• Expanding judicial discretion and adding to the list of considerations when individuals seek a reduced sentence under the Incarceration Reduction Amendment Act.
• Expanding the membership of the Sentencing Commission and giving the Chief of MPD a vote on

the Commission.

B25-247, the Female Genital Mutilation Prohibition Act of 2023, would prohibit the practice of female genital mutilation and cutting ("FGM/C") in the District. It would also prohibit a parent, guardian, or conservator from removing a person under their care from the District for the purpose of facilitating FGM/C in another state or country. Female genital mutilation and cutting is a harmful practice involving the full or partial removal, or injury to a woman's external genitals.

According to the World Health Organization, FGM/C is a practice with no valid medical purpose. Tragically, the practice still occurs across the United States, including in the District. The CDC has estimated that more than 51,000 women in the Washington metro area have undergone FGM/C in the past or are at risk. This bill would make it a criminal offense to engage in female genital mutilation and cutting; it would also create a private right of action for parties who are harmed by the practice. In addition, the bill would require that the Department of Health develop educational training and materials for community members and mandated reporters on the harms associated with FGM/C and how to recognize the signs that a person might be at risk.

GWHCC will continue to work side by side with MOLA and its leaders to ensure District of Columbia individuals, families, small business owners and their employees in the District of Columbia have access to high quality and affordable economic and health resources beneficial to them. We will continue to focus our efforts in developing creative marketing strategies for outreach, include bilingual staff of all identifiable languages in the DC demographic, and use bilingual promotional flyers and brochures to educate and facilitate an easy, efficient and convenient process supporting the implementation and sustainability of this Act in the District.

Thank you for the opportunity to testify.

Nicole Quiroga
President and CEO
Greater Washington Hispanic Chamber of Commerce

July 10, 2023

Committee on Judiciary & Public Safety
Council of the District of Columbia
1350 Pennsylvania Avenue, NW
Washington, D.C. 20004

Re: Bill 25-291, the "Safer Stronger Amendment Act of 2023"

Dear Chairwoman Pinto:

I write to you regarding the above-referenced bill, the "Safer Stronger Amendment Act of 2023." The bill creates several amendments that address gaps in the District's public safety and justice ecosystem that are necessary to build a safer, stronger DC. While this bill does not eliminate crime in the District, it is a first step in helping to reduce the recent uptick in violent crime.

The District has experienced a 27% increase in total crime, with violent crime increasing by 10%, property crime by 30%, and car thefts up by a staggering 111%. There is nothing more important that protecting the safety of every District resident and visitor that comes to our city. Tourism is a major economic force in the District. In 2019, the District had a record 24.6 billion visitors that spent a total of $8.2 billion dollars and generated $896 million in tax revenue. Due to the pandemic, the District lost 11.3 million visitors, $4.5 billion in visitor spending, and 37,366 tourism jobs. Although tourism has increased, and visitors are returning to the city, hotels and the hospitality industry are still recovering from the devastating impacts of the pandemic. Although tourism rates have increased, hotel occupancy rates are currently 10% below 2019 levels. Crime rates can have a negative impact on attracting tourists to our city and recovery efforts.

Crimes against tourists can significantly deter tourism. The perception that the District is not a safe place to visit can significantly impact the District's reputation and ability to attract tourists. In order to have a successful hospitality industry, the District must do all that it can to establish a reputation of having crime under control and providing a safe environment for visitors.

HAWDC knows that there is not one solution to ending violence. There must be a multi-tiered approach. This bill would enact legislation that would provide tools to protect residents and visitors and allow them to enjoy our neighborhoods. One additional tool that would be essential

to fighting crime is to increase the number of sworn officers. The Metropolitan Police Department (MPD) maintains its lowest sworn staffing numbers is more than 50 years with approximately 3,335 officers. Increasing the number of MPD officers available to patrol streets would help to significantly reduce crime before it can occur. While this bill seeks out efforts to ensure that perpetrators of violent crime are not released back on the streets without serving their time or having the proper supervision, additional attention needs to be made in crime prevention.

HAWDC supports this bill that addresses gaps in the District's public safety and justice ecosystem and urges the Council to move quickly on holding a vote on the bill. Creating a safer, stronger DC should not be delayed. Thank you for the opportunity to submit these comments for the record. Please do not hesitate to contact me if you have any questions.

Sincerely,

Solomon Keene, Jr.
President & CEO
Hotel Association of Washington, D.C

COMMENTS OF THE PUBLIC DEFENDER SERVICE
FOR THE DISTRICT OF COLUMBIA

concerning

THE SAFER STRONGER AMENDMENT ACT OF 2023

BILL 25-0291
Presented by

Heather N. Pinckney

before

COMMITTEE ON THE JUDICIARY AND PUBLIC SAFETY
COUNCIL OF THE DISTRICT OF COLUMBIA

Chairwoman Brooke Pinto

June 27, 2023

Heather N. Pinckney, Director
Public Defender Service
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Good evening, I am Heather Pinckney. I am a native Washingtonian and a proud graduate of Eastern High School. After 22 years as a criminal defense attorney at the Public Defender Service for the District of Columbia and in private practice, I am now honored to be the Director of PDS. Katerina Semyonova, Special Counsel on Policy and Legislation, and Jonathan Anderson, Chief of PDS's Special Litigation Division, are with me to help answer questions.

James Forman Jr., the author of the Pulitzer Prize winning book Locking Up Our Own, wrote about D.C., that "Black judges, mayors, and legislators who served during the 1970s, 80s, and 90s supported unforgiving criminal laws or imposed draconian sentences in the belief that they were advancing the public good. But now, surveying the devastation that mass incarceration has inflicted on America's Black communities, they'd like to take back some of those votes and sentencing decisions."[1] Now, rather than embracing new evidence-based solutions, or even trying to fix what exists and is flawed and broken, the Mayor's bill will only send the District backwards and deeper into mass incarceration.

The bill will result in the detention of non-dangerous children in understaffed facilities, which will add to the children's trauma. The bill attacks the Incarceration Reduction Amendment Act (IRAA) when in fact, IRAA recipients are people on whom the District relies to serve as credible messengers, violence interrupters, and safe passage workers. By adding new offenses, that overlap with each other and with current

[1] James Forman Jr., *Sometimes Justice Needs a Do Over*, Washington Post, September 19, 2019. Available at: https://www.washingtonpost.com/opinions/local-opinions/justice-sometimes-needs-a-do-over/2019/09/20/4216161a-d665-11e9-86ac-0f250cc91758_story.html

offenses,[2] the bill would allow a maximum prison sentence of 35 years for the simple possession – not the- use – of a firearm by someone with a prior felony conviction.[3] Creating more overlapping offenses grants ever more discretion to prosecutors and allows for grossly disproportionate sentencing, where the mere possession of a weapon can be punished more severely than manslaughter. Greater prosecutorial discretion as well as sentencing enhancements inject more bias and arbitrariness into a system already rife with inequity and racism. The bill also would require DNA testing, upon arrest, rather than conviction, increasing the possibility of wrongful convictions and subjecting people, particularly African Americans, to unnecessary and degrading intrusions of their privacy without any showing that there is evidence for comparison.[4] Additionally, the bill would alter pretrial release for adults in a way that prevents a judge from thoughtfully considering an individual's prior criminal history after actually hearing the government's evidence.

The Mayor is placing the District on this path despite the District's investments in understanding the root causes of crime. In 2020 and again in 2022, District-mandated reports by the Criminal Justice Coordinating Council (CJCC) concluded that system-involved youth have experienced significantly higher rates of homelessness, poverty,

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[2] An overlapping offense is one that allows additional punishment for conduct that at least in part is already made criminal and subject to punishment by another statute. For example, the offenses of carrying a pistol without a license (D.C. Code § 22-4504(a)), possession of an unregistered firearm (D.C. Code § 7-2507.06(a)(1)(B); and unlawful possession of firearm (D.C. Code § 22-4503) all punish the same conduct possessing a firearm.

[3] This is the statutory maximum sentence for possession of a firearm by someone with a prior felony conviction for a crime of violence, carrying a pistol without a license by someone with a prior conviction, and the new proposed offenses of possession of a stolen firearm and possession of a firearm with an obliterated serial number.

[4] Brandon L. Garrett and Erin Murphy, *Too Much Information Supreme Court 2013: Why collecting DNA from people who are arrested won't help solve more crimes*, Slate, February 12, 2013. Available at: https://slate.com/news-and-politics/2013/02/dna-collection-at-the-supreme-court-maryland-v-king.html

school disruptions, and abuse.[5] The CJCC found that economic stability, particularly access to stable housing, is an important protective factor for youth and families.[6] The same is true for everyone in our community.

The recent Mayoral order directing deputy mayors to submit "recommendations for a whole-of-government approach to crime reduction,"[7] does not make this legislation part of a comprehensive approach to public safety. That order was issued in May 2023, long after the Mayor's budget was submitted to the Council, and long after community members sounded the alarm on increasing gun violence and a lack of safety. This "whole government" approach must come first, and in order to be credible and viable, it cannot be tacked onto a bill that includes a broad range of previously proposed and rejected non-solutions to public safety problems.

The remainder of the testimony will address the Mayor's proposal by title.

Title I, Sentencing Commission Representation

PDS urges the Council to reject this proposed amendment which would add three Mayoral appointees to the D.C. Sentencing Commission, elevate the Chief of the Metropolitan Police Department to a voting member, and include the Deputy Mayor for Public Safety and Justice as a non-voting member. At the outset, there is no need for this

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[5] Criminal Justice Coordinating Council, *A Study of the Root Causes of Juvenile Justice System Involvement*, November 2020. Available at:

https://cjcc.dc.gov/sites/default/files/dc/sites/cjcc/CJCC%20Root%20Cause%20Analysis%20Report_Compressed.pdf

[6] Criminal Justice Coordinating Council, *A Study of Factors that Affect the Likelihood of Juvenile Justice System Involvement*, October 2022. Available at:
https://cjcc.dc.gov/sites/default/files/dc/sites/cjcc/CJCC%20-%20A%20Study%20of%20Factors%20that%20Affect%20the%20Likelihood%20of%20Juvenile%20Justice%20System%20Involvement%20%28October%202022%29.pdf

[7] Mayor's Order 2023-061, issued May 15, 2023. Available at:
https://together.dc.gov/sites/default/files/dc/sites/together/page_content/attachments/2023-061-Districtwide-Review-of-Violence-Reduction-Programs.pdf

change. A Sentencing Commission seat for a Mayoral appointee has been vacant for three years. If the Mayor would like to increase Executive representation on the Commission, she should appoint an individual to fill that vacancy.

Further, the Council should be leery of granting the Executive power to name so many appointees to the Commission. Three new Mayoral appointees may create a voting bloc that could be uniquely susceptible to political whims. Parole boards, which are typically comprised of executive appointees have been criticized as "failed institutions" in part because of this politization of their mission.[8] This is all the more true in this case, where the Mayor proposes to elevate the chief of MPD to the status of a voting member. MPD reports directly to the Mayor and is constantly subject to political whims from the public and from the police union about how to respond to crime. As a non-voting member, the chief of MPD can share any relevant perspectives or data, but voting should remain the purview of a set of judges, experts, and practitioners who are more insulated from political pressure and who have expertise in sentencing.

Title II, Safe Schools and Safe Students

Subtitle A. School Personnel

The Mayor's proposal would expand criminalization of consensual sexual conduct between students who have reached the age of consent and school-associated adults. Current law prohibits an adult from engaging in a consensual sexual relationship with a student who is at least 16 years old and therefore at the age of consent but is under age 20, if the student is enrolled in that school or school system and the adult is a teacher,

[8] Model Penal Code: Sentencing, §6.06 at 147-148. Available at: https://robinainstitute.umn.edu/publications/model-penal-code-sentencing-proposed-final-draft-approved-may-2017.

principal, coach, or other person of authority in that secondary school.[9] The Mayor's proposal would expand the definition to prohibit that consensual relationship for anyone who is a "contractor, consultant, or volunteer." The problem with this expansion is that it includes anyone in the specified roles regardless of their role at the complainant's school. For instance, a 25-year-old volunteer with the one high school's track team would be subject to 10 years of incarceration and sex offender registration for engaging in a consensual sexual relationship with a nineteen-year-old student at another secondary school within the District of Columbia Public Schools to which the defendant has no ties and where the defendant does not exercise any authority. If the Council seeks to protect students ages 16 to 19 from undue influence and other harms in otherwise consensual relationships, it should more closely link the defendant's status as a volunteer or contractor to the complainant's status as a student. Therefore, language about the "school system" should be removed and the definition should focus on whether the defendant is in fact in a position of power over the complainant at the complainant's school.

Subtitle B, Detaining Children

The proposed changes would expand the pretrial detention of children to require holding more children who are charged with offenses that are not inherently dangerous. Like adults who are accused of crimes, children accused of delinquent acts are presumed to be innocent. Under current law, a judge can detain a child who is alleged to be delinquent if "it appears from available information that detention is required to (1) protect the person or the property of others from significant harm, or (2) to secure the

[9] D.C. Code 23-3009.03, First Degree Sexual Abuse of a Secondary Education Student.

child's presence at the next court hearing."[10] There is a rebuttable presumption that detention is required for youth charged with certain crimes including armed robbery, armed carjacking, other armed crimes of violence, and the simple possession of a firearm.[11] The offenses that are in the news are already covered by this presumption of detention– meaning that children charged with these offenses are much more likely to be detained and have more significant hurdles to overcome to show that they may be released pretrial.

The Mayor's proposed changes would expand pretrial detention of youth by adding all "dangerous crimes" and "crimes of violence" to the rebuttable presumption of detention. The broad categories of "dangerous crimes" and "crimes of violence" include crimes that are not inherently dangerous and that are frequently charged in juvenile court for relatively non-dangerous conduct. For example, "crime of violence" includes robbery and burglary.[12] Under the D.C. Code, the offense of "robbery" lacks gradations as to the seriousness of the taking or as to the value of the thing taken. Robbery does not actually require force or violence against a complainant; pick-pocketing and "stealthy seizure … from the person" are considered a "robbery."[13] A child taking another child's calculator from the backpack the other child left open on a seat next to them can be charged with robbery. Burglary would include the theft of a sled from a garage or porch; the offense does not require that the child broke into, or even entered, someone's home.[14]

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[10] D.C. Code 16-2310.

[11] *Id*.

[12] D.C. Code § 23-1331.

[13] D.C. Code §22-2801.

[14] D.C. Code § 22-801(b).

"Dangerous crime" includes the drug offenses of distribution and possession with the intent to distribute a controlled substance, where "distribution" merely means transferring possession from one person to another; it does not require that the drugs be sold.[15] Legislating in broad strokes by adding these definitions to the rebuttable presumption of detention would lead to the detention of children who can be safely supervised in the community. It is no longer in doubt that detention is traumatizing to and creates significantly worse outcomes for children.[16] At the same time, a rebuttable presumption of detention is unnecessary for the expanded list of offenses included in the Mayor's proposed legislation because a judge is required to consider the facts of the youth and the allegations in each case and can detain children upon a finding that they pose a significant risk to community safety.

The Mayor's proposal would also reverse changes made in the Comprehensive Youth Justice Amendment Act (CYJAA)[17] and allow for the detention of youth in order to protect their own safety. As framed by the Deputy Mayor for Public Safety and Justice, this proposal seeks to detain youth who have been accused of a delinquent act, and who themselves are not dangerous to the community, but who may face retaliatory violence in their communities. To be clear, youth who are placed in detention are also not safe. They are subjected to the trauma of detention, de facto solitary confinement and the resulting psychological harms, and they are physically unsafe in understaffed DYRS detention

[15] D.C. Code § 23-1331.

[16] Richard Mendel, *Why Youth Incarceration fails: An Updated Review of the Evidence*, The Sentencing Project, March 1, 2023. Available at: https://www.sentencingproject.org/reports/why-youth-incarceration-fails-an-updated-review-of-the-evidence/

[17] Comprehensive Youth Justice Amendment Act of 2016, D.C. Act 21-568.

facilities and in poorly managed shelter houses, another option for securely detained youth where they have been subjected to community violence.[18]

Incarcerating youth "for their own safety" also has the perverse effect of inflicting life-long harm. Incarcerating youth increases their likelihood of dropping out of high school and becoming involved in the adult legal system.[19] The adult criminal legal system is itself rife with violence, and includes incarceration in dangerous federal prisons and family separation. In the District, these are harms that will be inflicted almost exclusively on Black youth, who make up nearly all of the youth who are charged in the delinquency system, and will perpetuate racial disparities in wealth and life outcomes that fueled their over-representation in this system.

If the Mayor is worried about children who do not present a threat to community safety being victimized in their own communities, there are ways to respond without putting children in cages. For the $600-dollar nightly cost, and $4200 weekly cost[20] of incarcerating youth, the District could provide temporary housing for the youth and their entire family anywhere in the city or could provide any number of services.

Further, allowing youth to be detained "for their own safety" will also open the door to detaining youth for a host of fairly typical adolescent behaviors. Prior to the passage of the CYJAA provision that removed the possibility of detention for the safety

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[18] Martin Weil and Peter Hermann, *Man Posing as Officer Shoots Two at D.C. Group Home, Police Say*, Washington Post, December 21, 2022. Available at: https://www.washingtonpost.com/dc-md-va/2022/12/21/man-dressed-officer-shoots-two/

[19] Richard Mendel, *Why Youth Incarceration fails: An Updated Review of the Evidence*, The Sentencing Project, March 1, 2023. Available at: https://www.sentencingproject.org/reports/why-youth-incarceration-fails-an-updated-review-of-the-evidence/

[20] *Sticker Shock, The Cost of Youth Incarceration*, Justice Policy Institute, July 2020. Available at: //justicepolicy.org/wp-content/uploads/2022/02/Sticker_Shock_2020.pdf

of the child, youth were routinely detained because they missed curfew or skipped school. Rather than addressing these problems by supporting families, children were torn from their homes and communities. There is every reason to believe that if this language is placed back into the statute, judges will resume detaining youth when other community-based options should be employed.

Let's also be clear about how these children will be held. Since February 2023, the Office of Independent Juvenile Justice Facilities Oversight (OIJJFO) has raised alarms about understaffing at DYRS's facilities. The OIJJFO warned about safety concerns this past February when the YSC averaged a daily population of 50 youth.[21] OIJJFO's Director, Mark Jordan, testified that: "If the population of either or both facilities were to increase significantly with the current workforce, it would place extreme pressure on the agency's ability to operate the facilities safely."[22] In June 2023, more than 70 children were held at YSC. During the week of June 19, 2023, the understaffing led to a "one-in-one-out" practice on four of the five housing units. Meaning, only one youth was allowed out of their cell at a time while the remaining eight to ten youth waited hours for a turn out of their cells. This amounts to solitary confinement, with youth locked in their cells for the majority of each day. Teachers taught youth, most of whom have IEPs, by holding packets up to cell windows. Sending children who do not pose a danger to community safety into this environment is reprehensible. Claiming to do it for their own good is unconscionable. Youth detention

[21] Testimony of Mark Jordan, D.C. Council Oversight Hearing for DYRS, February 13, 2023.

[22] *Id*.

should be a last resort and instead, the Mayor's proposed changes send more youth deeper into a system that will harm them without any community safety justification.

Title III, Illegal Discharge of a Firearm, Possession of a Firearm and Ammunition Penalties

The Mayor's proposal would add new offenses to the web of gun offenses that already exist in the D.C. Code and would increase punishment for some existing gun offenses, thereby creating more offense overlap and disproportionately high sentences for the simple possession of firearms. This appears "tough on crime" but will not impact prosecution, case closure, or deter the illegal possession of firearms.

The District already severely punishes the possession of unauthorized firearms and ammunition. More than a dozen statutes and subsections prohibit the mere possession of weapons in a variety of circumstances and by a range of individuals, including by providing higher penalties if a weapon is possessed by someone with a prior conviction or who is under a civil protection order. Adding new offenses will not resolve any issues that prosecutors may have in charging cases. Instead, under the Mayor's proposal, penalties for gun possession offenses, which are already high, would become vastly disproportionate to the harm caused, and will be out of line with other statutes. For instance, under the Mayor's proposal, an individual could face a maximum sentence of 35 years of incarceration for the possession of a firearm but 30 years of incarceration for manslaughter.[23] Such a result is achieved because an individual who possesses a firearm who has a prior conviction for a crime of violence is already subject to 15 years of

[23] D.C. Code § 22–2105 (penalty for manslaughter).

incarceration and a three-year mandatory minimum sentence.[24] They are also already subject to a 10-year maximum sentence for carrying a pistol without a license after a prior conviction.[25] The Mayor's proposal would add two 5-year felonies that could be charged for the possession of that single firearm: possession of a firearm with an obliterated serial number and possession of a stolen firearm. Stolen firearms and firearms with obliterated serial numbers are exceedingly common and do not reflect that the individual in possession of the firearm obliterated the serial number or stole it. These attributes also do not make the firearm itself any more dangerous.

Ultimately, adding these offenses and increasing sentences will not deter the possession of weapons or make the District any safer. Instead, it will give even greater power and discretion to the United States Attorney's Office, an office that is wholly unanswerable to District residents and in a system that is already rife with bias. It would allow severe over-charging and extremely lengthy sentences under circumstances that require a much more measured response and that do not involve any actual harm to individuals.

Title IV, Penalty Enhancements for Vulnerable Adults, Public Transit Passengers, Recreation Center Users and Transportation Providers

PDS opposes additional enhancements and the use of enhancements in the current D.C. Code. Criminal penalties for offenses are already extremely high and provide judges with the ability to sentence individuals to long periods of incarceration. The Mayor's proposal to add enhancements that would lengthen statutory maximum sentences for

[24] D.C. Code § 22-4503 (unlawful possession of a firearm).

[25] D.C. Code § 22–4504 (Carrying concealed weapons; possession of weapons during commission of crime of violence; penalty).

crimes committed near bus stops, at metro stations, and close to recreation centers, would not deter those crimes, and would have the net effect of arbitrarily increasing sentences through actions like punishing more severely a robbery committed against a person waiting for the bus than against a person who decides to give up waiting for the bus and walk home. The proposed enhancements regarding recreation centers also apply 24-hours a day, seven days a week, regardless of whether a recreation center is open.

The proposal is similar in effect to sentencing enhancements created by "drug free school zone" laws. An investigation into the impact of drug free school zones in Tennessee found that drug free zones encompassed 5.5% of the state, but much higher figures in cities.[26] More than 28% of Nashville and 38% of Memphis are covered by these zones which apply day and night, regardless of whether children are present.[27] In 2018, Nashville's District Attorney, Glenn Funk, reflected: "In places like Nashville, almost the entire city is a drug-free zone… What we had essentially done, unwittingly, was increase the drug penalties to equal murder penalties without having any real basis for protecting kids while they're in school."[28]

The effect of creating more enhancements and expanding existing enhancements is the increase of sentences across the board. As more people and places are covered by enhancements, sentences will become longer, again incarcerated more people for longer periods of time without deterring crime or making the District safer.

<u>Title V, Rebuttable Presumption; GPS Data for Prosecution</u>

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[26] C.J. Ciaramella and Lauren Krisai, Drug Free School Zones: The Myth of the Playground Pusher, Reason, January 2018. Available at: https://reason.com/2017/12/18/the-myth-of-the-playground-pus/.

[27] *Id*.

[28] *Id*.

Rebuttable Presumption of Pretrial Detention

The Mayor's proposal expands the rebuttable presumption of pretrial detention in adult cases and thereby limits judicial discretion to thoughtfully consider the facts of each case. The Supreme Court has held that: "In our society liberty is the norm, and detention prior to trial or without trial is the carefully limited exception."[29] This makes sense given that individuals who are accused of a crime are presumed to be innocent, their cases are typically in the early stages of investigation, and pretrial detention is devastating. Individuals held in the custody of the Department of Corrections endure terrible conditions, long periods locked in their cells, inadequate and unsanitary food, and poor medical care. Pretrial detention also robs people of time with their children and families, as they wait months and sometimes years for a trial. Pretrial detention disrupts education and employment and can result in the loss of housing, thereby destabilizing all of an individual's support systems in the community.

In light of the serious harm pretrial detention causes and in order to adhere to Constitutional requirements, the District's pretrial detention statute creates a general presumption in favor of pretrial release in many, but not all, instances.[30] Despite this presumption of release, a judge may hold an individual if the government proves by clear and convincing evidence that no combination of conditions (such as GPS monitoring or curfew) are sufficient to ensure the safety of any other person and the community and the person's return to court.[31]

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[29] *United States v. Salerno*, 481 U.S. 739, 755 (1987).

[30] D.C. Code 23-1321.

[31] D.C. Code § 23-1322(b)(2).

Through a separate section of the statute, there are eight bases that cause the presumption of release to be reversed and individuals to become subject to a presumption of detention.[32] The Mayor's proposal would add another basis that would trigger a rebuttable presumption of detention where the court finds probable cause to believe that an individual committed a crime of violence and has previously been convicted of a crime of violence.[33] Under current law, even without a rebuttable presumption of detention, the majority of individuals in this situation would be detained. In deciding whether there are conditions of release that can secure the safety of the community, a judge already considers the history and characteristics of the individual including their past conduct and criminal history.[34] In almost all instances, the court's consideration of the individual's criminal history would lead it to detain someone with a recent conviction for a crime of violence. An individual with a recent conviction for a crime of violence would also typically be on supervised release under the authority of the United States Parole Commission (USPC). The USPC would issue a warrant as a result of the new case

[32] D.C. Code § 23-1322(b)(1). Individuals are subject to a presumption in favor of detention if a judge finds probable cause that the individual: (1) committed a dangerous crime or a crime of violence while armed with or having readily available a pistol, firearm, imitation firearm, or other deadly or dangerous weapon; (2) threatened, injured, intimidated, or attempted to threaten, injure, or intimidate a law enforcement officer, an officer of the court, or a prospective witness or juror in any criminal investigation or judicial proceeding; (3) committed a dangerous crime or a crime of violence, and has previously been convicted of a dangerous crime or a crime of violence which was committed while on release pending trial for a local, state, or federal offense; (4) committed a dangerous crime or a crime of violence while on release pending trial for a local, state, or federal offense; (5) committed 2 or more dangerous crimes or crimes of violence in separate incidents that are joined in the case before the judicial officer; (6) committed a robbery in which the victim sustained a physical injury; (7) violated § 22-4504(a) (carrying a pistol without a license), § 22-4504(a-1) (carrying a rifle or shotgun), § 22-4504(b) (possession of a firearm during the commission of a crime of violence or dangerous crime), or § 22-4503 (unlawful possession of a firearm); or (8) violated gun offender registration requirements while on probation, parole, or supervised release for committing a dangerous crime or a crime of violence and while armed with or having readily available a firearm, imitation firearm, or other deadly or dangerous weapon.

[33] "Crime of violence" is defined at D.C. Code 23-1331(4).

[34] D.C. Code 23-1322 (e)(1).

and even if they were released by the Court, the individual would be detained as a result of the USPC's warrant.

Despite the likelihood that individuals contemplated by the Mayor's proposal would be detained under current law, adding to the rebuttable presumption of detention is harmful. Adding to the rebuttable presumption of detention usurps the judge's discretion to consider all of the facts related to the individual and the case. For instance, this rebuttable presumption would prevent a judge from applying a more nuanced approach with someone whose prior conviction was from more than 20 years ago, or where the facts of the prior conviction show that it was not committed in a violent way.[35]

Importantly, the Mayor has not produced any evidence that this change is necessary because individuals in this narrow subset are being released by the court and then are accused of committing new offenses. Data from the Pretrial Services Administration shows that 92 percent of the individuals who are released pretrial remain arrest-free.[36] Prior to amending the pretrial release statute, the Council should request the CJCC study the eight percent of individuals who have been arrested while on pretrial supervision. Prior to legislating, the Council should learn about what is not working for this population and what solutions could help. Relatedly, the study should also examine those individuals, a subset of the 92 percent, who were charged with more serious felonies and remained arrest-free to determine what was working for that population. Rather than detaining more people and worsening life outcomes, the Council should work

[35] For instance, the D.C. Code defines robbery as a crime of violence, but it can be committed by taking something without the use of any force, like pickpocketing or stealthily taking something from a table next to where the property owner is sitting.

[36] Data reported by the Pretrial Services Agency. Available at: https://www.psa.gov/sites/default/files/FY%202018-2022%20-%20Fact%20Sheet-Arrest-Free%20Rates%20for%20DC%20Defendants%20Under%20Pretrial%20Supervision.pdf.

to build on the success of the 92 percent of individuals who are released pretrial and are not rearrested, for any offense, while on pretrial supervision. The study might also point to where detention is overused and suggest how the detention statute can be written more precisely so it does not needlessly detain individuals – at great cost to those individuals and our communities, and at District expense.

GPS Data for Prosecution

Under current law, information and reports, including GPS data, held by the Pretrial Services Agency (PSA) cannot be admitted on the question of guilt in most proceedings. The information can be used to impeach a defendant, in perjury proceedings, and on the question of guilt in proceedings for the offense of failure to appear for a court hearing as required, offenses committed while on release, or for contempt related to violation of release conditions. The Mayor's proposal reverses this position, expands it to include GPS data maintained for the purposes of supervised release, probation, and parole and provides that GPS data "shall be admissible on the issue of guilt in any judicial proceeding."

Under current law, there is no prohibition on the Court admitting GPS data from the United States Parole Commission (USPC) or the Court Services Offender Supervision Agency (CSOSA). The narrow limitation under current law applies to information held by the PSA. This limitation makes sense given that the role of the PSA should be supervising and assisting the individual so that they thrive during supervision. The non-adversarial supervision relationship is beneficial because it encourages individuals to turn to PSA for help and should not be turned into another way to accumulate data for the purpose of prosecution.

Further, the Mayor's proposal is flawed as a legal proposition. The Court should not be instructed that it "shall" admit evidence at trial. Evidence must be subject to a relevance analysis and scrutiny as to whether the prejudicial impact of the information – the potentially highly inflammatory evidence that a person was on electronic monitoring – is not substantially outweighed by its probative value. The Court must also decide the admissibility of the evidence, considering the reliability of the science and methods that form the basis for GPS tracking. The evidence may also need a custodian. The direction that the evidence simply "shall" be admitted is problematic.

Title VI, GPS Data for Persons Under Supervision

The Mayor's proposal requires CSOSA, DYRS, the Social Services Division of Superior Court, and PSA to provide MPD, upon request, with all GPS data for individuals on pretrial release, predisposition release, supervised release, probation, or parole, that "is deemed by the Chief of Police as necessary in conducting a criminal law enforcement investigation." As a threshold issue, the District cannot mandate action by federal agencies. The Home Rule Act provides that "the Council shall have no authority … to "Enact any act, or enact any act to amend or repeal any Act of Congress, which concerns the functions or property of the United States or which is not restricted in its application exclusively in or to the District."[37] CSOSA, PSA, and the Social Services Division of D.C. Superior Court are all federal actors and are not subject to mandates from the D.C. Council. The Council should strike these entities from the Mayor's proposed legislation.

[37] D.C. Code §1-206.02.

With respect to the single District entity covered by this proposed legislation, DYRS, the Council should act with caution. DYRS supervises a small number of youth and the purpose of the supervision is to encourage the rehabilitation of those youth. Nearly all of the youth that DYRS supervises are Black. This legislation would encourage the over-policing of Black youth by incentivizing GPS monitoring of committed youth, and impacting their supervision in ways that are not rehabilitative, such as preventing them from swimming in a pool, requiring them to spend time charging the device, and forcing them to carry the stigma of GPS monitoring when they are at school or in the community.[38] It would also infringe on their personal liberty by permitting real time sharing of their location with no oversight by a judicial officer or someone outside of MPD. The same would apply for GPS data sharing by Court Social Services.

Further, while CSOSA currently shares GPS data with MPD, that sharing should be walked back. The District should limit MPD's access of GPS data from supervision agencies, even the agencies from which it voluntarily receives information. Instead, to protect residents' privacy interests, MPD should be required to have GPS data requests approved by an outside entity through a process similar to obtaining a search warrant.[39] That limitation is an appropriate check on MPD given the privacy interests of District residents in their historical GPS data which could reveal associations, and religious and medical practices, and the limitation would not meaningfully hinder criminal investigations.

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[38] *See e.g.* Jennifer Granick et al., *Mission Creep and Wiretap Act Super Warrants: A Cautionary Tale*, 52 Loy. L. A. L. Rev. 431 (2018-2019).

[39] In *United States v. Jackson*, 214 A.3d 464 (D.C. 2019), the D.C. Court of Appeals held that a search warrant was not required for MPD to obtain GPS data that was obtained by CSOSA, at the request of MPD, but in a manner that was consistent with its own policies.

Title VII, Strangulation

Strangulation is already criminalized under the statutes for simple assault[40], significant injury assault[41], and aggravated assault[42], depending on the level of injury. As with other aspects of the proposed legislation, this proposal will not prevent domestic violence and the United States Attorney's Office does not suffer from an inability to prosecute domestic violence cases related to strangulation.

If the Council creates a new offense of strangulation within significant injury assault, PDS recommend adding specificity to the offense definition, particularly around pain and physical injury. PDS recommends the changes below.

"(2)(A) Whoever unlawfully assaults, or threatens another in a menacing manner, and intentionally, knowingly, or recklessly causes significant bodily injury to another shall be fined not more than the amount set forth in section 101 of the Criminal Fine Proportionality Amendment Act of 2012, effective June 11,2013 (D.C. Law 19-317; D.C. Official Code § 22-3571.01), or be imprisoned not more than 3 years, or both.

(B) For the purposes of this paragraph, the terms shall have the following meanings

"(i) "Significant bodily injury" shall mean:

"(I) An injury that requires hospitalization or immediate medical attention;

"(II) An injury that causes any loss of consciousness; or

"(III) A contusion, petechia, or other bodily injury, or impairment of functioning ~~physical condition~~, to the neck, throat, or head sustained during strangulation or suffocation.

"(ii) "Strangulation or suffocation" shall mean a restriction of normal breathing or circulation of the blood by applying pressure on the throat, neck, or chest, or by obstructing the nose or mouth.".

[40] D.C. Code § 24-404, simple assault, is punishable by 180 days in jail, criminalizes any offensive touching.

[41] D.C. Code 22-404(a)(2) significant injury assault, punishable by 3 years of incarceration, covers conduct where the injury requires hospitalization or immediate medical treatment.

[42] D.C. Code § 24-404.01, aggravated assault, punishable by 10 years of incarceration, includes conduct where the individual's conduct created an extreme risk of serious bodily injury to the complainant or where the injury to the complainant involved unconsciousness, extreme physical pain or a substantial risk of death.

Title X, DNA Sample Collection

The Mayor's bill proposes collecting DNA samples from individuals who have been arrested or are facing charges for various first-degree sex offenses and to run those samples through the national Combined DNA Index System (CODIS). This proposal would require police to take DNA samples from arrestees, prior to prosecutors making a charging decision about the case and prior to a judge finding that there is probable cause for the case to move forward. The Mayor's proposal leaves the process entirely in the hands of MPD, meaning that an individual could have their DNA taken based on nothing more than a police officer's charging decision.

While the Mayor and United States Attorney's Office support this measure as a crime fighting proposal, it would have an extremely limited impact on solving crime and would involve a great deprivation of privacy. Arrestee testing in Maryland resulted in a match for only 1.2% of the samples entered.[43] The District already collects DNA samples from any person who has been convicted of any felony and from individuals who have been convicted of misdemeanor sex offenses.[44] Those samples are already uploaded into CODIS and can be matched with any evidence samples. Thus, the only arrestee samples that are not already in CODIS are samples that would be taken from individuals who have not been previously convicted of a felony or any misdemeanor sex offense. If the arrestee is convicted of the charged offense, or any qualifying offense, a DNA sample would be taken post-conviction and entered into CODIS. The difference between having

[43] The Mid-Atlantic Innocence Project calculated this rate of "hits" based on information contained in the Annual DNA Report for 2022 from Maryland. Available at: https://mdsp.maryland.gov/Organization/Documents/2022%20Annual%20DNA%20Database%20Report.pdf

[44] D.C. Code § 22-4151.

a DNA sample at arrest and at the time of conviction may be a matter of waiting four to six months. Waiting those months ensures due process for individuals who are merely charged with offenses.

Further, there should be absolutely no confusion that DNA sampling is available as a prosecutorial tool to secure a conviction in the pending case. Where the facts present the possibility of using DNA evidence in a case, prosecutors routinely seek and obtain search warrants for DNA samples from the defendant. In such instances, the government only needs to show probable cause to believe that the DNA to be obtained through a buccal swab is evidence of a crime.[45] Once a judge signs the search warrant, a DNA sample is taken from the individual and the analysis is available for comparison against any evidence samples.

Because DNA testing is readily available when it is a legitimate tool to obtain a conviction in the pending case and samples of individuals who have been convicted of the long list of qualifying DNA offenses already have their DNA loaded into CODIS, this proposed legislation is about allowing an invasion of privacy against individuals who are presumed innocent and who have no prior serious convictions. Worse, it allows an invasion of the privacy of individuals whose arrest will not even result in charge by prosecutors. As with the rest of the District's criminal legal system, the burden of this proposal will fall almost exclusively on Black residents who make up make up 90% of individuals held at the D.C. Jail.[46] The Mayor's proposal also allows for this serious

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[45] *In re G.B.*, 139 A.3d 885, 894 (D.C. 2016).

[46] D.C. Department of Corrections, Facts and Figures, January 2023. Available at: https://doc.dc.gov/sites/default/files/dc/sites/doc/publication/attachments/DC%20Department%20of%20Corrections%20Facts%20and%20Figures%20January%202023.pdf

intrusion before there is any testing of the allegations by a judge or through a trial. Given that DNA samples will be available to prosecutors to run through CODIS within a matter of months if they secure a conviction, and that a DNA sample will be available upon the granting of a search warrant application, the benefit of this proposal is sharply outweighed by its glaring racism and potential harms and it should be rejected.

The Mayor's proposal also ignores the current reality at the Department of Forensic Sciences (DFS). DFS is not accredited to perform DNA testing and is not authorized to upload data into CODIS. The District is spending significant funds to outsource DNA testing that should be performed by DFS. The failures at DFS have also been connected to concerns about public safety. United States Attorney Matthew Graves said that prosecutors were declining less serious cases for "myriad reasons including that the city's crime lab remained unaccredited."[47] At the same time, the District must undertake a massive retesting of evidence from DFS's work in ballistics and tool-marks. While that work is separate from the DNA unit, given that there has been no progress on the retesting for more than two years, the District should not undertake another project, such as arrestee DNA testing, that will add to the burden of DFS while producing little to no public safety impact.[48]

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[47] Keith L. Alexander, *D.C. U.S. Attorney Declined to Prosecute 67% of those Arrested, Here's Why*, Washington Post, March 29, 2023. Available at: https://www.washingtonpost.com/dc-md-va/2023/03/29/us-attorneys-office-charges-declined-dc-police/.

[48] Alex Koma and Sloane Airey, *Failing the Test: Bowser's Promised Crime Lab Evidence Retesting Is Nowhere to Be Seen, Despite Years of Work*, City Paper, May 12, 2023. Available at: https://washingtoncitypaper.com/article/603904/failing-the-test-bowsers-promised-crime-lab-evidence-retesting-is-nowhere-to-be-seen-despite-years-of-work/.

Title XI, Incarceration Reduction Amendment Act

The Mayor proposes five changes to the Incarceration Reduction Amendment Act (IRAA): (1) re-inserting "nature of the offense" into factor two; (2) striking language from Supreme Court opinions instructing the Court to consider rehabilitation despite the "brutality and cold-hearted nature of the offense;" (3) requiring judges to consider remorse; (4) requiring the court to consider any community impact statements; and (5) changing language that judges "shall" grant IRAA petitions if individuals are no longer a danger to the community and the interests of justice warrant a sentence reduction to "may." This Committee should reject all 5 of these proposed amendments; IRAA should not be amended.

In every IRAA case, judges consider the "nature of the offense" by considering the facts of the underlying offense. Consideration of the offense is inherent in at least three of IRAA's factors: factor (4) report or recommendation received by the United States Attorney; factor (6) victim impact statements; and factor (9) "the defendant's role in the offense and whether and to what degree another person was involved in the offense."[49] IRAA also has a catchall factor, factor (11), which requires the court to consider "any other information [it] deems relevant to its decision."[50] IRAA also provides that the Court may "consider any records related to the underlying offense."[51]

We have also been here before. The Council struck the "nature of the offense" from IRAA factor (2) in 2018 because the nature of the offense was universally over-emphasized by the United States Attorney's Office as a basis for denying relief. In 2020,

[49] D.C. Code § 24-403.03(c).

[50] D.C. Code § 24-403.03(c).

[51] D.C. Code § 24-403.03(b)(2).

then-Councilmember Mary Cheh proposed reinserting the language. This was resoundingly rejected by the Council.

The current Chair of this Committee, Councilmember Pinto, rightly observed: "These cases are about restorative justice, these cases are about giving people a second chance, and they are about looking at what has happened since what was likely a terrible and heinous crime and what you've done to commit yourself to recovery and rehabilitation under tremendously difficult odds."[52]

In rejecting this amendment, Councilmember McDuffie was clear: "The way we address and support victims is to work harder to address the root causes that compel young people to pick up guns and shoot them to resolve disputes."[53]

Nothing has changed in the three years since the Council last rejected this language.

In the same vein, the Mayor's legislation proposes to strike language from IRAA factor (10) that was taken directly from the United States Supreme Court's opinions in *Roper v. Simmons*[54] and *Graham v. Florida*[55] in which the Supreme Court stated: "An unacceptable likelihood exists that *the brutality or cold-blooded nature of any particular*

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[52] D.C. Council, legislative meeting, December 1, 2020. Discussion of Councilmember Mary Cheh's amendments begins at 31:49. Available at: https://dc.granicus.com/MediaPlayer.php?view_id=2&clip_id=5958 Councilmember Pinto's cited remarks begin at 53:00.

[53] *Id*. Councilmember McDuffie's remarks begin at 57:38.

[54] *Roper*, 543 U.S. 551, 553-54 (2005), "An unacceptable likelihood exists that *the brutality or cold-blooded nature of any particular crime* would overpower mitigating arguments based on youth as a matter of course[.]" *Roper*, 543 U.S. at 553–54 (emphasis added).

[55] *Graham*, 560 U.S. 48, 78 (2010)("The Court concluded that an 'unacceptable likelihood exists that the brutality or cold-blooded nature of any particular crime would overpower mitigating arguments based on youth as a matter of course[.]'").

crime would overpower mitigating arguments based on youth as a matter of course[.]"[56] These Supreme Court precedents respectively about the unconstitutionality of the death penalty and of the life imprisonment without the possibility of parole as applied to juveniles, were the inspiration for IRAA. The science on which the Supreme Court based these opinions demonstrates that young people who commit even the worst offenses are likely to mature out of criminal behavior. All IRAA cases involve long sentences and serious crimes. The language in the factor that the Mayor proposes to delete is necessary to reinforce that the focus of IRAA is whether the person can demonstrate that they are rehabilitated.

The Mayor's legislation would also add an explicit requirement of remorse to IRAA. Many of our clients are deeply remorseful for their crimes, and judges can and do consider their remorse. Conversely, judges also consider the lack of an expression of remorse. But remorse should not be a prerequisite for relief. *Requiring* remorse precludes IRAA relief for individuals like Troy Burner, an IRAA recipient, who won relief through IRAA prior to his exoneration.[57] There are 21 exonerees from D.C. Superior Court on the National Register of Exonerations. Based on their age at the time of the commission of the offense, 14 of the District's 21 exonerees would have been eligible to petition for relief based on IRAA if it had existed at the time of their

[56] *Id*.

[57] As one Superior Court judge explained: "Asserting one's innocence or exercising one's Constitutional rights to trial and appeal and rehabilitating oneself are not mutually exclusive propositions. Order, at 20, *United States v. Johnson*, 1999-FEL-8932 (D.C. Super. Ct. 2019) (McKenna, J.)

convictions.[58] Under the Mayor's proposal, all of those wrongfully convicted individuals would be ineligible for relief under IRAA.

The insertion of remorse also creates difficult scenarios regarding proof. Individuals who are sentenced to life terms in the Bureau of Prisons are gone from the community. Frequently, they have no way of expressing remorse other than through their actions and growth while in prison. In these instances, remorse has become an adversarial battleground with the United States Attorney's Office arguing that remorse is not sincere because an individual went to trial, or because they filed an appeal, or because in the absence of any earlier opportunity to make a statement in Court, the client's first *public* expression of their remorse occurs at their IRAA hearing. However, BOP residents are prohibited from contacting victims or their families by phone or mail. BOP also frequently prohibits lawyers from speaking to officials within the prison. It is not realistic to expect that a client's BOP case manager or someone who led programming in BOP would be able to speak to an individual's remorse. Therefore, the subjective assessment of an individual's remorse may rely entirely on statements made by the individual during an emotional hearing, decades after the offense.

The Council should also reject the proposal to add community impact statements to the factors that a judge must consider in assessing whether the individual is non-dangerous and the interests of justice warrant relief. Inviting community impact statements makes little sense. The very structure of IRAA means that the hearing will be held, *at a minimum*, 15 years after the crime was committed. Most IRAA hearings have happened nearly 25 years after the crime and in some cases, the time between the offense

[58] National Registry of Exonerations. Available at: https://www.law.umich.edu/special/exoneration/Pages/detaillist.aspx

and the hearing has been more than 30 years. Anyone who was lived in D.C. 25 or 30 years ago, or even just 15 years ago, knows how much communities have changed since then. Some communities, like Barry Farms and Sursum Corda, no longer exist. Further, any community impact would have to include the impact of continued incarceration. Given the breadth of issues that would have to be addressed and frequently the lack of a direct tie to the events, this change should be rejected.

The false claim that judges need more discretion to deny IRAA motions is behind the proposal to change "shall" to "may" at the beginning of the statute. Judges already have great discretion allowed by the catchall factor that they "shall" consider "any other information the court deems relevant to its decision" as well as the finding they are required to make that "the interests of justice" warrant granting the motion. By substituting the word "may" for the word "shall," the Council would be suggesting that there could be a good reason for denying a motion despite that the fact that the court considered "any information" it deemed relevant and found that *justice* merited granting the motion. By definition then, only an unjust reason could support the court denying a motion it concluded it would be "in the interests of justice" to grant. Why would this Council even suggest, let alone invite, judges impose *injustice* on D.C. residents? This proposed amendment should be rejected swiftly and in no uncertain terms.

Finally, it is irresponsible and false to suggest that the approximately 155 people who have come home under IRAA are behind the District's public safety problems. Most of the individuals who have returned home have served more than 25 years of incarceration.[59] At least one individual served 40 years before being released through

[59] Information collected by the Public Defender Service regarding 150 IRAA cases.

IRAA. IRAA recipients are rehabilitated and embrace the opportunity to serve their communities. Of the 155 returning citizens, only two have been charged with crimes against persons. This represents 1.2% of the individuals who have come home under IRAA.[60] Currently, only 6.4% percent of IRAA recipients have been convicted of a new offense or have a pending case.[61] This is substantially lower than the recidivism rates of individuals released from BOP custody at the conclusion of their sentences. BOP states that its "overall recidivism rate (as defined by rearrest or return to any jurisdiction's custody) is around 43%" and that rate is already "lower than most studies of state prisoners using comparable definitions and methodologies."[62] This difference supports acknowledging the incredible rehabilitative efforts of IRAA petitioners and the careful consideration that judges have given to IRAA motions.

In conclusion, I want to say that we have been here before. This is my city; I grew up here and lived here throughout the 80s and 90s. I have watched my hometown address crime with more mass incarceration and seen that mass incarceration destroy generations of families. As a community, in order to address public safety challenges, we must not turn to the racist, failed, and devastating strategies of mass incarceration and the denial of rights and liberties. There are more effective ways to confront these issues and this bill is not one of them.

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[60] This figure was derived by analyzing and researching information provided by the United States Attorney's Office.

[61] *Id*.

[62] Data reported on BOP's website. Available at: https://www.bop.gov/about/agency/#:~:text=The%20BOP%C3%AF%C2%BF%C2%BDs%20overall%20recidivism,using%20comparable%20definitions%20and%20methodologies.

Testimony Before The Committee on the Judiciary and Public Safety

Tuesday, June 27, 2023

Jay Haddock and Hector Torres

Residents of Ward 6

Chairperson Pinto and the committee thank you for allowing us to submit this written testimony on the Safer Stronger Amendment Act of 2023 and for bringing forth this very important matter.

We have been residents of our great city since 1978 and during that time have seen the city go through many phases of change. An economic engine that continues to thrive and a city that has come into truly being a world class city and recognized as a powerhouse capital. Our focus has been on economic growth, and we have achieved many parts of that. However, our public safety has not become the obsession that we have had with economic improvements. These two - go hand in hand – whether you are a resident or the cherished tourist that we seek to visit us year-round. Of course, the pandemic has created a difficult issue for us all but even more for those who continue to struggle to make ends meet in DC. This can create a very difficult disparity that must be addressed to combat crime as well as do the things to attenuate it, ever approaching the levels we are seeing.

We support strong law enforcement, strong policing, and accountability but we also see things that can possibly be changed to address it both on the street and domestically. We also do not support de-funding the police.

Some things that we personally see that can perhaps be considered:

- Foot patrols by our MPD officers to create a sense of relationship in our communities. Extended use of segways, bike and scooter patrols – which were introduced and yet recently not seen. In SW where we live, we rarely see police patrols even though we have a headquarters office on Maine Avenue. Thankfully, we have an MPD officer that is a neighbor, and many times comes by in his squad car. The Wharf has created a great amount of foot and vehicle traffic in SW and yet this continues to be absent. In fact, you may go to the Wharf, and you will hardly see any police presence as I guess they rely on the private security the location provides. We are certain this is also the same in other areas of the city.
- Increase the number of real after school/summer programs that will ensure that our youth remain active in activities that are positive and offer a refuge from the street scene. Those major corporations that call DC home can certainly support this effort and help to fund programs that offer mentorships, employment or private – public programs to address this area of need with meaningful activities.
- Strengthen our adult education schools that offer second chances to individuals that were not able to continue their education because of economic impact, domestic issue, or incarceration. These schools are always in question as to their effectiveness. They produce great deliverables for both immigrants and residents and gives them the ability to continue to find ways to improve themselves personally and economically. The DC government should treat them with the same support they offer K-12.

- Continue the security camera funding and expand it as much as possible. This is a great deterrent for any kind of crime that may be perpetrated.
- Increase lighting in some of our neighborhoods and even place panic poles as universities have on their campuses in areas the city deems necessary. If you can have speed cameras in many parts of the city, we certainly have these in the neighborhoods. Even better to ensure that every major development has security cameras as the federal office buildings have covering the exterior perimeter of their building. We do not want to create a police state but focus on a safe environment.
- Increase visitation of MPD officers to schools and begin the thinking that the police is a friend not an adversary and make this a mainstay in police/education relationships.
- Strengthen at all levels workforce development and make it a private/public relationship.

These are some of the things that we feel can be employed and while they may be in existence at present they should be strengthened and not allow them to fall by the wayside.

Being seniors, we think back to the times that there was a relationship between the community and the police, and this is a basic need that needs to be placed at the front of any safer program. We for the most part support the contents of the amendment but also do not want to make it where it is a punishment and not have social rehabilitation or social improvements attached to it. Yes, strengthen penalties for crimes but also strengthen programs that can avert it. We live in a diverse city that requires diverse thinking and inclusion and we must engage the community in all solutions to the problems we face. We are certain that there are certain cities that are trying out new socially focused policing and have had results. Let us study best practices and see if we can employ them. We must also engage our DMV neighbors to collaborate, mirror and work with us on joint crime enforcement and deterrents.

Again, we feel that many parts of the Safer Stronger Amendment Are necessary, but they must be coupled with those things that not solely punish but offer remedies that can make those who felt left out find a way to get back in. It is quite evident that economic need drives criminality.

Thank you for your time and your leadership on this matter and we thank Mayor Bowser for her efforts in continuing to make DC the great city that it is and taking these steps to continue to combat crime. Together we can reduce crime and continue our positive track for a better city with her leadership, The Council and MPD.

Respectfully,

Hector J. Torres

Jay Haddock

Proud Residents of Ward 6

Testimony of the Innocence Project & the Mid-Atlantic Innocence Project
Opposing Provisions of B25-291, "the Safer Stronger Act"
Committee on the Judiciary & Public Safety
Council of the District of Columbia
July 11, 2023

The Innocence Project and the Mid-Atlantic Innocence Project represent wrongfully convicted persons and work to reform the criminal legal system to prevent future injustices. We support the testimony of other experts raising concerns regarding the Safer Stronger Act including the formerly incarcerated individuals who testified about their lived experiences, Campaign for the Fair Sentencing of Youth, Council for Court Excellence, Second Look Project, DC Justice Lab, and the Public Defender Service.

We write separately to weigh in on proposed changes to the Incarceration Reduction Amendment Act to require statements of remorse which will uniquely affect our clients and the proposal to collect arrestee DNA samples because of our unique expertise on the use of DNA in the criminal legal system. We recommend these provisions be removed from the Act for the reasons outlined below. We are available to assist the Committee on revisions to the bill as needed and to provide further background on these concerns.

Respectfully submitted,

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Concern #1: Amendment of IRAA to Require Statements of Remorse

The proposed changes to the IRAA requiring a statement of remorse will have unintended harmful impacts on wrongfully convicted people in the District who have yet to be exonerated. This requirement was left out of the Act in comparison to other laws for this explicit purpose. As recorded by the National Registry of Exonerations, 21 people have already been exonerated to date in the District, with the most recent wrongful conviction occurring as recent as 2013. Innocent people convicted of crimes they did not commit as children are not less deserving of

relief than other people convicted of crimes as children, but this change would ensure that they are less likely to receive relief under IRAA and would be forced to spend more time in prison for crimes they didn't commit. We believe the reasons for these changes rely on several faulty assumptions:

> **Assumption #1**: Those who do not express remorse must be lying about their innocence and therefore deserve to be penalized;
> **Assumption #2**: There is correlation between remorse and recidivism; and,
> **Assumption #3**: This is only one factor and would not be outcome determinative.

Innocent defendants already are penalized for going to trial rather than pleading guilty, demonstrating a lack of remorse at sentencing, and demonstrating a lack of remorse in parole proceedings.[1] This is true regardless of the fact that there is no evidence demonstrating that a lack of remorse leads to higher recidivism rates.[2] Further, there is no guarantee that this one factor would not be used as the determining factor in denial of IRAA petitions as so often is the case for wrongfully convicted persons seeking parallel relief in other jurisdictions.

Enshrining the lack of remorse in the IRAA would place wrongfully convicted residents in the "Catch-22" of either allowing judges to rely on their lack of remorse for a crime they maintain their innocence of as the primary reason for punishing innocent people more harshly than others or require the innocent person to falsely claim remorse for a crime they had no part in which will endanger their future legal claims of innocence.

Impact on the Innocence Protection Act

Our offices represent District residents whose goal is to achieve full exoneration. Claims under the Innocence Protection Act (IPA) in District courts categorically take extensive time to litigate, leaving our clients with the need to pursue temporary remedies like parole, compassionate release, and IRAA petitions in order to be removed from their wrongful imprisonment while awaiting final adjudication of their claims of innocence.

> **Example #1**: Troy Burner had hearings on his IPA and IRAA petitions in fall 2019. The IRAA petition was granted in November 2019, but the IPA petition was not granted until March 2020. Notably, although the USAO argued that he did not deserve IRAA relief because he lacked remorse, he prevailed on the IPA *and* received $5 million in compensation from the District of Columbia for his wrongful conviction.
>
> **Example #2**: Rodney Brown filed his IPA petition in January 2020, had a hearing on the petition in fall 2022, and still is awaiting a decision on the IPA petition. The Second Look

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[1]See, E.G, Nilam A. Sangvi And Elizabeth A. Delosa, The Innocence Penalty: Is It More Pronounced For Juveniles, 125 Dickinson L. Rev. 727, 728 (Noting That The Average Post-Trial Sentence Is Three Times Larger Than The Average Post-Plea Sentence); And The Innocent Prisoner's Dilemma: Consequences Of Failing To Admit Guilt At Parole Hearings, 93 Iowa L. Rev. 491 At 513 ("a Defendant May Even Be Explicitly Punished At Sentencing For Persisting In His Innocence) And 515 ("The Available Quantitative And Qualitative Data Support The Assertion That A Prisoner's Acceptance Of Responsibility Proves Vital To His Prospects For An Affirmative Parole Decision.")

[2] Id. At 537 (Citing to An English Study in Which Individuals Labeled High Risk Because Of Their Failure to Express Remorse Actually Had a Lower Recidivism Rate Than Those Who Did Express Remorse).

Project filed an IRAA petition on his behalf in January 2022, and he prevailed on that claim in June 2022. The USAO also argued that his lack of remorse should result in the denial of his IRAA petition.

In addition to the difficulty it would cause innocent clients while they await adjudication of their innocence claims, the IPA requires petitioners to submit a signed affidavit, under penalty of perjury, attesting to their innocence. If remorse becomes a requirement under the IRAA, it will make it difficult, if not impossible, for our clients to pursue both remedies. They will be left with the unjust choices below:

Choice #1: File an IPA petition and an IRAA petition without expressing remorse, thus running the very real risk of losing the IRAA petition.

Choice #2: File an IPA petition and an IRAA petition with an expression of remorse, thus running the risk of perjury charges.

Choice #3: Give up litigating your innocence, with the hope that you will go home sooner under IRAA.

Choice #4: Give up litigating under IRAA, running the risk that you will spend even more years in prison for a crime you didn't commit.

Concern #2: Collection of Arrestee DNA Samples

According to the National Registry of Exonerations, to date, DNA evidence has been used to exonerate 579 individuals.[3] Therefore, we understand the utility and power of DNA evidence and databases. However, we believe that DNA should only be collected once there is probable cause and the evidence produced from the sample can be used to establish guilt beyond all reasonable doubt.

Establishing Probable Cause

Law enforcement officers should establish probable cause prior to collecting an arrestee's DNA. Establishing probable cause is the burden of the prosecution. An investigation should not solely rest on a potential DNA match. The prosecution must first prove that the crime did happen, and that the arrestee's DNA is relevant. An arrestee's DNA is relevant when the DNA profile, yielded from sexual assault kit (SAK) samples, consists of a mixture of two or more individuals or is a single source profile belonging to someone other than the victim. Once this has been established, requesting or mandating a DNA sample from the arrestee may be reasonable. However, if all the SAK samples produce single source profiles of the victim's DNA, the arrestee's DNA will not be relevant to the investigation.

Potential Fourth Amendment Violations

[3] Exoneration Detail List, https://www.law.umich.edu/special/exoneration/Pages/detaillist.aspx?SortField=Exonerated&View={faf6eddb-5a68-4f8f-8a52-2c61f5bf9ea7}&FilterField1=DNA&FilterValue1=8%5FDNA&SortDir=Desc (last visited Jul 6, 2023).

One of the main goals of arrestee DNA collection is to conduct a Combined DNA Index System (CODIS) search to determine if the arrested individual can be linked to other crimes. However, the Fourth Amendment prohibits suspicionless searches. Using an arrestee's DNA as a tool to search CODIS, in hopes of identifying them as a suspect for a crime they were not arrested for or accused of, is a Fourth Amendment violation.[4] An arrest is not a conviction. Individuals are often falsely accused or suspected of a crime. Therefore, an arrest alone does not justify a DNA search.

Questionable Effectiveness of Arrestee DNA Collection

Arrestee DNA collection is not an effective tool for identifying suscepts in unsolved crimes. The state of Maryland can be used to illustrate this. In 2022, a total of 8,260 DNA samples were collected from arrested/charged individuals. All samples were searched through CODIS, yet the percentage of DNA hits/matches is less than 1.7%.[5] There is no data to determine if those hits resulted in a conviction; therefore, the resulting conviction percentage may be even lower. Such low percentages do not rationalize a Fourth Amendment violation.

DNA Expungement

Federal law requires that states establish procedures for expunging arrestee profiles that do not lead to convictions. However, there is no specificity regarding how expungement should be initiated or no standards defining the extent to which the state should be involved. Because of this lack of transparency, most states place the burden of initiating expungement on the arrestee. For arrestees in many states, initiation of the expungement process includes writing formal requests to their trial court, their state laboratory, and the prosecuting attorney of their county.[6] This burden can be extremely overwhelming for arrestees, especially those without formal legal representation.

In cases where the expungement process is successfully initiated, arrestees face the highly likely possibility of their DNA profiles never being expunged. A recent sample of state expungements found that in states without automatic expungement, only 0.0084% to 0.0140% of expungement-eligible profiles were removed from state indices.[7] The expungement rates in states with "automatic" or state-initiated expungement procedures are better than in states without such procedures. However, even with automatic expungement, the best state expungement rate was only 30.5% (Maryland) and the average expungement rate for these states was 17.74%.[8] This means that a majority of states still have access to the DNA profiles of arrestees that were never convicted—this then becomes a genetic privacy issue. An automatic expungement policy should

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[4] Xiaochen Hu (Fayetteville State University), Mai E. Naito (University Of West Georgia) & Rolando V. Del Carmen (Sam Houston State University), *Pre- and Post- Conviction DNA Collection Laws in the United States: An Analysis of Proposed Model Statutes*, J. CRIM. JUSTICE LAW (2017), https://jcjl.pubpub.org/pub/v1-i1-hu-naito-delcarmen-dna-collection-laws (last visited Jul 6, 2023).

[5] 2022 Annual Report Maryland State Police Forensic Sciences Division Statewide DNA Database Report, https://mdsp.maryland.gov/Organization/Documents/2022%20Annual%20DNA%20Database%20Report.pdf.

[6] Elizabeth E. Joh (University of Pennsylvania), *The Myth of Arrestee DNA Expungement*, 164 U. PA. L. REV. ONLINE. 51 (2015), https://scholarship.law.upenn.edu/cgi/viewcontent.cgi?article=1157&context=penn_law_review_online (last visited Jul 6, 2023).

[7] 2022 Annual Report Maryland State Police Forensic Sciences Division Statewide DNA Database Report, *supra* note 3.

[8] *Id.*

be paired with pre-conviction DNA collection statutes to prevent an invasion of genetic privacy and misuse of genetic data.

Racial Disparities

Arrestee DNA profiles in state indices exhibit a racialized trend. The collection of arrestee profiles overwhelmingly impacts people of color, especially African Americans. In Maryland, the collection of arrestee profiles became effective in January 2009. With this, the racial disparity of the state database was revealed. Of the 11,643 arrestee DNA samples collected in 2009, over 7,000 (61%) of the samples were collected from African Americans.[9] As of 2022, the racial disparity worsened with 5,532 of the 8,260 (67%) arrestee profiles collected being from African Americans.[10] These numbers are highly alarming, considering that African Americans only made up 29.1% and 31.7% of Maryland's population in 2009 and 2022, respectively.[11] The implementation of arrestee profile collection–coupled with the lack of expungement of arrestee profiles–will further racial biases and disparities that already exist in the criminal legal system.

[9] 2009 Annual Report Maryland State Police Forensic Sciences Division Statewide DNA Database Report, https://mdsp.maryland.gov/Organization/Documents/2009%20Annual%20DNA%20Report.pdf.

[10] 2022 Annual Report Maryland State Police Forensic Sciences Division Statewide DNA Database Report, *supra* note 3.

[11] USA Facts, *Our Changing Population: Maryland* (2022), https://usafacts.org/data/topics/people-society/population-and-demographics/our-changing-population/state/maryland/?endDate=2021-01-01&startDate=2009-01-01; U.S. Census Bureau, *Quick Facts: Maryland* (2023), https://www.census.gov/quickfacts/MD.

Council of the District of Columbia
Committee on the Judiciary and Public Safety
Brooke Pinto, Chair
Testimony of Irving Brockman
Public Hearing
The Safer Stronger Amendment Act of 2023
Tuesday, June 27, 2023
Room 500
Wilson Building 1350 Pennsylvania Ave NW Washington DC

Good afternoon Chairwoman Pinto and members of the Committee,

Thank you for this opportunity to testify. My name is Irving Brockman and I am a recipient of the Incarceration Reduction Amendment Act. I am a member of Free Minds Book Club & Writing Workshop, which builds community to foster personal development and systems change for justice-involved youth and adults through the literary arts, workforce development, trauma healing, peace-building, and member-led advocacy.

Had it not been for IRAA, I would have never been afforded the opportunity to be free. My freedom had been denied many times before, and because of IRAA I am free today. This bill blessed not only me, but my family and community. It is a privilege to have been chosen for consideration of the IRAA bill and subsequently freed from prison. I know without a doubt that I would not be addressing you all today in this forum had it not been for the IRAA bill. Because of the current IRAA bill in its entirety, I am now associated with current and former politicians, former police detectives and current, and former police officers all working towards preventative measures of our at risk youth. These are individuals that you would have never convinced me years ago that I would ever be associated with as a free man. I now give back to the community that I once terrorized.

This is something that I would have never been able to do from a jail cell, which is more impactful as a free man. Since I've been home, I've been employed full-time, purchased a car, and obtained a passport. Freedom through the IRAA bill afforded me these opportunities. Freedom is just the beginning through IRAA. I have much gratitude for the support provided by the Free Minds staff with their bi-weekly IRAA support group meetings and countless others resources. Without such support after my release, I would not have been able to thrive. The IRAA bill must continue forward without any changes in verbiage because without it, there will be juvenile offenders incarcerated that would be spending decades behind bars without the opportunity towards freedom. Thank you!

My name is Jacob Brown and I live in the Bellevue neighborhood of Washington DC. When I heard that there was a chance to weigh in on Mayor Bowser's public safety legislation, I wanted to offer my support.

I have been living in Washington, DC for 45 years. Over the years, I have had all kinds of jobs — from serving as a sheet metal mechanic to doing AC repairs and construction work. But recently it became harder for me to keep doing this work as I got older, so I was looking for new ways to bring in extra income and keep up with my expenses. That's when a few months ago I started making deliveries with DoorDash — and I haven't looked back since.

Just like all of my jobs on construction sites or at repair shops, DoorDash made it clear that they want to help make sure everyone feels safe when on a delivery. If I ever need to reach out, they have a team ready to help — at any hour — and there are plenty of resources available to make people like me feel supported.

I'm hopeful about the seriousness that Mayor Bowser is giving to public safety too. A lot has changed about the District in the nearly five decades I've been here. But what has remained the same is the importance of making sure everyone feels like a part of the community and that our neighborhoods are great places to work and live.

That's why it's so important that the Council work with Mayor Bowser to identify solutions that will improve public safety for everyone across the District.

Sincerely,
Jacob Brown

Council of the District of Columbia
Committee on the Judiciary and Public Safety
Brooke Pinto, Chair
Testimony of Jamal Childs
Public Hearing
The Safer Stronger Amendment Act of 2023
Tuesday, June 27, 2023
Room 500
Wilson Building 1350 Pennsylvania Ave NW Washington DC

Good afternoon Chairwoman Pinto and members of the Committee,

Thank you for this opportunity to testify. My name is Jamal Childs and I am a recipient of the Incarceration Reduction Amendment Act. I am a member of Free Minds Book Club & Writing Workshop, which builds community to foster personal development and systems change for justice-involved youth and adults through the literary arts, workforce development, trauma healing, peace-building, and member-led advocacy.

For more than 10 years prior to my release I anticipated, or should I say, envisioned my coming home and helping my family and community. Not only did I want to be free, I wanted to bring forth some type of tangible change that would affect my community and family for the better. However, besides the IRAA act, there are so many obstacles to individuals who made a terrible mistake in our youth to come home and repair the neighborhoods that we once destroyed.

When I heard that it was being considered to change the wording of the law, which would make it more difficult for individuals like myself to be released, the only question I could ask was why? Why change a law that is bettering our communities, assisting at risk youth, and overall fulfilling a need in the urban neighborhoods that hasn't been there for over many, many decades?

I came home to a city that was unrecognizable to me. I saw Black and white couples walking the streets at 2 o'clock in the morning, and I thought that I would never see that possible in DC. I believe it's possible for the entire city, not just certain parts. I am driven to better my community. I am motivated to alter the course regarding young kids' lives so that they won't have to experience the same pains and consequences that I experience and I'm not alone in this. There are so many others just like me who were incarcerated and have come home wanting to make a difference.

Do you want a better DC? Keep the laws the same. Do not change the IRAA, for the future of DC is in all of our hands. I am currently establishing a nonprofit organization set on reversing the cycle in our household and communities, teaching our young about work, accountability and responsibility. About family, home property and actions. These type of programs need to be sponsored by individuals who have the experience hands-on of coping and dealing with, and understanding mistakes, and how ignorant we were when we made those decisions. So instead of passing more incarceration, which perpetuates violence, death and criminality, let us reverse this cycle. Let us bring forth the change that's needed. So I ask you today not to change the IRAA wording. I thank you for the opportunity and time to speak today.

To whom it may concern:

My name is James Cole, and I am an Acting Crew Chief with Georgetown EMS. Georgetown EMS is an entirely volunteer and student run, full-service EMS agency operating in Washington DC. Our primary response boundaries include, Foxhall, Burleith, West Georgetown, and Georgetown University.

On October 28th, 2022, I was on duty with Georgetown EMS and responded to a call for service for an intoxicated male. Upon arriving to the scene, the male patient became extremely combative with myself and the rest of our crew on scene. I immediately request Georgetown Campus Police respond to assist. However, less than a minute after I made the radio call for assistance, the patient began punching and attacking me. I was bit multiple time by the patient on my chest and right forearm requiring me to be transported to the hospital for observation.

After this incident, I was informed by Campus Police that as an EMS provider in the district, there were no special provisions to protect us against assault under the law. In fact, I was told that the only provisions were for "firefighters". While this covers DC Fire and EMS employees, it fails to protect the countless other EMS providers who work across the District. This includes my colleagues at Georgetown EMS, George Washington EMS, and American Medical Response. I urge the council to review providing stronger safety provisions to increase the punishment for assaults on EMS personnel to ensure that we can safely care for our patients and not fear being attacked on our calls for service.

Thank you for your time,

James A. Cole
Georgetown EMS
Acting Crew Chief

Council of the District of Columbia
Committee on the Judiciary and Public Safety
Brooke Pinto, Chair
Testimony of James Dunn
Public Hearing
The Safer Stronger Amendment Act of 2023
Tuesday, June 27, 2023
Room 500
Wilson Building 1350 Pennsylvania Ave NW Washington DC

Good afternoon Chairwoman Pinto and members of the Committee,

Thank you for this opportunity to testify. My name is James Dunn and I am a recipient of the Incarceration Reduction Amendment Act. I am the Congressman John Lewis Fellow for Free Minds Book Club & Writing Workshop, which builds community to foster personal development and systems change for justice-involved youth and adults through the literary arts, workforce development, trauma healing, peace-building, and member-led advocacy. I am also the Vice Chair for Thrive Under 25.

I am here today to urge the Council to keep the Incarceration Reduction Amendment Act and Second Look Amendment Act as they were originally passed, and to not adopt the changes of the proposed Safer Stronger Amendment Act of 2023. I believe IRAA is instrumental in creating a safer, healthier, and more inclusive DC. I have witnessed first-hand the personal and community progress that has been made by IRAA recipients, including mentoring youth through peacebuilding initiatives, using art as a source of hope and healing, and giving daily proof that positive change in our community is possible.

Since coming home under IRAA, I have engaged in several opportunities to give back to the community. I am particularly passionate about working with youth and young adults under 25, and motivating them to envision and pursue positive alternatives for their futures. Through my work as Vice Chair for Thrive Under 25, I have assisted in developing programming that ensures safe communities for DC youth and families. This is in conjunction to my fellowship through Free Minds, where I use poetry and my lived experience to mentor youth who have experienced or are at risk of experiencing violence. With Free Minds, I am also a Peer Supporter, providing social emotional support to fellow returning individuals as they navigate the challenges of coming home. I was also the recipient of several mini-grants aimed at funding creative ideas for getting DC youth engaged in positive outlets, which I used to create my initiative called From the Streets to Wall Street. Through this program, I teach financial literacy to youth. I am also an outreach worker with Cure the Streets, a violence interruption program to reduce gun violence.

Coming home under IRAA has allowed me to be on the frontlines of creating solutions for a better, stronger DC. I know so many of my brothers still incarcerated have their own innovative ideas that are needed as we continue this ongoing work. They are an essential piece of the puzzle, and deserve the opportunity to come home and contribute.

Council of the District of Columbia
Committee on the Judiciary and Public Safety
Brooke Pinto, Chair
Testimony of Jarrell Allen
Public Hearing
The Safer Stronger Amendment Act of 2023
Tuesday, June 27, 2023
Room 500
Wilson Building 1350 Pennsylvania Ave NW Washington DC

Good afternoon Chairwoman Pinto and members of the Committee,

Thank you for this opportunity to testify. My name is Jarrell Allen and I am a recipient of the Incarceration Reduction Amendment Act. I am a member of Free Minds Book Club & Writing Workshop, which builds community to foster personal development and systems change for justice-involved youth and adults through the literary arts, workforce development, trauma healing, peace-building, and member-led advocacy.

I am here today to urge the Council to keep the Incarceration Reduction Amendment Act and Second Look Amendment Act as they were originally passed, and to not adopt the changes of the proposed Safer Stronger Amendment Act of 2023. I believe IRAA is instrumental in creating a safer, healthier, and more inclusive DC. I have witnessed first-hand the personal and community progress that has been made by IRAA recipients, including mentoring youth through peacebuilding initiatives, using art as a source of hope and healing, and giving daily proof that positive change in our community is possible.

Since coming home under IRAA in 2020, I have engaged in several opportunities to give back to the community. I have been an active Poet Ambassador with Free Minds, where I connect with youth and community groups throughout the city and beyond, using poetry and my lived experience to disrupt the cycle of violence and promote peacebuilding. In 2022 and 2023, I was honored to travel with Free Minds to speak with Gateway Community College in New Haven, Connecticut. It was incredibly rewarding to be able to sit at a table with college students, and share my story through engaging conversations and an exchange of ideas and solutions for healing the communal harm of incarceration. I could share my story to help them along their journey and motivate them to stay on the path of education no matter what obstacles they may face. I felt like they saw the humanity and potential in me. That humanity and potential is in every one of my brothers still behind bars. That is why I ask you to keep IRAA as it is. Thank you for your time.

Joshua Bernstein, CEO of Bernstein Management Corporation

Testimony <u>in favor</u> of the Safer, Stronger Amendment

DC Council's Committee on the Judiciary and Public Safety

June 27, 2023

My name is Joshua Bernstein. I am testifying today in support of the Safer, Stronger Amendment.

I am the CEO of Bernstein Management Corporation, which owns and manages 42 properties in our city. We have been owning and operating properties in Washington for more than 70 years. With nearly 20,000 people who live and work in our buildings, we have a real-time perspective on what is happening and how it is impacting people's lives here.

DC experienced rapid growth in the 1950s and early 60's, followed by decades of decline in population and the hollowing out of once thriving commercial corridors. It took decades of leadership, oversight and investment to recover from that decline.

I am a big believer in and supporter of our city and its potential to be a model for equitable prosperity. In the investment world, there are very few who share that belief. In case you didn't know, most institutional investors are no longer investing in DC. They are selling or walking away from the properties they own here and refusing to invest here anymore. Economic and regulatory concerns play a part in that, but the rising levels of criminality and lawlessness are becoming the predominant reason why.

We are one of the few remining investors willing to bet on our future and even we are losing our resolve.

We recently made significant investments in the Shaw, Petworth and SW Waterfront neighborhoods. Crime has been a stated reason for move-outs and for refusal to rent there. Not many of us would be comfortable living in a neighborhood where theft and vandalism is commonplace and where people are routinely harassed, robbed, injured and killed. That is an absurdly obvious observation, and yet it is true in these and far too many other neighborhoods in the city today. It's like the proverbial frog in hot water—how are we not mobilizing everything we can to reduce these horrible occurrences?

We recently dropped a contract to invest in a number of retail spaces because the interviews with tenants felt like a crime log. I can offer several specific examples:

- Liquor store closing for the summer, because of fears of violence
- Clothing store having to lock their front door to reduce theft
- Employees having their vehicles broken into weekly
- Vagrancy and public urination deterring customers
- Repeated break-ins
- Tenants requesting to get out of their lease

Most of these crimes go unreported since there is little benefit to doing so.

Of course crime has horrific impacts for those directly impacted, but it has many ripple impacts too. Those ripple impacts will adversely impact the quality of life for everyone who lives and works here.

Our law enforcement professionals need all the tools we can give them to detain those who are a threat to public safety.

John Guggenmos
DC Nightlife Council Chair

Testimony by John Guggenmos, Safer Stronger Amendment Act of 2023, June 27, 2023

Thank you, Councilmember Pinto and members of the Committee; I am here today as the Chairman of the DC Nightlife Council, representing a diverse and vibrant nightlife industry that relies on a safe and secure city to thrive. Our members, who contribute significantly to our community's vibrancy and cultural richness, are deeply troubled by the growing prevalence of violence. Nightlife is woven into this city's social and economic fabric, and our survival hinges on the promise of safety and security; the escalating wave of violence is a trend that is steadily eroding the appeal and vitality of our city. Therefore, we are here today to express our unequivocal support for the Safer Stronger bill.

At the outset, I want to address an issue of paramount importance. The safety of our city's residents and its economic prosperity are inextricably linked. As such, the city council must assume responsibility for the escalating violence in the city. Accountability is not selective; it applies in times of success and, more crucially, in times of challenge. We urge the council to acknowledge this rise in violence and actively address it through swift and comprehensive action in all agencies. We urge our elected officials to have substantive discussions around public safety and drop the rhetoric designed to polarize, like calling the number of police officers “magic” numbers – is not helpful, and the playground politics for clickbait avoids a substantive discussion. The solutions offered with the Safer Stronger Amendment are worthy of a discussion and are a step in the right direction.

A recent psychological study by Dr. Elizabeth Hinton from Harvard University has shown that proactive community-centered policies like the Safer Stronger Amendment can positively affect public safety. This refutes any suggestions that such programs would exacerbate the problem. Dr. Hinton's research shows the collective psychological impact of initiatives prioritizing safety and justice.

Additionally, I want to emphasize our conviction that pursuing safer streets does not equate to a compromise on racial justice. The desire for safety and security isn't a question of ideology; it's about shared values. We reject the false choice.

The Amendment empowers our judiciary with more agency in pre-trial detentions. This is a crucial step towards addressing the alarming trend of potentially violent offenders being released into the community within days of their arrest. Such instances undermine the public's faith in the justice system and undermine participation in the vibrant city life we cherish.

Moreover, the bill expands the definition of "significant relationship" to prosecute first-degree sexual abuse in secondary education. This will ensure greater protection for our students, some of our society's most vulnerable and precious members.

The Amendment enhanced penalties for offenses relating to firearms, including illegal discharge, possession of tampered or stolen firearms, and trafficking, and is one tool to strike a tidal wave of gun violence.

The bill also provides new tools for law enforcement agencies, such as using GPS data in prosecuting offenses and expanding the definition of "significant bodily injury" to include strangulation. These provisions enhance their capabilities, which is paramount in the face of evolving challenges and crime patterns. Not using current technology would be like my parents not wanting to use the Internet.

The removal of the cap on rebates for the private security camera program is another significant improvement. This provision encourages the installation of surveillance equipment, a proven deterrent to crime that also significantly aids in solving cases and bringing offenders to justice.

Finally, the Safer Stronger Amendment's stringent regulations on the possession, sale, transfer, and use of guns and other dangerous weapons, including enhanced penalties for possessing ammunition after previous convictions, will help to prevent potentially dangerous individuals from posing a threat to public safety.

In conclusion, the Safer Stronger Amendment represents a much-needed tool for curbing violence in our community. Its provisions demonstrate an understanding of the multifaceted nature of public safety.

The DC Nightlife Council urges the Committee and the entire Council to expedite the passage of this legislation. Our industry and our community depend on safety and peace for mutual prosperity. The Safer Stronger Amendment is a step towards making our shared vision for a safer, more vibrant community a reality. Thank you.

Joshua Bernstein, CEO of Bernstein Management Corporation

Testimony <u>in favor</u> of the Safer, Stronger Amendment

DC Council's Committee on the Judiciary and Public Safety

June 27, 2023

My name is Joshua Bernstein. I am testifying today in support of the Safer, Stronger Amendment.

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Of course crime has horrific impacts for those directly impacted, but it has many ripple impacts too. Those ripple impacts will adversely impact the quality of life for everyone who lives and works here.

Our law enforcement professionals need all the tools we can give them to detain those who are a threat to public safety.

Tuesday, June 27, 2023

Testimony of Joshua Lopez, Vice Chair of the Metro DC Hispanic Contractors Association, on Bill 25-291, the Safer Stronger Amendment Act of 2023, presented to the COMMITTEE ON THE JUDICIARY AND PUBLIC SAFETY

Thank you Chair Pinto and members of the Committee on the Judiciary and Public Safety for holding this hearing today on the Safer Stronger Amendment Act of 2023. My name is Joshua Lopez and I currently serve as the Vice Chair of the Metro DC Hispanic Contractors Association. We are a strong DC based organization with over 250 companies as members of our association. The DC Hispanic Contractors organization was created to support the advancement of the construction community by facilitating tools, information, and advocacy to ensure success amongst immigrant & Hispanic owned construction businesses in Washington DC and surrounding jurisdictions.

We stand here in full support of Mayor Bowser's common sense, Safer Stronger Amendment Act of 2023. Over the years, Hispanic contractors have played an instrumental role in the development of the Washington, DC. Look at every construction job across the city and you will likely see Hispanic workers on the job site getting the work done. Hispanic workers have been the backbone for every DC government development job, including the construction and development of DC schools, hospitals, recreation centers, affordable housing, libraries and agency buildings. We are thankful for the continued opportunities and investment the city has made in the construction industry and we will continue to serve as partners in this capacity. We are business owners, homeowners and taxpayers. DC's success is our success and vice versa.

Unfortunately, in recent years, Hispanic construction workers have been targeted by criminals, causing an increasing number of armed robberies and in some cases victims of murders on construction sites. We are reaching a breaking point with the increase likely hood of being a victim of a violent crime. This has created a tense work environment where people fear for their safety simply for showing up to work.

- Elias Flores
- Balmore Mauricio Flores
- Abdulio Arias-Lopez

These are names of people who have been murdered on job sites over the last few years. In one case MPD arrested an individual accused of stealing from more than 40 Latino workers at 20 construction sites over a three-month period.

MPD's Latino Liaison Unit has been an active partner in doing outreach and checking in on job sites across the city but they are a small unit and can only cover but so much ground.
Mayor Bowser's proposed legislation directly addresses many of the concerns of the Hispanic Contractor's Association. Most, if not all, of the robberies are carried out with guns. Stiffening penalties for illegal gun possession is common sense. Many of the robberies are targeted and are carried out over and over again by the same people. Keeping violent offenders in jail pending trial again makes sense and will be effective at keeping not only Hispanic contractors safe, but

the DC community as a whole safe. We believe in giving people second chances and we are partners with organizations across the city when it comes to workforce development and job opportunities - but when you murder and engage in violent crime against innocent people, you cross the line. We believe in accountability and safety for all.

Again, we thank the council for holding this hearing today and we urge all parties to continue to work together to make our city safer. We must not shy away from reality; we have a crime crisis in our city. It is during our most difficult times where true leadership steps up. Getting this passed and approved before the summer recess will show District residents that we are serious about addressing the most pressing issue of our time.

Testimony to the DC Council's Committee on the Judiciary and Public Safety
Re: The Safer Stronger Amendment Act of 2023
Submitted June 26, 2023

Thank you for this opportunity to provide testimony to the District of Columbia Council's Committee on the Judiciary and Public Safety regarding B25-291, the Safer Stronger Amendment Act of 2023. I am the victim of crimes committed by then-youthful offenders in the District of Columbia who are seeking to be released from incarceration under the existing terms of §24–403.03 of the Code of the District of Columbia. I urge the Council to adopt the Safer Stronger Amendment Act's proposed amendments to §24–403.03 without delay.

The proposed amendments would provide discretion, rather than a mandate, to reduce the term of imprisonment imposed for an offense committed prior to the defendant's 25th birthday if certain conditions are met. This change to the law would better reflect the complexity and gravity of incarceration term reduction decisions, the implications of which are unique to each case. The use of the word "shall" in the current law silences the voices of reason, diminishes the value of victim impact statements, and unwisely ties the hands of judges, potentially preventing them from acting in the public's best interest. Replacing "shall" with "may", as proposed, would foster more informed and rational decision making.

Equally, if not more importantly, the proposed amendments would modify the conditions to be considered by including the nature of the crime and whether the defendant has demonstrated remorse. This is common sense and I implore the Council to adopt these amendments. As the victim of a truly heinous assault (armed gang rape, sodomy, and forced oral copulation) committed by juvenile serial offenders in the District of Columbia (who, to my knowledge, have not demonstrated an iota of remorse in the 41 years since committing their crimes), I was dumbfounded to learn that the District's existing incarceration reduction law actually *precludes* consideration of these factors. I find it difficult to believe that the D.C. Council sees no distinction between a crime of opportunity or passion committed by an individual in a moment of poor judgment versus premeditated and/or repeated acts of violence, gratuitous torment, and human degradation; nor between the rehabilitation status of a defendant who truly regrets his/her actions and one who demonstrates no remorse. Disregarding these distinctions is disrespectful to victims and to society in general and could easily lead to decisions that would put an unsuspecting public at grave risk.

I am well aware of the fact that human brains do not fully mature until the age of 25 or so. I am a biologist by training and have long been fascinated by brain science. I am also a mother who has raised a son to adulthood and housed and served as a surrogate parent to a teenaged male who had spent his childhood in and out of foster care and homelessness due to abuse and neglect by his biological parents. I also volunteer as a Court Appointed Special Advocate for youth in my county's dependency system. My ongoing training for the latter role often focuses on the stages of brain development, the implications of those stages on decision making and impulse control, and the challenges children and young adults face in navigating the world with immature and/or traumatized brains. In short, I am very familiar with the "hallmark features of youth" cited in the

existing law and I support taking them into consideration in sentencing youthful offenders, *along with other relevant factors*.

The current incarceration reduction law states that the "hallmark features of youth…counsel against sentencing them to lengthy terms in prison, *despite the brutality or cold-blooded nature*" of a young person's crime [emphasis added]. This is not protective of our communities and it makes a cruel mockery of the provision that allows consideration of victim impact statements. Writing a victim impact statement is an extraordinarily stressful, and often triggering, task, especially for victims of brutal, cold-blooded crimes. It forces the victim to re-live the worst experience of their life to inform a judge of what the victim uniquely knows the defendant to be capable of doing to another human being. Why should a victim put herself through that, if judges are directed to disregard the brutality or cold-blooded nature of the crime? While some offenders may, indeed, "grow out of" their brutal or cold-blooded tendencies, others may not. It is reasonable for victims and the public to expect that risk to be taken into consideration.

The Safer Stronger Amendment Act would untie judges' hands and allow them to incorporate consideration of the nature of a defendant's crime and the defendant's remorse or lack thereof, *along with* the presumed diminished culpability of youthful offenders. In so doing, the Safer Stronger Amendment Act would ensure that incarceration term reduction decisions are better informed, more respectful of victims, and appropriately protective of our communities.

Thank you for considering my testimony.

Kathleen Martyn

Council of the District of Columbia
Committee on the Judiciary and Public Safety
Brooke Pinto, Chair
Testimony of Keela Hailes
Public Hearing
The Safer Stronger Amendment Act of 2023
Tuesday, June 27, 2023
Room 500
Wilson Building 1350 Pennsylvania Ave NW Washington DC

Good afternoon Chairwoman Pinto and members of the Committee,

My name is Keela Hailes and I am the Senior Reentry Manager with Free Minds Book Club & Writing Workshop, a nonprofit here in Washington, DC that builds communities to foster personal development and systems change for justice-involved youth and adults through the literary arts, workforce development, trauma healing, peace-building, and member-led advocacy. Through this role, I personally know and work with IRAA recipients as they prepare for reentry before coming home. Once they are home, I connect them to job services and other resources, and also facilitate a bi-weekly IRAA Support Group.

Here is a poem I wrote about the transformational impact of IRAA and Second Look:

What I Know about IRAA/Second Look

I know that a multitude of great men have been reunited with waiting children, parents, aunts, uncles, cousins friends and society

I know that these great men have impressed me as I have witnessed them accomplish awesome feats in various varieties

I know that these great men have pushed past insurmountable odds with acute intentionality

I know that these great men have become loving fathers, entrepreneurs, artists effective mentors and innovators, change makers, authors and content creators, public speakers, and passport possessors caretakers, home owners, bread winners for their families, the spouse and the man of the house, providers, protectors, present grandfathers and most awesome of all their brothers keepers

I know that these great men are consistent exemplary quality of life seekers.

I know that these great men go the extra mile to better the lives of those they touch

These great men have paid their debt

I know that these great men will never forget

I know that these great men have cried much

I know that these great men have had their fair share of pain

I know that these great men soldier on through the rain

I know that these great men sometimes feel that they have lots to prove

I know that these great men have proved many wrong

As these great men continue to make beautiful lives like a beautiful song

I know that these great men choose excellency with careful awareness

As they chart paths and make their own life decisions for the friends they left behind

I know that these great men are thinking of those friends constantly

And are encouraging them that their time is coming

You see these great men are not an anomaly

The men they left behind are not a dichotomy

If they were, how do we explain these great men before us today

The solid character they display

These great men were shaped with maturity growth, epiphanies, revelations and life changing transformations

As we sit in this room there are great men who have been growing, transforming, evolving, planning, praying and changing, they have been instructing and mentoring, building, connecting, contemplating, creating and waiting

To link arms with the great men this room

So that they too can become present loving fathers, entrepreneurs, artists effective mentors and innovators, change makers, authors and content creators, public speakers, and passport possessors caretakers, home owners, bread winners for their families, the spouse and the man of the house, providers, protectors, present grandfathers and most awesome of all become the latest brothers in the brotherhood of being their brothers keepers

So I ask you today

Why should this growing network of brotherhood be curtailed?

Rev. Rob Keithan
Minister of Social Justice
rkeithan@allsouls.ws • (202) 517-1468

All Souls Church Unitarian

a diverse, spirit-growing, justice-seeking community

Testimony Against B25-291, the Safer Stronger Amendment Act of 2023
From Rev. Robert C. Keithan, All Souls Church Unitarian
June 26, 2023

Hello, Councilmember Pinto and Staff. I am Rev. Rob Keithan, Minister for Social Justice at All Souls Church Unitarian in Ward 1. I am also a proud member of the Washington Interfaith Network's Public Safety Team, and I've called DC home for nearly 30 years.

I am here today to state my opposition to this Amendment, and especially two of its most harmful provisions: increasing youth detention, and weakening IRAA. But even moreso, I'm here to ask questions, and call attention to what's not in this bill.

I understand that the Mayor, and Members of this Council, feel an urgent need to do something to address crime in our city. I feel a great sense of urgency as well. On this, I believe, we agree. What I do not understand is why we're having a hearing about an ad-hoc assortment of punitive policy measures with little to no supportive data rather than on implementing one or more of the multiple, extensively-researched and data-driven reports about how to reduce gun violence and increase public safety in Washington, DC.

If years of researching this issue has taught me anything, if years of listening to impacted people and community leaders has taught me anything, it is this: we will never, EVER police or punish our way into public safety. The more punitive an approach is taken, the more it has disastrous and debilitating impacts on communities that make problems even worse.

For example, this Amendment seeks to increase the detention of youth. Yet the District's own Criminal Justice Coordinating Council concluded in its 2020 report that "involvement in the system, particularly secure detention, is well-established to have lasting negative effects on youth".

By contrast, addressing the root causes that undermine public safety has vast benefits. And to anyone who thinks it's too expensive, I say this: either way we're going to pay. It's just a question of what we're paying for. We can focus on policing and punishment, spending our money after crime has been committed with little to no community benefits to show for it, or we can invest in addressing the root causes in ways that break cycles of poverty, break cycles of violence, and actually create lasting progress. I urge you to make this systemic work, guided by extensive research, both an urgent and long-term priority. Thank you.

Global Girls Worldwide Women

DIGNITY • JUSTICE • EQUITY

WRITTEN TESTIMONY IN SUPPORT OF **B25-0247**
SUBMITTED TO COUNCIL OF THE DISTRICT OF COLUMBIA
JUNE 26, 2023

Distinguished Judiciary and Public Safety Committee Members:

Global Girls Worldwide Women adamantly supports and urges the passing of B25-0247, the Female Genital Mutilation Prohibition Act of 2023.

FGM/C results in lifelong physical and emotional harm. It is intended to deny girls' agency and autonomy over their bodies and sexuality, while causing significant and even life-threatening physical harm.

There are no physical benefits to this practice, only egregious harm. The risk of infection, health consequences to other organs, and difficulties in childbirth resulting in complications or death to the mother and/or the baby are almost certain to occur in some form.

There are no religious or cultural tenets that require FGM/C. The trauma a girl experiences from this violent, frightening, excruciatingly painful practice remains throughout life. We need to mitigate the traumas that girls experience, not turn a blind eye to those that persist unequivocally without sanction.

Under the United Nations Sustainable Development Goals Target 5, 193 countries including the United States, have promised to end FGM/C by 2030. FGM/C has been determined to be a human rights violation and is under the umbrella of gender-based violence.

GGWW urges those who represent the District of Columbia to support B25-0247.

GGWW works toward gender equity by providing resources to girls and women, supporting allies, raising awareness and calling for reform. We believe individuals and local movements to heads of nations are essential in securing equity and safety.

Testimony of Kevin S. Thomas, Chairman
Commission on Fathers, Men and Boys
Before The
Council of The District of Columbia
Committee on The Judiciary and Public Safety

B25-291, the Safer Stronger Amendment Act of 2023

June 27, 2023

Good afternoon Chairwoman Pinto and members of the Committee. I am Kevin Thomas, Chairman of the Mayor's Commission on Fathers, Men and Boys. Thank you for the opportunity to appear before this committee to provide testimony regarding B25-291, the Safer Stronger Amendment Act of 2023.

As chairman of the Commission on Fathers, Men and Boys, I have made it a priority for our commission to not only be intentional in our efforts to be informed on policy matters at the federal and city levels of government but also, to lend our voices to the public discourse surrounding these policies to ensure that we are advocating for the thousands of fathers, men and boys in the District of Columbia. One of our most important duties as commissioners is to provide The Council and the Mayor with sound and evidenced-based advisement to ensure that their actions are in the best interest of our constituency. That is what brings me here today.

Violent crime has been on the rise at an alarming pace, leaving our city leadership and members of our community desperately looking for answers to how to make our streets safer.

I believe that the Safer Stronger Amendment Act of 2023 is a step in the right direction. We have all witnessed the impact that guns have had across the city and nationally. Here in DC, it seems that we can't go a day without turning on the television and hearing about a shooting that occurred and for some of us, it has been even closer to home. In 2015, my 21-year-old cousin was a victim of gun violence and as if being shot to death wasn't horrific enough, his body was set ablaze in a vehicle in Southeast and left to burn to the point that he had to be identified by dental records. His killer(s) remain at large and so many other families across this city have had their lives forever changed because guns have become far too accessible to people with ill intentions.

It is time that we increase penalties for violent crimes in which both our most vulnerable citizens and those who help to make our city run efficiently are being victimized. It is indeed time to make strangulation a felony offense. We witnessed how horrific having the life choked out of you can be in the cases of Eric Garner and Jordan Neely in New York and there is no place for such practice here in DC, whether by law enforcement or anyone else.

It is time to make sure that adults and youths who have committed heinous crimes are able to be held prior to adjudication when they are a clear danger to themselves or others.

We must also ensure that our city provides resources for our citizens and community stakeholders to protect themselves and to aid law enforcement in making our city more secure. This includes cameras and other means to help ID and convict those committing crimes in our cities.

But before I close, let me make it clear that while we can implement laws and regulations as deterrents, we must couple that with the understanding that many of the issues that we see in our city regarding crime stems from lack of accountability at home, socio-economic issues and the belief that there is no other way out of their present circumstances or alternative to a life of crime. Our parents and guardians have a responsibility to ensure that they are creating environments that set our youth up for success, not for a life of crime. And our city must do our part to make sure everyone, across all of eight wards, can thrive and prosper legitimately.

I am in favor of the Safer Stronger Amendment Act of 2023 and urge the Council to support It as well. Thank you.

Kevin S. Thomas

Chairman, Commission on Fathers, Men and Boys

Kristen Barden, Executive Director, Adams Morgan Partnership BID

Testimony for B25-291 Safer Stronger Amendment Act of 2023.

My name is Kristen Barden and I am the Executive Director of the Adams Morgan Partnership BID (AMPBID). I have been in this position since November 2008.

I am writing with my support for the passage of the Safer Strong Amendment Act of 2023. I am going to focus my remarks on two aspects of this proposed legislation.

I would first like to mention my support of the increase to the reimbursement amounts for the Private Security Camera Systems. We have had many of businesses take advantage of that program and more would be encouraged to do so if more of the costs were reimbursed. Some have not participated because the costs savings was not significant enough to off set the time and expense of purchasing and installing camera systems. If more of the expenses are reimbursed, more businesses will participate. The camera we installed on the front of City Bikes store on Champlain Street in Adams Morgan has helped solved many crimes committed in Unity Park. Just last night we received another request from MPD for footage from that camera for a fight that occurred in the park on June 6th. We gladly sent them the footage.

Second, I'd like to support the provision to make is easier for the Courts to hold suspects/defendants pre-trial if they have been previously convicted of a violent crime. My support comes from direct first-hand experience with violent criminals. In February 2023, Adams Morgan experienced a series of overnight break-ins to our commercial corridor.

For weeks, every morning I would wake up and look at my phone and another business had their window or front door broken and were vandalized or the thieves stole the cash register and the little amount of cash that may have been left in there. Most business owners don't leave any cash in the drawer overnight but the damage at each business was thousands of dollars. Not to mention the sense of insecurity and violation this series of crimes was inflicting on the whole community. Finally in early March, two suspects were arrested. AND both were held in custody until their upcoming trial. AND GUESS WHAT FOLKS…the break-ins stopped. Because MPD caught the two people committing the crimes and they were held. This is just one story but it is clear to me why holding suspects prior to trial is so important in fighting crime in our city.

Thanks very much.

July 11, 2023

Dear D.C. Council's Committee on the Judiciary and Public Safety,

Thank you for the opportunity to testify on June 27, 2023, at the public hearing regarding Mayor Muriel Bowser's bill, "Safer Stronger Amendment of 2023". My name is Kristen Hubbard. I was an eighteen-year-old Freshmen in college when I was carjacked, with my college friend, at gunpoint by Joshua Haggens and Richard Settles, on the evening of January 18, 1992, into the afternoon of January 19, 1992. Joshua Haggens and Richard Settles proceeded to kidnap us, repeatedly, and brutally raped and sodomized us, for nearly twenty-four hours. By God's grace, we lived to be able to stand here today, and retell the horror of that night, again, as we have for over the thirty years.

We are currently being revictimized, not because the Defense has uncovered substantive or technical flaws in the prosecution's case. To the contrary, we are here because of actions of the D.C. Council, championed by former Ward 6 Council member, Charles Allen, notably the former Chairperson of this very Committee on the Judiciary and Public Safety, that expanded the Omnibus Public Safety and Justice Act of 2020, or Second Look Amendment Act of 2019, into the Incarceration Reduction Amendment Act (IRAA). This allows any person who committed a crime before the age of 25, and who has served a minimum of fifteen years in prison, to apply to the DC Superior Court to have their sentence resentenced. And under this act the prosecution is not permitted to factor in the egregious and unspeakable crimes Joshua Haggens committed that cold, January night. That burden is, once again, placed on the shoulders of the victims and their families.

"We should recognize the value of mercy and rehabilitation…and stop paying to incarcerate people who don't pose a danger to the community."- Councilmember Charles Allen, Ward 6.

The "Safer Stronger Amendment of 2023" is tough on gun violence, the proliferation of guns, offers protections for vulnerable populations, and for our public transportation infrastructure operators who are victimized by violent criminals. It is NOTEWORTHY that Title 11/IRAA, focusing on amendments to that existing bill, is located at the end of the bill, and is but a modest attempt at equity, and must NOT be confused with the seemingly tough on crime and gun violence it purports.

With Title 11/IRAA in place as modified, those tough on violent crime laws packaged in the "Safer Stronger Amendment of 2023" bill, in response to well-deserved criticism for the unnecessary and astronomical rise in violent crime, catalyzed by the DC Council's legislation in these recent years, is but a foil. This is because the IRAA systematically reduces any sentencing after fifteen years, therefore, making any meaningful deterrent against violent crime mute.

How many survivors and victims that have been revictimized by the DC Council's implementation of IRAA were necessary for someone to have a pulse, and a conscience, to finally take a stand? I am here because this bill, even with a modified Title 11/IRAA in place, is fiction. The revictimization of victims,

survivors, and their families of nearly six hundred violent criminals, released under IRAA, and the new victims and survivors of violent crime, because of their recidivism, puts that blood and trauma on the hands of those sponsoring this bill with the weakly modified Title 11/IRAA in place. I understand that tough on violent crime, without serious modifications to Title 11/IRAA, renders the overall bill a counterfeit.

"We on the council, we don't wear badges, we're not able to investigate when there is a crime."- Council Chairman Phil Mendelson, in response to the Emergency Bill proposed this week.

What Mr. Mendelson conveniently ignores is that he has been an integral part in the creation and successful implantation of the IRAA that allowed violent criminals to be released from prison, without regard for the requisite infrastructure within the prison system, and within the public, thereby removing any deterrent and guaranteeing more violent crime.

The IRAA intentionally silences victims, predominantly Black and Brown victims. For the "Safer Stronger Amendment of 2023" bill to now say a judge "may" consider the nature of the crime, but not require, and to characterize the overwhelming percentage of violent crimes committed in DC as being by "immature and impetuous" youth, with youth defined as anyone twenty-five and younger, is insulting. Mr. Mendelson and the DC Council are scapegoating the community, MPD and the AUSA for their legislative decisions.

The IRAA, as it is currently implemented, is devastatingly flawed, highly unfair and insensitive to the lived experiences of the victims and survivors, like me, and to the communities plagued by violent criminals like Joshua Haggens. The IRAA, with its bias favoring the perpetrator at the expense of the victims and survivors has the feel of a cynical, political vehicle. The overwhelming majority of these cases involve Black on Black crimes, as is the case of myself and my college friend; and, unfortunately, these cases do not make headlines. The media does not care about Black victims, unless the aggressor is White. Our country does not care about violence against Black women, or about missing Black women – both of which we were on that night of January 18, 1992. This council dedicates and advocates its' efforts, regarding the current legislation, without care for the Black and Brown victims and survivors they serve. Shame on them-shame! Your survivors who, for many in the DC Council, look like you, these communities affected that look like you, where is our desentencing? Why is our dream deferred? Which Black lives really matter to you? What lives matter to you for that matter?

The fact that the United States District Attorney "may" but is not required to present the details and merits of these crimes, because of the restrictions intentionally remaining in the modified Title 11/IRAA, is abhorrent; does not, in any way, consider the citizen-base in its entirety –in this case, the value of the lives of two Black women. These Councilmembers do not represent the victims and survivors of this sadistic violence. Their deliberate legislation pursues "not perfection", but "justice", by re-victimizing their forgotten constituents, again, through obvious prosecution restrictions that prohibit, or otherwise constrain presentation of evidence of the convictions in their entirety, in favor of recharacterizing the supposed reformed criminal with selective erasure.

I implore this committee to not only know what truly happened to us that bitter cold night of pure terror, despite the neutered version presented by Joshua Haggens' legal representation, funded by activists organizations, whose singular objective is to have criminals resentenced and released, based solely on

the idea that a GED, and participation in elite university lecture series, such as The Prison Scholars Program, directed by Marc Howard, and/or completion of anger classes, is successful rehabilitation and atonement. These are grossly inadequate and insufficient standards, particularly for extremely violent criminals and serial rapists.

The IRAA makes the erroneous conclusion that all convicts can be rehabilitated, void of any real balanced consideration for the victims and survivors, except for the meager $200,000 annual grant to the victim's advocacy programs; an insulting sum, yet a sum that captures just how little this legislative body regards the victims of violent criminals.

Do we really believe it is justice to resentence a serial rapist, a predator and sadist, who was apprehended a few nights later at the scene of our kidnapping crashing the car of yet another victim?

Are you comfortable with Miller v. Alabama, stating that the human brain (black and brown) is not fully developed until twenty-five years old, therefore, not culpable of heinous crimes?

And if so, do we not send men and women to war at age eighteen?

And what about the men and women under the age of 25 serving in the Metropolitan Police Department? Are they not cognitively fully developed?

And what about men and women under the age of 25 serving on jury duty?

When do we stop proliferating the trope of urban environments (mental underdevelopment) as an excuse for violent criminality, and do something to structurally change the urban environment and prevent systemic poverty and urban welfare? These programs and legislations seek to reduce Black incarceration numbers without due diligence in factoring the criminal violence of the individual convicts. Further, nothing is being done to improve the structural community environments which are being used to rationalize this criminal behavior. Or are we just concerned with the aftermath and justify it with bandaids that do not truly address the root causes of crime in urban areas.

The politics of the IRAA, and its myopic and dangerous agenda, have absolutely nothing to do with the facts of Joshua Haggens' conviction, and cannot absolve or "justice-away" the thirty-plus year sentence he has given me and my friend, our families, our friends, and communities.

No. Joshua Haggens is an apex predator, unremarkable in appearance, which allows him to hunt his own people. He is a serial rapist, a sadist, whom I fear would offend again and use that gun he had on his next victims. That blood would be on your hands. I fear for the community that he would be released into. I fear for the young women, especially women of color, which would fade into the grey of our vain and gluttonous political environment, voiceless, and undervalued.

Black Lives Matter, yes-absolutely. The IRAA, as it is written, begs the horrible and unconscionable question, "Which Black Lives?" The assailants that have committed atrocities, aligned with organizations with an agenda, or with the Black Victims, and the communities lost in this entire conversation, since 2016? History will be the judge. I pray for my friend, myself, our families, our supporters, and the men and women who fight tirelessly for our voice, and for another day; and woe to the communities, for political and unbalanced social justice, on the backs of Black and Brown Victims' Lives, who must absorb and experience these horrors, in the name of reform.

Sincerely,

Kristen Hubbard

Good afternoon,

Please see my official testimony.

Good afternoon Chairwoman Pinto all Judiciary and Public Safety committee members, Councilmembers and the public.

I am Lanet Brown, native District resident, a criminal defense attorney for the District and Maryland, a mother and a wife.

Thank you for the opportunity to testify about issues that directly impact me; there is probably no greater issue in this category than public safety. With that, please accept my testimony in opposition of the Safer, Stronger Legislation proposed by the Executive.

The new Safer Stronger legislation lists a number of ways that if implemented will enhance public safety according to the executive. For purposes of this discussion I'd like to focus on the proposal around strengthening provisions that allow individuals to petition for early release to ensure the voices of victims and community receive proper consideration. This appears to be coded as an attempt to amend the Incarceration Reduction Amendment Act ("IRAA").

IRAA codified in DC Code as § 24–403.03. Labeled as: Modification of an imposed term of imprisonment for violations of law committed before 25 years of age. The statute says this among other things: "The court, in determining whether to reduce a term of imprisonment pursuant to subsection (a) of this section, shall consider 11 factors; factor 6 says "6) Any statement, provided orally or in writing, provided pursuant to § 23-1904 or 18 U.S.C. § 3771 by a victim of the offense for which the defendant is imprisoned, or by a family member of the victim if the victim is deceased;" this is save a few words identical to the proposal in Safer, Stronger. The council already codified the proposed language put forth by the Executive. And, this factor is not at the discretion of the court, the court must consider it. Therefore, the proposed language is duplicative and of no real value.

I commend the Executive for addressing public safety. There is no secret that the District has been ravished by an uptick in violence. That does not mean that the Executive should cast a wide net in attempting to find a solution. The District invests millions of dollars in violence intervention programs and other wholistic approaches to public safety. A better use of resources perhaps is to check the temperature of the programs, and with a scalpel dig in to measure their successes.

Finally, I mentioned that I am a wife. My husband, Rodney Brown, was released under IRAA a little

over a year ago after serving 28 years incarcerated. I am proud of him. He has remained fully compliant with the terms of his probation, including sustaining gainful employment, mentoring youth detained on the YME block in DC Jail under the tutelage of US Magistrate Judge Faruqui; he is an exceptional husband and a proud father of 2 girls - a 6 year old and a 4 month old.

My husband is friends with many of the IRAA releases. Together they have formed a strong bond with the help of wonderful organizations like the Second Look Project and Free Minds Book Club. These guys are some of the most brilliant minds I know. They care deeply about investing in the community and giving back in ways only those who have touched the criminal justice system can relate.

My husband - like the others released - are not the ones committing these crimes. In fact, hardly any of the IRAA releases returned to court on a probation show cause or for a violent offense. That means they were released, and they are doing the hard work of being a productive member of society.

The safer legislation unnecessarily targets those who would benefit from IRAA. The Executive failed to list any statistics that would support the proposal, but the reality is the IRAA guys are the best evidence of a returning citizen and whether or not recidivism is rampant. The truth is they are doing exceptionally well and added enhancements to the IRAA serves no purpose.

I hope you strongly consider this testimony as you consider this legislation.

I am happy to provide further details or comment if needed. I may be reached at (202) 374-7434.

Sincerely,

Sincerely,
Lanet

Criminal Justice Coordinating Council

A Study of Factors that Affect the Likelihood of Juvenile Justice System Involvement

Report

Prepared By: Erin Partin, Statistician
October 2022

About the Criminal Justice Coordinating Council

As an independent agency, the Criminal Justice Coordinating Council (CJCC) for the District of Columbia is dedicated to continually improving the administration of criminal justice in the District. The mission of CJCC is to serve as the District of Columbia's forum for District and federal members to identify cross-cutting local criminal and juvenile justice system issues and achieve coordinated solutions for the criminal and juvenile justice systems.

CJCC is the home of the DC Statistical Analysis Center (SAC). The mission of the SAC is to apply the highest level of scientific rigor and objectivity in the study of criminal justice policies, programs and practices, and to identify activities that improve the administration of justice. The SAC aims to produce empirical research and analysis that informs stakeholders and enhances policy decision-making in the District.

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I. Executive Summary

While intended to rehabilitate children, juvenile justice system involvement is well-established to have long-term negative effects on youth.[1] There are, therefore, strong incentives to target resources to serve the needs of children and their families prior to the occurrence of delinquent behavior. Before determining where such resources should be targeted, it is important to understand (1) which risk factors contribute the most to youth delinquency and (2) which protective factors reduce the likelihood of delinquent behavior among the highest-risk youth.

The Council of the District of Columbia mandated the Criminal Justice Coordinating Council submit a report to the Mayor and Council on the root causes of youth crime and prevalence of adverse childhood experiences that incorporates results from a voluntary survey of youth with juvenile justice system involvement on their perspectives. The CYJAA specified that the report should examine factors "such as housing instability, child abuse, family instability, substance abuse, mental illness, family criminal involvement, and other factors deemed relevant by the CJCC" (D.C. Law 21-23).

In accordance with this mandate, CJCC obtained administrative data from multiple sectors on a representative sample of youth enrolled in public schools in the District during the 2016 – 2017 school year and identified youth with justice system involvement, which was defined as being arrested or petitioned/charged the following year. During the fall of 2018, the CJCC conducted surveys and focus groups with DYRS-committed and DOC-incarcerated youth under the age of 21, and, during the spring and summer of 2018, conducted interviews with youth service providers.

Effective April 2, 2022 D.C. Council amended the law to read, "By October 1, 2022, the CJCC shall submit a report to the Mayor and the Council that analyzes protective factors that reduce the risk of District youth entering the juvenile and criminal justice systems."[2] To that end, this iteration of the report contains both a replication of prior empirical research as well as discussion surrounding protective factors and how they are currently implemented in the District or how they could be implemented.

The first Study of the Root Causes of Juvenile Justice System Involvement report was issued in November 2020 and addressed the following questions:

1. How do youth with juvenile justice system involvement differ from youth who do not become involved in the juvenile justice system?
2. What factors affect the likelihood that youth become involved in the juvenile justice system?
3. How and why do these factors impact youth behavior?

This updated analysis seeks to answer the same questions through replicating the initial methodology with updated administrative data. We examined the differences between youth with justice system involvement and youth without justice system involvement with respect to demographics; access to economic resources; experiences with childhood maltreatment; educational experiences; mental, behavioral, and neurodevelopmental disorder diagnoses; and proximity to crime.

Next, we constructed a mathematical model to evaluate which factors had a statistically significant effect on the probability that a youth would become involved in the juvenile justice system. Using these

[1] Azier and Doyle 2015; Gatti, Tremblay, and Vetaro 2009; Holman and Ziedenberg 2006; Lundman 1993.
[2] D.C. L24-0105

probabilities, we calculated a risk score and divided the sample cohort into four risk quartiles for further analysis. After examining the results of the empirical analysis, we investigate the literature surrounding protective factors as well as the District's implementation of some evidence-based programming and opportunities for future data collection and collaboration.

How do youth involved in the juvenile justice system differ from youth who are not involved in the juvenile justice system?

For the purposes of this study, involvement in the juvenile justice system is defined as being arrested or petitioned for an offense during the study period. A finding of delinquency is not a required component for involvement under our study parameters. We find that **Black youth** and **males** are overrepresented in the District of Columbia's juvenile justice system. Youth who become justice-system involved also have significantly higher rates of:

Economic Resources	Childhood Maltreatment	Educational Experiences
• Homelessness • TANF recipiency • Medicaid recipiency	• Removal to foster care • Reported abuse • Reported neglect	• Unexcused absences • Excused absences • Suspensions • Grade retention
Mental, Behavioral, & Developmental Disorders/IEP Eligibility		**Neighborhood Environment**
• Externalizing disorders • Comorbid disorders • Psychotic disorders • Specific developmental learning disorders • Specific developmental motor disorders • IEP eligibility		• Residence on gun violence "hot blocks"

What affects the likelihood that youth become involved in the juvenile justice system?

Using a multivariate logistic regression analysis and the administrative data we were provided, we identified the factors that have a statistically significant impact on the likelihood of juvenile justice system involvement.

We find that Black youth and males are at the highest risk of involvement. Youth who experience homelessness have a greater likelihood of juvenile justice system involvement, as do youth who experience abuse and neglect. Of the educational factors we evaluate, unexcused absences have a significant impact. Youth with externalizing and comorbid disorders are more likely to have contact with the juvenile justice system. Finally, youth who reside on a "hot block" with high gun violence incidence are more likely to become involved with the juvenile justice system.

The primary difference in findings between this report and the previous version is that suspensions are no longer a statistically significant factor for juvenile justice system involvement. This change may be

attributed to changes in District legislation that narrowed the circumstances in which students may be suspended.[3]

What protective factors and programs can reduce the likelihood that youth become involved in the juvenile justice system?

Protective factors can be grouped into five primary categories: individual protective factors, family factors, peer factors, and school and community factors. These can be further divided into demographic factors, economic indicators, behavioral and mental health issues, housing instability, exposure to violence, and educational factors. Many of the risk factors addressed in the empirical analysis have corollary protective factors or, by providing structured resources, have the potential to become protective factors.

Evidence-based programs and policies include mentoring programs, academic tutoring, after-school athletics, youth employment programs, anti-bullying campaigns, and economic supports. Developing data collection benchmarks and information sharing partnerships between the agencies and organizations currently providing many of these services will enable further District-specific program evaluation and empirical analysis.

[3] D.C. Law 22-157

II. Study Overview

In 2020, the Criminal Justice Coordinating Council (CJCC) published the Study of the Root Causes of Juvenile Justice System Involvement, a report mandated by the Council of the District of Columbia that looked at the factors that affected the likelihood that youth would become involved in the juvenile justice system.[4] Subsequently, the Council mandated CJCC to conduct a follow-up study that would build on the initial report. The follow-up study would determine what factors prevent youth from becoming involved in the juvenile justice system and which of these factors are most effective.

This report replicates the earlier statistical analysis and incorporates an in-depth review of the literature relating to protective factors against juvenile justice system involvement, an overview of current policies and programs in the District of Columbia, and a discussion of how to improve data collection and collaboration moving forward.

In this analysis, we define juvenile justice system involvement as an individual being arrested or petitioned between June 2019 and July 2020. Importantly, youth involvement in the justice system does not, in this analysis, imply that a youth has been found guilty of any offense. To examine the differences between youth with juvenile justice system involvement and youth without juvenile justice system involvement, we drew a representative sample of youth enrolled in District of Columbia public schools (DCPS), public charter schools (PCS), or Department of Youth Rehabilitation (DYRS) students during the 2018 – 2019 school year. Using data provided by the Metropolitan Police Department (MPD) and District of Columbia Superior Court (DCSC), we identified which youth became system involved in the subsequent year. Since the observation period of this study overlaps with the beginning of the COVID-19 pandemic and public health emergency, there may be some variation relative to the prior study.

The Office of the State Superintendent (OSSE), Department of Human Services (DHS), Child and Family Services Agency (CFSA), Department of Health Care Finance (DHCF) and MPD provided additional data on the sampled youths' demographics, economic resources, housing stability, childhood maltreatment histories, educational experiences, mental disorder diagnoses, behavioral disorder diagnoses, neurodevelopmental diagnoses, and neighborhood environment. Appendix A contains a full description of the sample selection, data process, and variables.

The statistical model constructed to identify the factors that affect juvenile justice system involvement follows the same framework as in the earlier analysis. We constructed a statistical model to estimate the effect on the likelihood of juvenile justice system involvement using administrative data including gender, race, age, Temporary Assistance for Needy Families (TANF) recipiency, homelessness, Medicaid recipiency, removal from the home by CFSA, reported abuse, reported neglect, number of excused and unexcused absences, grade level retention, number of days excluded from school for disciplinary reasons, internalizing disorder diagnoses, externalizing disorder diagnoses, comorbid disorder diagnoses, psychotic disorder diagnoses, specific motor disorder diagnoses, specific learning disorder diagnoses, IEP eligibility, and residence on a gun-violence hot block. Appendix B contains details on the model specifications.

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[4] The 2020 report can be accessed here: https://cjcc.dc.gov/sites/default/files/dc/sites/cjcc/CJCC%20Root%20Cause%20Analysis%20Report_Compressed.pdf

Report Layout

Section III presents descriptive statistics on how youth with juvenile justice system involvement and youth without juvenile justice system involvement differ from one another.

Section IV identifies the factors that were statistically significant with respect to juvenile justice system involvement and presents changes in average predictive probabilities associated with the likelihood of justice system involvement.

Section V summarizes the findings from a literature review regarding the protective/pro-social factors that reduce the likelihood of juvenile justice system involvement and identifies existing programs in the District of Columbia as well as opportunities for future data collection and collaboration. The CJCC initially planned to incorporate administrative data from the Department of Parks and Recreation, Department of Employment Services, and the Department of Human Services regarding the extent to which youth in the study sample participated in prosocial programs offered by these agencies for inclusion in the statistical model. However, due to privacy concerns identified by these agencies, the data were not made available for this study.

Section VI summarizes the empirical results and discusses how current and future policies and programs could increase protective factors and reduce the likelihood of juvenile justice system involvement.

Definitions

Below is a list of factors included in the statistical analysis and their definitions. More information on the sources and measurement of these elements is in Appendix A.

Demographic

Age:	Age on 5/31/19
Gender:	Male/Female
Race:	Black/African American; White; Hispanic/Latino; Other

Economic Resources

Homelessness:	Verified as homeless in SY18-19 in accordance with the McKinney-Vento (MKV) Assistance Act
TANF:	Received TANF benefits between 5/31/18 – 6/1/19
Medicaid >365 days:	Received Medicaid for >365 cumulative days between 5/31/13 – 6/1/19

Childhood Maltreatment

Removed from Home:	Outcome of a CFSA referral was the youth being removed from home due to maltreatment
Child Abuse:	Had a substantiated or inconclusive finding, or family assessment abuse matter on record with CFSA as of 5/31/19
Child Neglect:	Had a substantiated or inconclusive finding, or family assessment neglect matter on record with CFSA as of 5/31/19

Educational Experience

Grade Retention:	Whether a youth was enrolled in the same grade in SY18-19 as they were in SY19-20
Excused Absences:	Count of a youth's number of excused absences in SY 18-19
Unexcused Absences:	Count of a youth's number of unexcused absences in SY 18-19
Suspensions:	Count of a youth's number of suspensions in SY 18-19

Mental, Behavioral, and Neurodevelopmental Disorder Diagnoses and IEP Eligibility

Internalizing Disorder:	Has internalizing disorder diagnosis but no externalizing disorder, according to Medicaid claims data
Externalizing Disorder:	Has externalizing disorder diagnosis but no internalizing disorder, according to Medicaid claims data
Comorbid Disorder:	Has internalizing and externalizing disorder diagnoses, according to Medicaid claims data
Psychotic Disorder:	Has psychotic disorder diagnosis, according to Medicaid claims data

Specific Learning Disorder:	Has specific developmental learning diagnosis, according to Medicaid claims data
Specific Motor Disorder:	Has specific developmental motor disorder diagnosis, according to Medicaid claims data
IEP:	Whether a youth had an Individualized Education Program (IEP) in place in SY18-19

Neighborhood Environment

Gun Violence Hot Block:	Whether a youth's residential address is on one of the 25 blocks with the most violent gun crime incidents

III. Profile of Youth in the District of Columbia With Juvenile Justice System Involvement

While most young people engage in some form of delinquent behavior, only a small proportion engage in serious delinquency and become involved in the juvenile justice system. Involvement in the juvenile justice system does not mean that a youth is guilty of the accused behavior, nor does it represent the totality of youth delinquency. With these caveats in mind, it can still be useful to observe measurable differences between youth involved in the justice system involvement and youth who are not.

For this study, we drew a random sample of youth enrolled in DCPS, public charter schools, and DYRS education programs during the 2018 – 2019 school year. The previous section briefly describes the factors included in the analysis with further details available in Appendix A. Table 1 presents summary statistics for each factor.[5]

Table 1: Descriptive Statistics for Sample

Average Age 14.9	
Male: 54.7% Female: 43.3%	
Black: 74.8% Hispanic: 15.9% White: 6.5% Other: 2.8%	
Homelessness: 6.5% Medicaid >365 days 59.0%	TANF 15.3%
Removed From Home 5.9% Removed 1.7 times on average Age of First Removal 7.9	Reported Neglect 25.5% Reported Abuse 13.4%
Average Excused Absences 6.2 Average Unexcused Absences 16.0 Grade Retained 11.7%	Suspended 20.2% 2.1 Average Suspensions 5.9 Average Days Excluded
Internalizing Only 7.7% Comorbid Disorders 9.1% Specific Learning Disorder 9.6% IEP 25.4%	Externalizing Only 5.8% Psychotic Disorder 1.8% Specific Motor Disorder 3.2%
Hot Block 9.1%	

We matched sampled youth to justice system data to identify which youth became involved in the juvenile justice system between June 1, 2019 and July 31, 2020. We define juvenile justice system involvement as a youth being arrested or petitioned in the follow-up period.[6] It is important to note that the COVID-19 pandemic may influence the number of youth arrests. Of public-school youth in the District, 4.4% became involved in the juvenile justice system during the follow-up period.

[5] Due to an over-sampling of youth involved in the juvenile justice system, certain data elements presented in Table 1 – including the share of students with suspensions and IEPS – are upwardly biased relative to the population means.

[6] Justice system involvement does not, in this analysis, mean that a youth has been adjudicated delinquent or found guilty of any charge. Rather, it encompasses any contact with the justice system from arrest through conviction.

There are many differences between youth involved in the juvenile justice system and those who are not, but not all factors statistically contribute to juvenile justice system involvement. The differences between youth who were arrested or petitioned and those who were not involved in the justice system are illustrated in Table 2. All differences presented below are statistically significant at the .05-level.

Table 2: Differences Between Youth With No Juvenile Justice System Involvement and Youth With Juvenile Justice System Involvement

Youth Without Juvenile Justice System Involvement	Youth With Juvenile Justice System Involvement
Average Age 14.7	Average Age 15.6
Male: 49.7% Female: 50.3%	Male: 70.9% Female: 29.1%
Black: 69.1% Hispanic: 18.9% White: 8.5% Other: 3.5%	Black: 93.0% Hispanic: 6.2% White: 0.1% Other: 0.7%
Homelessness 4.8% TANF 12.3% Medicaid >365 days 53.8%	Homelessness 11.7% TANF 24.1% Medicaid >365 days 73.3%
Removed from Home 2.9% Age of First Removal 6.4 Reported Abuse 10.2% Reported Neglect 17.0%	Removed from Home 14.7% Age of First Removal 9.3 Reported Abuse 23.0% Reported Neglect 49.8%
Suspended 11.8% Average Suspensions 1.7 Days Excluded 4.4 Grade Retained 5.8% Average Excused Absences 5.7 Average Unexcused Absences 13.5	Suspended 44.2% Average Suspensions 2.3 Days Excluded 7.2 Grade Retained 30.2% Average Excused Absences 7.6 Average Unexcused Absences 38.6
Internalizing Only 10.2% Externalizing Only 4.1% Comorbid Disorders 6.4% Psychotic Disorder 0.7% Specific Learning Disorder 6.9% Specific Motor Disorder 1.7% IEP Eligible 18.9%	Internalizing Only 45.1% Externalizing Only 10.3% Comorbid Disorders 43.7% Psychotic Disorder 4.8% Specific Learning Disorder 17.1% Specific Motor Disorder 7.7% IEP Eligible 44.1%
Hot Block 7.8%	Hot Block 13.0%

Risk of Juvenile Justice System Involvement

Not all youth face the same risk factors or have the same protective factors. As with the earlier iteration of this report, we included the factors that research has generally accepted as most influential in whether a youth comes into contact with the juvenile justice system.

We constructed a multivariate logistic regression model to test the relationship between each risk/protective factor and likelihood of juvenile justice system involvement controlling for all other factors. After calculating the predicted probability of juvenile justice system involvement for each youth in the sample we divide the sample into risk quartiles. Most youth with involvement in the juvenile justice system (93.3%) had predicted probabilities that placed them in the top-two risk quartiles and 78.3% were in the 4th (highest) risk quartile.

The average predicted probability of youth in the highest risk quartile is 12.8% while the average predicted probability for the lowest risk quartile is 0.3%. This means that, on average, youth in the highest risk quartile have a 12.8 out of 100 chance of becoming juvenile justice system involved compared to a 0.3 out of 100 chance for youth in the lowest-risk quartile. These statistically significant differences indicate that the number of risk factors a youth has greatly increases their chance of juvenile justice system involvement. However, as such a small minority of youth – even in the highest risk quartile – ever become system involved these factors are not deterministic.

As shown above in our comparison of youth with juvenile justice system involvement and youth without juvenile justice system involvement, there are clear differences between the risk quartiles, presented below.

Table 3: Descriptive Statistics for Sample Quartiles

Quartile 1 (lowest risk)		**Quartile 2**	
Average Age 14.1		Average Age 14.9	
Male: 30.3% Female: 69.7%		Male: 42.6% Female: 57.4%	
Black: 39.1% Hispanic: 27.4% White: 25.9% Other: 7.7%		Black: 73.0% Hispanic: 22.6% White: 3.3% Other: 1.1%	
Homelessness 2.0% Medicaid >365 days 40.9%	TANF 6.4%	Homelessness 4.6% Medicaid >365 days 53.2%	TANF 12.2%
Reported Abuse 2.6% Reported Neglect 8.3%	Removed from Home 0.3% Age of First Removal 4.1	Reported Abuse 6.2% Reported Neglect 15.6%	Removed from Home 2.3% Age of First Removal 7.0
Average Excused Absences 5.2 Average Unexcused Absences 6.3 Grade Retained 1.9%	Suspended 6.0% Average Suspensions 1.5 Days Excluded 3.3	Average Excused Absences 5.5 Average Unexcused Absences 13.8 Grade Retained 5.6%	Suspended 11.9% Average Suspensions 1.5 Days Excluded 3.7
Internalizing Only 5.0% Comorbid Disorders 2.2% Specific Learning Disorder 5.6% IEP Eligible 8.6%	Externalizing Only 1.6% Psychotic Disorder 0.5% Specific Motor Disorder 0.5%	Internalizing Only 8.1% Comorbid Disorders 5.3% Specific Learning Disorder 8.9% IEP Eligible 18.7%	Externalizing Only 3.8% Psychotic Disorder 0.7% Specific Motor Disorder 0.8%
Hot Block 3.2%		Hot Block 7.4%	
Quartile 3		**Quartile 4 (highest risk)**	
Average Age 15.3		Average Age 15.5	
Male: 67.5% Female: 32.5%		Male: 78.5% Female: 21.5%	
Black: 87.1% Hispanic: 10.0% White: 1.1% Other: 1.8%		Black: 95.1% Hispanic: 3.8% White: 0.4% Other: 0.7%	
Homelessness 6.5% Medicaid >365 days 66.2%	TANF 17.2%	Homelessness 11.0% Medicaid >365 days 75.8%	TANF 25.5%
Reported Abuse 18.8% Reported Neglect 28.1%	Removed from Home 4.8% Age of First Removal 9.5	Reported Abuse 26.4% Reported Neglect 49.9%	Removed from Home 16.2% Age of First Removal 8.6
Average Excused Absences 6.3 Average Unexcused Absences 23.9 Grade Retained 14.0%	Suspended 23.2% Average Suspensions 2.1 Days Excluded 5.9	Average Excused Absences 7.9 Average Unexcused Absences 34.9 Grade Retained 25.5%	Suspended 39.5% Average Suspensions 2.3 Days Excluded 7.0
Internalizing Only 13.2% Comorbid Disorders 10.7% Specific Learning Disorder 10.5% IEP Eligible 29.1%	Externalizing Only 5.8% Psychotic Disorder 1.5% Specific Motor Disorder 3.0%	Internalizing Only 16.8% Comorbid Disorders 28.5% Specific Learning Disorder 13.2% IEP Eligible 45.2%	Externalizing Only 12.1% Psychotic Disorder 4.4% Specific Motor Disorder 7.1%
Hot Block 11.0%		Hot Block 14.9%	

IV. Factors Affecting Juvenile Justice System Involvement

Demographic Factors

Our model shows that age, gender, and race have significant associations with juvenile justice system involvement. These findings are consistent with the previous analysis and the existing literature.[7]

Age

The probability of juvenile justice system involvement for youth in the highest-risk quartile peaks at 18.8% when youth are approximately 15.6 years old, with the peak for all youth occurring at 7.4% at about age 16.

Figure 1: Probability of Juvenile Justice System Involvement by Age

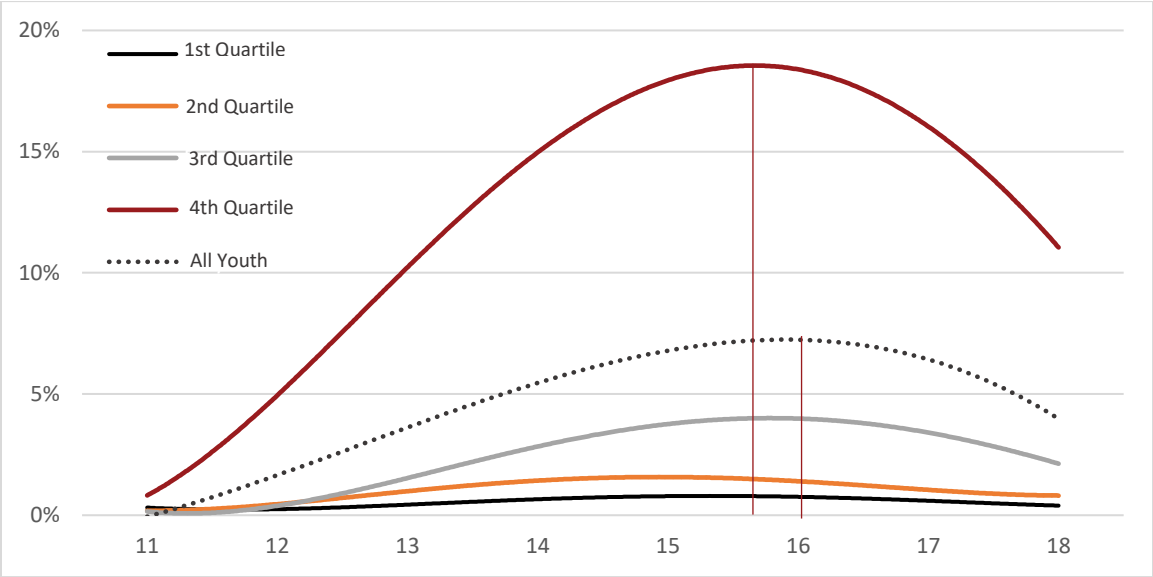


Table 4: Probability of Juvenile Justice System Involvement by Age

1st Quartile		2nd Quartile		3rd Quartile		4th Quartile	
11	0.3%	**11**	0.2%	**11**	0.1%	**11**	1.2%
12	0.3%	**12**	0.4%	**12**	0.5%	**12**	4.6%
13	0.4%	**13**	1.1%	**13**	1.7%	**13**	10.2%
14	0.6%	**14**	1.3%	**14**	2.2%	**14**	14.8%
15	0.9%	**15**	1.7%	**15**	4.3%	**15**	18.8%
16	0.7%	**16**	1.3%	**16**	3.8%	**16**	17.2%
17	0.6%	**17**	1.1%	**17**	3.2%	**17**	15.4%
17.9	0.4%	**17.9**	0.8%	**17.9**	2.2%	**17.9**	11.0%

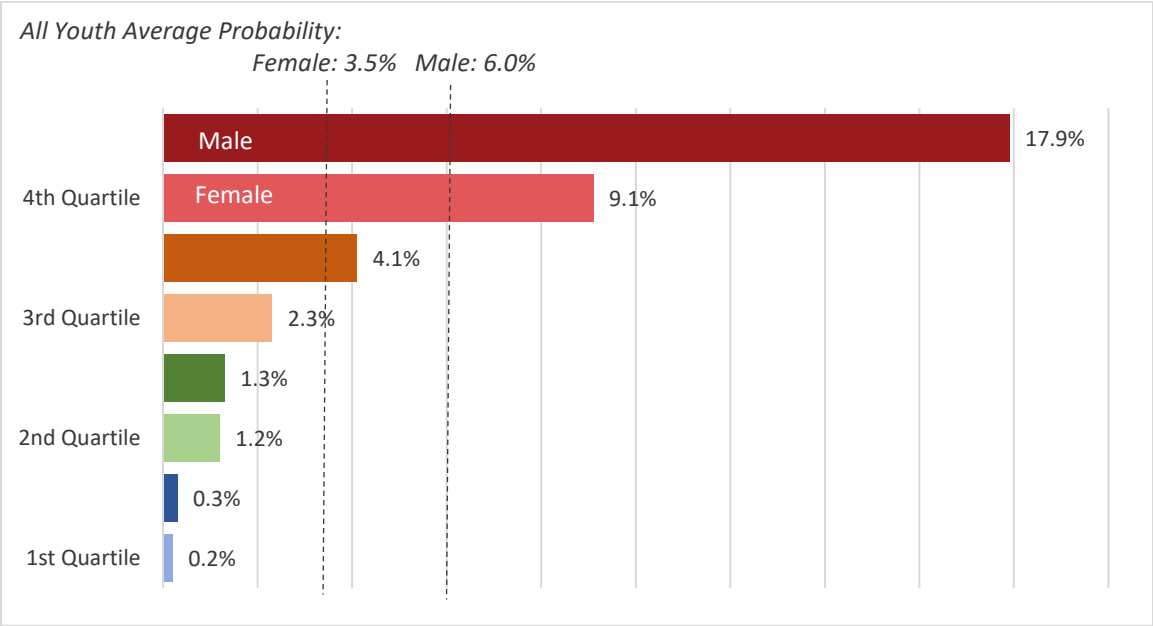
[7] Byrnes, Miller, and Shafer1999; CJCC 2020; DeLisi and Vaughn 2016; DSG 2015; Hindelang 1981; Moffit 1993

These findings are consistent with the previous report and research literature. The age-crime curve shows an increase in offending through early adolescence with peak likelihood during the teenage years, then a slow decline through the early 20s.[8]

Sex

Holding all else constant, males are nearly twice as likely as females to become involved in the juvenile justice system. The predicted probability of juvenile justice system involvement across all males is 6.0% and the predicted probability across all females is 3.5%. Males in the top risk quartile have the greatest chance of juvenile justice system involvement at 17.9%. Again, these results are consistent with the literature and previous iteration of the Root Cause Analysis report.[9]

Figure 2: Probability of Juvenile Justice System Involvement by Sex and Risk Quartile

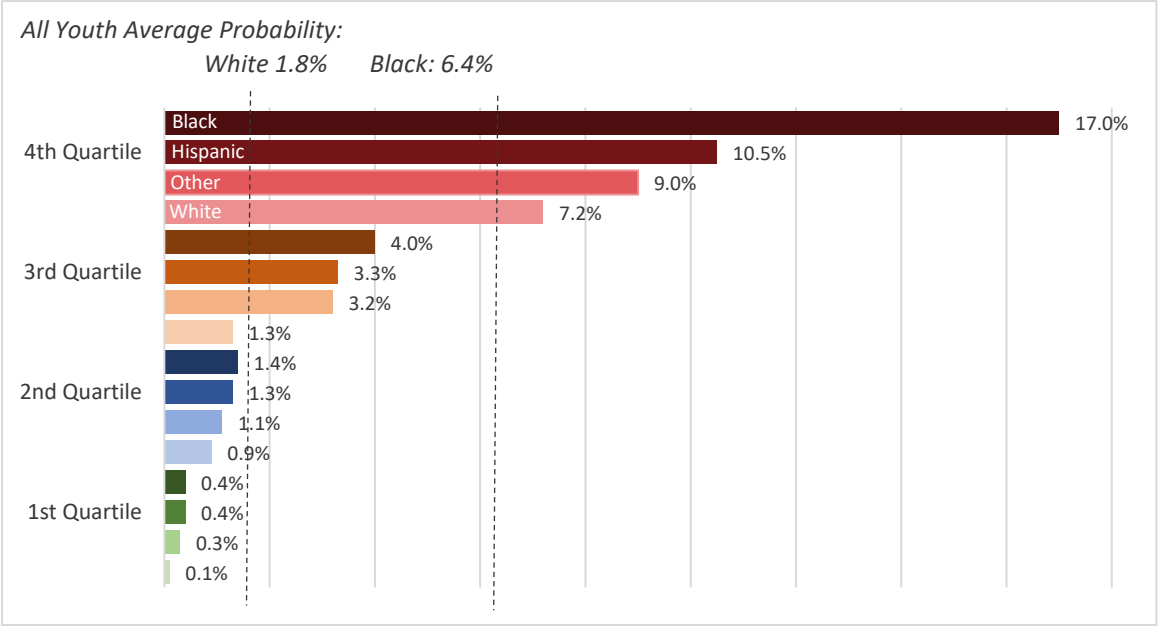


Race/Ethnicity

Black youth are statistically significantly more likely to become involved in the juvenile justice system than youth of any other race or ethnically Hispanic youth. In the highest risk quartile, the average predicted probability of juvenile justice system involvement of a youth is Black is 17.0% -- 1.62 times that of ethnically Hispanic youth and 2.36 times as high as the average predicted probability for White youth.

[8] Piquero et al. 2007; Farrington 1986
[9] CJCC 2020; DeLisi and Vaughn 2016

Figure 3: Probability of Juvenile Justice System Involvement by Sex and Risk Quartile



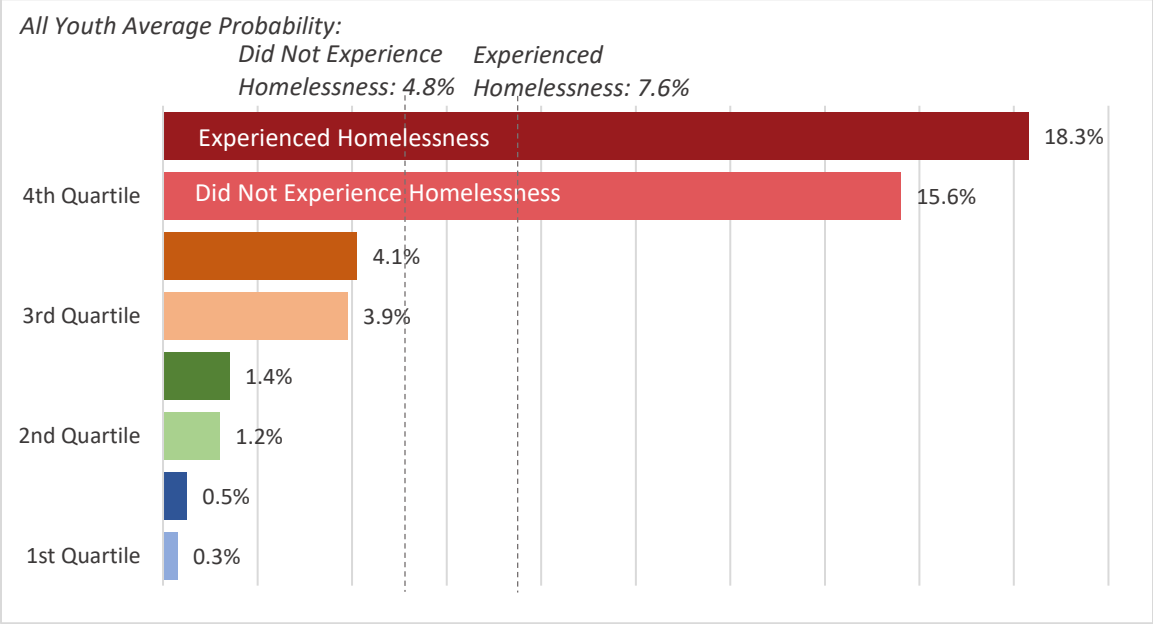
As the data analyzed for this report examines only formal juvenile justice system involvement, we cannot evaluate whether the statistical effect of race is due to differential rates of offending or a differential system response. However, the statistical effects persist even when holding all other risk factors constant. One explanation is that current and historic discrimination results in Black youth being exposed to more risk factors, and thus more likely to engage in delinquent behavior or more likely to face enforcement action for certain offenses. The literature and focus group interviews conducted in the previous report support this as a possible explanation.

Economic Resources

Homelessness

Youth identified as experiencing homelessness are 1.58 times more likely to become involved in the juvenile justice system, holding all other factors constant.

Figure 4: Probability of Juvenile Justice System Involvement Homelessness Status and Risk Quartile



These results may underestimate the impact of homelessness as youth who are experiencing homelessness but have not come to the attention of their local education agency or youth who are not enrolled in the public education system are not included. In addition, there is no flag distinguishing runaway or throwaway youth and youth from families experiencing housing instability, so we cannot separately evaluate the differential effects of extreme poverty and family stability.

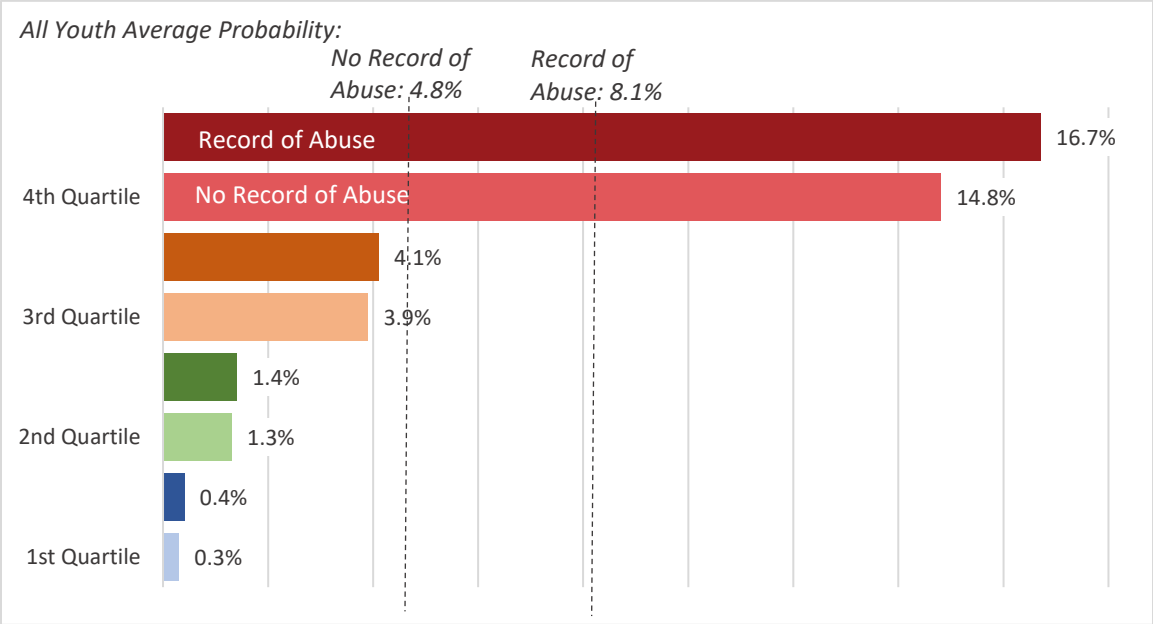
The two additional factors of economic instability we included – TANF recipiency and Medicaid eligibility – did not have statistically significant effects. This is consistent with the previous report.

Childhood Maltreatment

Abuse and Neglect

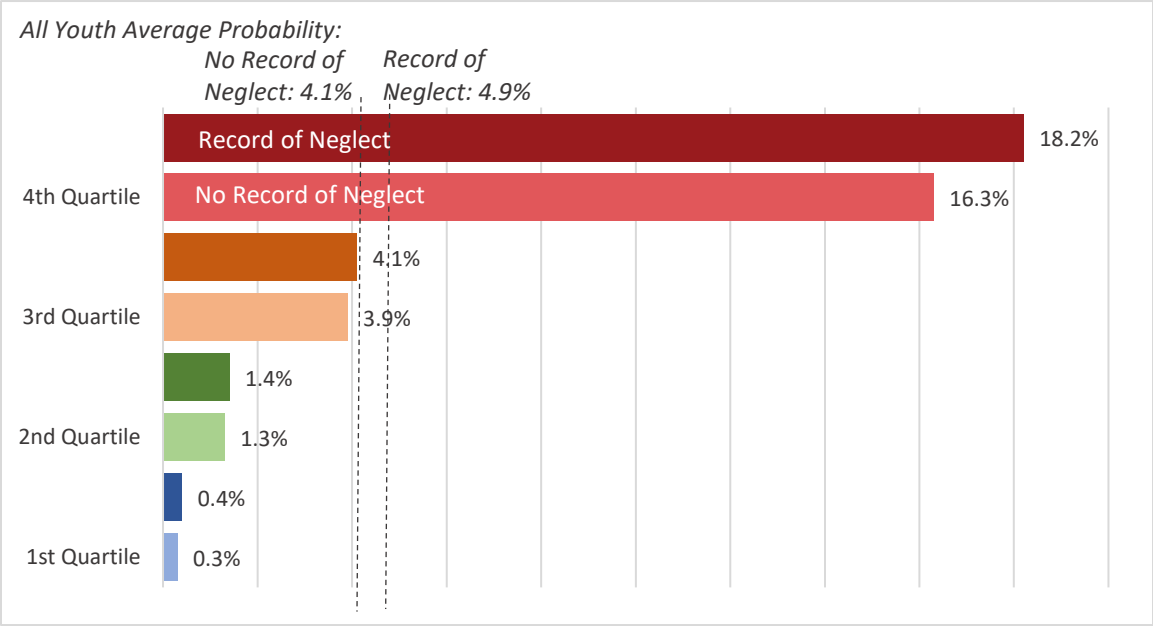
Youth with documented histories of abuse and/or neglect are statistically significantly more likely to become involved in the juvenile justice system. There is a 1.68 times increase associated with having at least one CFSA Family Assessment case or substantiated investigations of abuse. The 1.2 times increase in average probability of juvenile justice system involvement for youth with an open CFSA Family Assessment or substantiated investigation of neglect is smaller, but still statistically significant. These results are consistent with the academic research on childhood maltreatment.[10]

Figure 5: Probability of Juvenile Justice System Involvement of Youth With/Without a Record of Abuse



[10] E.g., Behl 2003; Chiu, Ryan, and Herz 2001; Gisso 2002; Hamilton, Falshaw, and Browne 2002; Loeber and Farrington 2000; Maxfield and Widom 1996; Schwartz and Rendon 1994; Smith and Thornberry 1995; Vidal et al. 2017; Wiig, Wisdom, and Tuell 2003

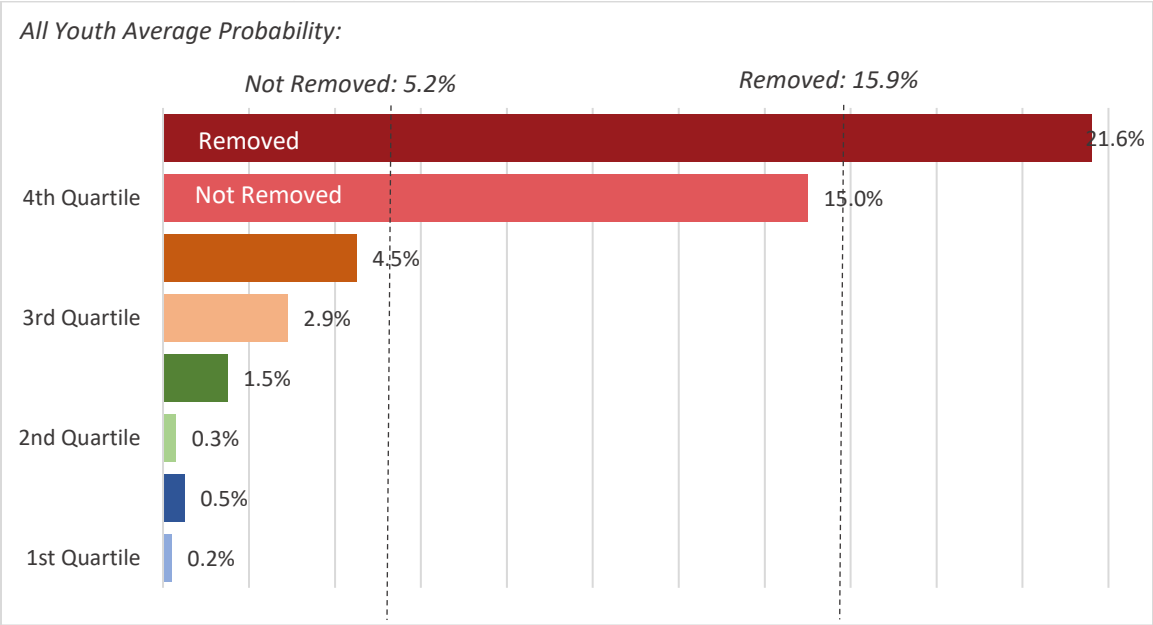
Figure 6: Probability of Juvenile Justice System Involvement of Youth With/Without a Record of Neglect



Removal From Home

A history of removal from the home is also statistically significant with respect to the predicted probability of a youth coming into contact with the juvenile justice system. Youth who are removed from their home by CFSA are 3.06 times more likely to become involved in the juvenile justice system.

Figure 7: Probability of Juvenile Justice System Involvement of Youth With/Without a Record of Removal



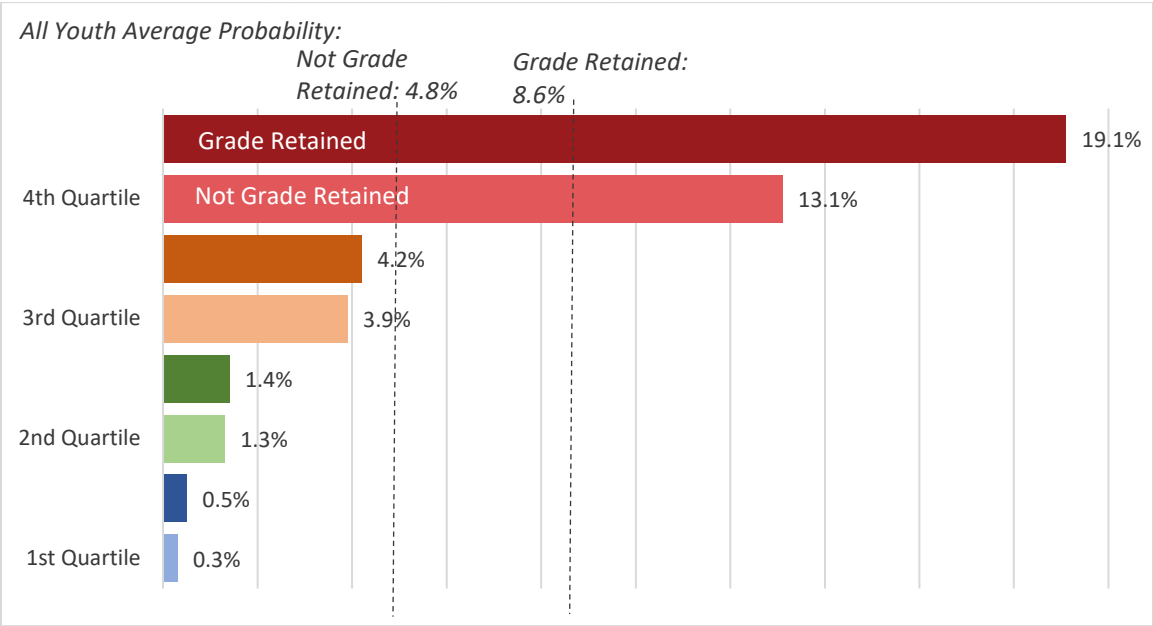
Educational Experience

Educational experience, educational environment, and academic performance have been proven to be both risk factors for delinquency and protective factors against juvenile justice system involvement. The direction and extent of the causal relationship is complex and still up for debate. There is, however, evidence that truancy, grade retention, and school-based discipline are indicators of increased probability of juvenile justice system involvement although the causal direction remains uncertain.[11]

With the data available to us we test these relationships and do find that grade retention and the number of unexcused absences is significantly associated with an increased likelihood of juvenile justice system involvement. Unlike the previous report, the number of suspensions has only a marginally significant effect on the likelihood of juvenile justice system involvement and thus is not included.[12]

Grade Retention

Figure 8: Probability of Juvenile Justice System Involvement for Grade Retained and Non-Grade Retained Youth



Grade retention, where a student is not promoted to the next grade at the end of the school year, is often treated as an indicator of poor academic performance or engagement. This analysis finds that grade retention is associated with an increase of 1.79 times the likelihood of subsequent juvenile justice system involvement for all youth. Youth in the highest quartile who are grade retained have an average predicted probability of 19.1% compared to non-grade retained youth in the same quartile who have an average predicted probability of 13.1%.

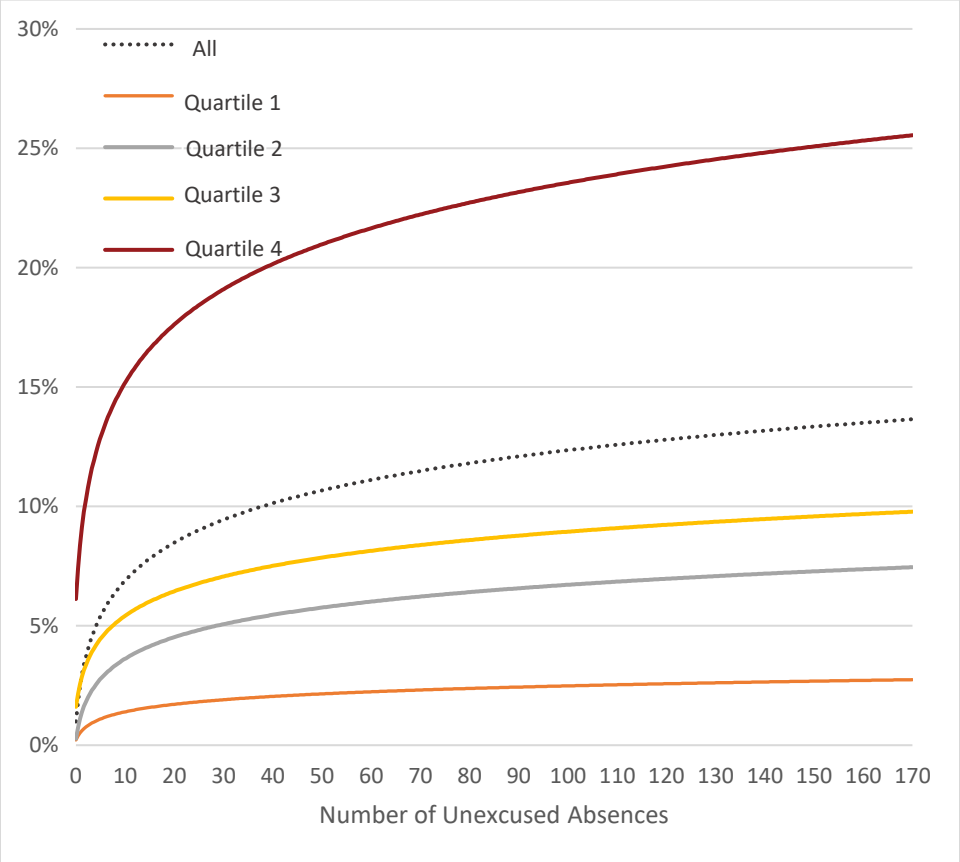
[11] Christle, Jolivetter, Nelson 2005; Hirschfield and Gasper 2011; Jimerson et al. 1997; and Rocque et al. 2017

[12] Since the prior report, legislation has narrowed the circumstances under which a student may be suspended (D.C. Law 22-157)

Not only is grade retention an indicator of current academic struggles, but it may also signal further disengagement in the future.[13]

Unexcused Absences

Figure 9: Probability of Juvenile Justice System Involvement Increases With the Number of Unexcused Absences



The association between unexcused absences and delinquency is well-documented.[14] We find that the likelihood of juvenile justice system involvement increases by more than 3 times if a youth accrues the average number of unexcused absences (16.0). The predicted probability increases with the number of unexcused absences, but the rate of growth slows after the first 30 unexcused absences.

[13] Roderick 1994; Shepard and Smith 1990
[14] Rocque et al. 2017

Mental, Behavioral, and Neurodevelopmental Disorder Diagnoses and IEP Eligibility

Internalizing-Externalizing Comorbidity and Externalizing Disorders

Figure 10: Probability of Juvenile Justice System Involvement Increases with Internalizing-Externalizing Comorbidity

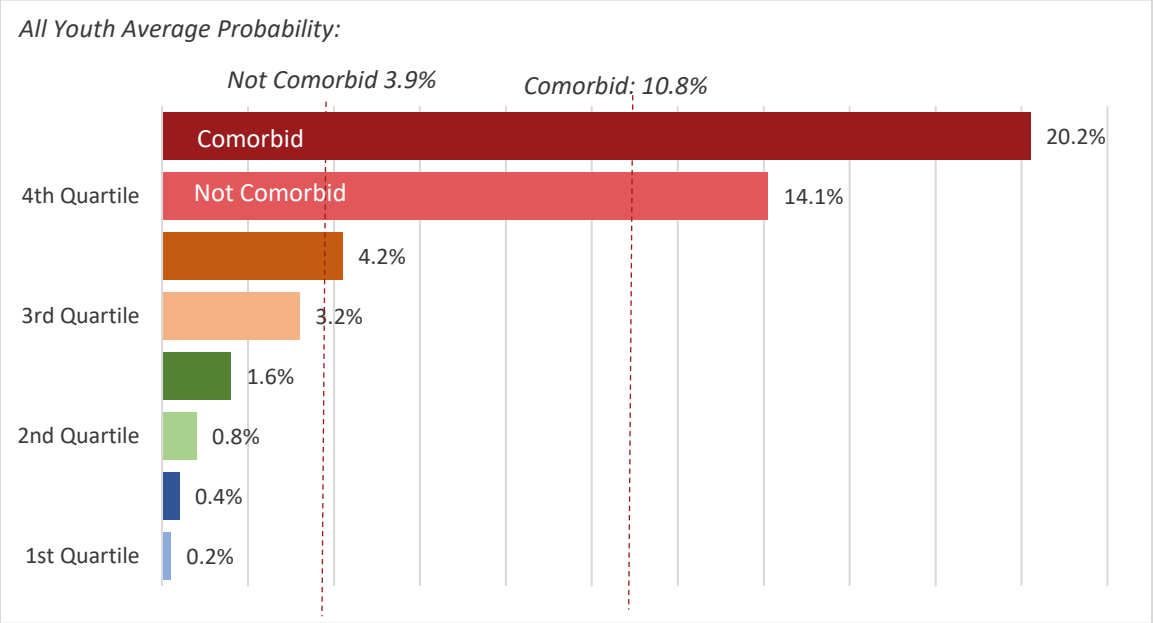
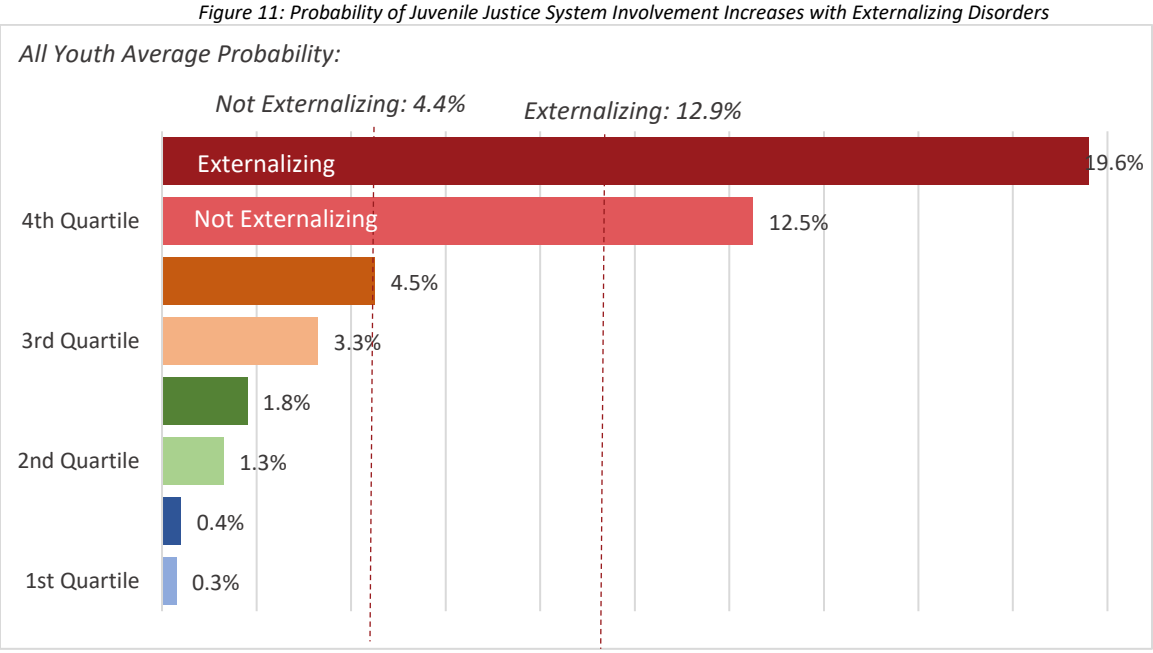


Figure 11: Probability of Juvenile Justice System Involvement Increases with Externalizing Disorders



We include five disorder categories/domains in this analysis: internalizing disorders, externalizing disorders, internalizing-externalizing comorbidity, psychiatric disorders, specific developmental learning disorders, and specific developmental motor disorders. The analysis shows that youth with internalizing-

externalizing comorbidity and youth with externalizing disorders are 2.77 and 2.93 times, respectively, more likely to become involved in the juvenile justice system with all other factors held constant.

The predicted average probability for high-risk youth with comorbid disorders is 20.2% compared to 14.1% for high-risk youth without comorbidity. The predicted average probability for high-risk youth with externalizing disorders is 19.6% compared to 12.5% for high-risk youth without externalizing disorders. We found no statistically significant increase in the likelihood of juvenile justice system involvement for youth with internalizing disorders, psychiatric disorders, specific developmental learning disorders, or specific developmental motor disorders.

We classified the disorders represented in this analysis under internalizing and externalizing groupings in following with the literature.[15] A further discussion of the disorder classification process is in Appendix A.

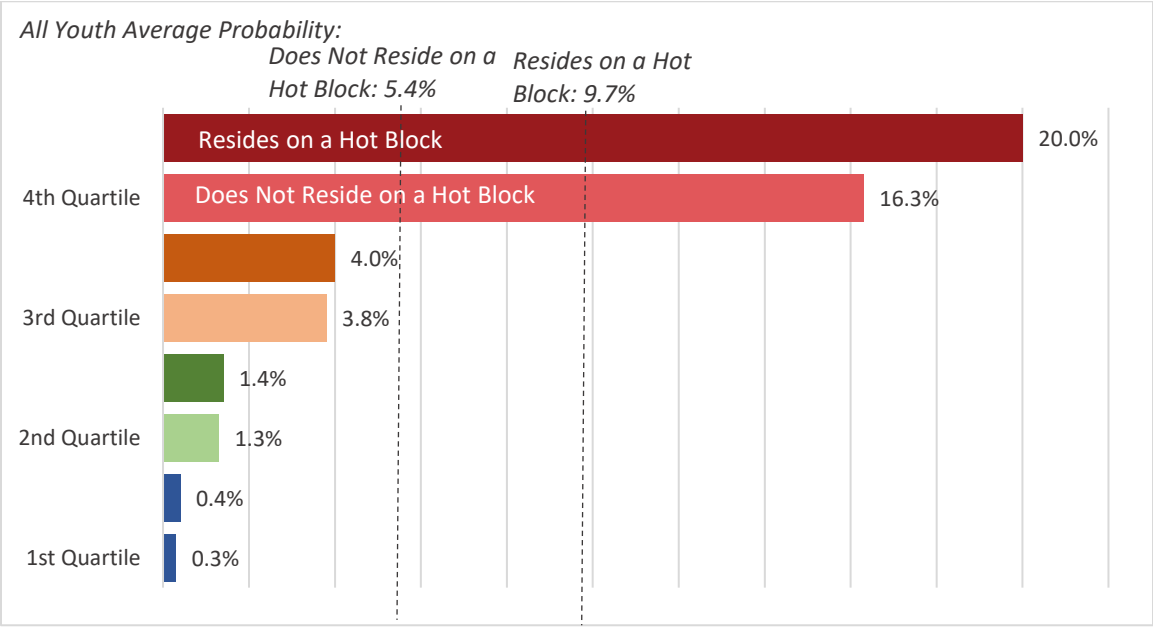
[15] Cicchetti & Rogosch, 2002

Neighborhood Environment

Hot Block

We find that youth residing on one of the District's top 25 "hot blocks" – the 25 blocks with the highest incidence of gun violence – are statistically more likely to become involved in the juvenile justice system. The average predicted probability of juvenile justice system involvement for youth who live on a hot block is 9.7% compared to 5.4% for youth who do not live on a hot block. Youth in the highest risk quartile who live on a hot block have a predicted probability of 20.0% of becoming justice-system involved. That is 1.23 times higher than youth in the top quartile who do not reside on a hot block.

Figure 12: Probability of Juvenile Justice System Involvement by Neighborhood Factors and Risk Quartile



The literature provides evidence exposure to community violence contributes to delinquency.[16] In addition, social disorganization theory argues that ecological factors can hinder the development of social ties. A lack of strong community is a significant risk factor, while a cohesive neighborhood environment may serve as a protective factor against youth juvenile justice system involvement.

[16] McCord, Widom, and Crowell 2001

V. Protective Factors

Types of Risk and Protective Factors

The Office of Juvenile Justice and Delinquency Prevention (OJJDP) recognizes the following categories of risk factors that are likely to increase the risk of juvenile justice system involvement: individual factors, family factors, peer factors, and school and community factors. This is consistent with the findings of this report as well as the previously published version.[17]

The broad categories above include demographic factors, economic indicators, behavioral and mental health issues, housing instability, exposure to violence, and education and attendance struggles. By identifying which factors have the greatest impact on a young person's risk of becoming juvenile justice system involved, we can attempt to determine which pro-social factors help prevent juvenile justice system involvement among the highest risk youth. This will enable us to examine possible areas for intervention as well as review which evidence-based policies have proven to be the most effective.

Individual Protective Factors

According to OJJDP, "individual-level protective factors focus on the personal characteristics that affect risk and engagement in delinquency, violence, and other problem behaviors."[18] These include problem-solving skills, positive outlook and expectation for the future, and community connectedness. Individual protective factors can be built through a variety of programming, including early childhood education programs, parental support programs, and mentoring programs.

Early Childhood Education

One way to encourage the development of individual-level skills and protective factors is through robust early childhood education programs. Garcia, Heckman, and Ziff (2019) use a randomized controlled trial to find statistically significant reductions in juvenile crime among individuals enrolled in a high-quality, intensive early childhood program with long-term follow-up.[19] These findings agree with the vein of research finding statistically significant reductions in violent adolescent behavior following similar early-childhood interventions.[20]

Even earlier research suggests that large-scale, less targeted programs lead to improved outcomes as well. Reynolds et.al. (2001) evaluate the long-term effectiveness of a federal center-based preschool and school–based intervention programs for urban low-income children.[21] The children participating in the study attended a half-day preschool program for 3- to 4-year-olds, compared to the control group who was not enrolled. Both the pre-school and non-pre-school cohorts were tracked for a fifteen-year follow-up, after which youth who participated in the pre-school program displayed more years of completed education and lower rates of arrest for violent and non-violent crime than non-participants.

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[17] CJCC 2020; OJJDP 2003
[18] OJJDP 2015
[19] Garcia et al. 2019
[20] Moffit 2018; Heckman et al. 2010
[21] Reynolds et al., 2010

Several decades of research support the idea that early childhood education and pre-school programs help youth build robust social skills and support youth success. The District of Columbia has long considered early childhood development a critical issue, and there are several current programs and policies in place that support these goals.

Parent Infant Early Childhood Enhancement Program (PIECE)
PIECE has two main components: 1) early intervention screening and assessment, followed by individual and family therapy, Parent Child Interaction Therapy (PCIT) and Child Parent Psychotherapy for Family Violence and 2) support for mothers with mental health issues including access to a psycho-educational parenting group.[22]

Thrive by Five
Thrive by Five is the District's first comprehensive childhood health and early learning initiative.[23] The program provides a centralized repository of resources for families and service providers focused on early childhood health and development.

Birth-to-Three for All Amendment Act of 2018
This law (D.C. Law 22-179) became effective October 30, 2018 and laid out a comprehensive framework to support youth and families by creating and expanding programs providing access to early childhood education and linking families to other key resources.[24] Some of these resources include:

- *HealthySteps© Program*: supports early childhood development through evidence-based practices linking children to pediatric primary care and child development specialists.
- *Help Me Grow Program:* provides a free and confidential telephone service that connects families to care coordinators who in turn link families to additional resources and services.
- *Home Visiting Program*: requires the DC Department of Health to administer funds for home vising services and conduct an analysis of home visiting needs, capacity, and utilization.

Not all early-childhood intervention programs are created equal, however. Poor quality pre-school programs can have minimal positive impact on child development.[25] Conversely, socially diverse pre-school programs can have outsized positive effects.[26]

Mentoring Programs

Mentoring programs have proven to be effective in improving emotional well-being, self-control, and self-esteem of children via non-parental adult support. Mentors can serve as a trusted adult who helps youth develop strong socio-emotional tools and coping strategies, thus enabling them to avoid or navigate interpersonal challenges or conflicts that could otherwise lead to delinquent behaviors.[27]

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[22] DBH 2022
[23] See: https://thrivebyfive.dc.gov/
[24] D.C. Law 22-179
[25] Haskins & Barnett 2010; Pianta et al. 2009
[26] Melhuish et al. 2015
[27] Herrera, Dubois, and Grossman 2013

One example of a mentoring program is the Great Life Mentoring program (GLM). This program aims to provide stability for youth by having them engage in their community with one-on-one support from an adult mentor who is from the community. The program provides mentors a 20-hour training course before pairing them with a youth for monthly supervision meetings. Using attachment theory training, the GLM program positions mentors to connect with youth and reframe experiences and perceptions of self and belonging to solve conflicts.

A research team observed 91 youth who were involved in GLM for a 15-year period while comparatively observing 400 youth who received mental health services by the same agency but did not participate in GLM.[28] Youth in GLM had a favorable trend over time in clinician ratings of their adaptive functioning, as well as less likely to have an unplanned, client-initiated ending to their treatment and more likely to have a planned ending.

Proper implementation is critical for youth mentorship programs. Take, for example, a study examining the effectiveness of a youth mentoring program in Sweden.[29] The researchers randomly assigned eligible 14-year-olds to either the mentor program or to a control group. They then measured the youths' emotional and behavioral levels, as well as substance use through self-reports. While youth with a mentor reported feeling more trusting of their mentors and more likely to reach out for help, there was no statistically significant difference between the mentor group and control group. Ensuring that mentors have the appropriate background to connect effectively with the youth and that there is adequate supervision is key.

There are several agencies and organizations in the District of Columbia that provide youth mentoring services, including DC Dream Center, MENTOR Washington, and the Department of Youth Rehabilitation Services (DYRS).[30] The DYRS Credible Messenger program is a mentoring intervention for youth with juvenile justice system involvement where experienced advocates, neighborhood leaders, and individuals with relevant life experiences serve as credible messengers to help youth transform attitudes and behaviors around violence through a restorative justice mission.

Programs like the Big Brother Big Sister (BBBS) Community-Based Mentoring Program (CBM) can also provide support for at-risk youth and enable them to develop strong intra-community relationships to serve as the bedrock for a support system. Current research supports the efficacy of such mentorship-based programs, but appropriate implementation is key.[31]

These, and other organizations provide mentoring support to youth across the District. The extent of program data that is collected is unclear, but establishing strong working relationships with these organizations, as well as others who provide youth mentoring services, would be beneficial in performing future assessments of the District's mentoring resources.

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[28] DuBois et al. 2018
[29] Bodin 2011
[30] See: https://dcdreamcenter.com/mentoring, https://mentorwashington.org, and https://dyrs.dc.gov/page/after-schoolmentoring-programs for examples.
[31] Matz 2014

Family Protective Factors

Having close family relationships that include support and clear rules and expectations for behavior can be a strong protective factor. Children who experience higher parental involvement in their social, behavioral, and educational development display lower rates of drug use and delinquency.[32] Encouraging parental involvement in a child's school environment as well as providing parents with tools and resources to develop positive parenting habits can bolster these protective factors. In addition to parenting resources, financial security and access to economic resources are important for creating strong family protective factors.

Parental Resources

One program that has shown promise is the Families and Schools Together (FAST) program. The program operates internationally and focuses on at-risk youth by creating a supportive multi-family group environment. Youth, parents, and school staff join weekly after school meetings to come together and form supportive social networks. There is evidence that the program reduces behavioral problems and improves academic performance during and after the term of the program.[33]

While FAST does not currently operate in the District, many of the programs covered under PIECE and Thrive by Five do provide parental support, particularly for very young children.

There are, however, several programs in the District for youth with juvenile justice system involvement or justice-adjacent youth and their families. These include:

> Alternatives to the Court Experience (ACE) Diversion
> The ACE diversion program is designed as a "front door" for all diversions from juvenile justice entities in the District.[34] The objective is to provide services and community supports instead of prosecution for youth who commit status offenses or low-level delinquency offenses.
>
> Parent and Adolescent Support Services (PASS)
> DHS operates the PASS early intervention program for youth ages 10-17 who have committed status offenses. The program provides evidence-based support to children and their families before referrals of the child or family to the juvenile justice system or child welfare services.
>
> Child and Family Services Agency (CFSA) Interventions
> CFSA investigates reports of abuse and neglect and, when appropriate, links families to services, offers family team meetings and safety plan development while working with the family to provide safe care within the family setting, provides safe out-of-home care, and assists in re-establishing permanent homes.

Economic Supports and Opportunities

Economic stability – particularly access to stable housing – is an important protective factor for youth and families. Youth who experience homelessness are at a greater risk of becoming involved with the justice system. The District has several strategic plans to address youth homelessness. In addition,

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[32] Ripley-McNeil and Kramer 2021
[33] Kratochwill et al. 2009; McDonald et al. 2006
[34] DC DHS 2022

access to economic resources and opportunities are key protective factors. Some key programs are briefly described below.

Homeward DC

Homeward DC, first released in 2015 and now in its second iteration (Homeward DC 2.0) is a strategic plan to end long-term homelessness in the District of Columbia.[35] The comprehensive approach scaled housing services for families, reformed the family shelter system, and expanded rental subsidies. Recent reports show a steep reduction in the number of families experiencing homelessness on any given night from 1,500 at the start of implementation to 400 as of January 2021.

The District of Columbia Interagency Council on Homelessness (ICH), the Community Partnership for the Prevention of Homelessness (TCP), and the ICH's Strategic Planning Committee recently presented the FY2021-2025 strategic plan for Homeward DC 2.0, outlining future goals for the initiative.[36]

Solid Foundations DC

Solid Foundations DC is a data-driven plan first issued in 2017 that focuses on the needs of the District's youth under 25 with the goal of ending youth homelessness.[37] While most unhoused youth are between the ages of 18 and 24, the plan also addresses the issue of minor youth experiencing homelessness which is a risk factor for juvenile justice system involvement. The core outcomes of the plan are to provide youth (1) stable housing, (2) permanent connections, (3), education and employment, and (4) social emotional well-being. The plan aims to use data driven models to develop a streamlined system to connect youth experiencing homelessness with resources.

Temporary Assistance for Needy Families (TANF)

The TANF program provides cash payments and other support services to low-income families with children.[38] According to the federal Department of Health and Human Services, an average of 6,354 families in the District of Columbia per month received benefits during fiscal year 2021.[39]

In addition to cash payments, the DC Department of Human Services (DHS) provides access to the TANF Employment Program (TEP), childcare subsidies, behavioral, mental, and substance abuse support, and the Tuition Assistance Program Initiative for TANF (TAPIT).

Mayor Marion S. Barry Summer Youth Employment Program (MBSYEP)

The MBSYEP is an initiative funded by the DC Department of Employment Services (DOES) that provides youth ages 14-24 with subsidized placements in summer work experiences.[40] More than 5,200 individuals under the age of 17 participated in 2020.[41] Research shows that

[35] DC ICH 2022
[36] ICH 2022
[37] Ibid.
[38] DC DHS 2022
[39] HHS 2021
[40] DOES 2022
[41] DOES 2021

participation in summer youth employment programs reduces delinquency in the following years.[42]

Other Guaranteed Income Programs

- THRIVE East of the River[43]
- DC Department of Human Services (DHS) Career Mobility Action Plan (Career MAP) initiative[44]
- Strong Families, Strong Future DC pilot, administered by the Deputy Mayor for Planning and Economic Development (DMPED), in partnership with Martha's Table[45]

Peer Protective Factors

Youth peer relationships have a strong impact on behavior. Close connection to non-delinquent peers has a mitigating effect on the risk of juvenile delinquency, while close connections to youth who are engaged in delinquent behavior increase the risk.[46] Peer mediation and bullying prevention programs can serve to foster relationships, improve social skills, and reduce conflict.[47]

Bullying Prevention Programs

Research shows that both victims and perpetrators of childhood bullying are at greater risk of later delinquency.[48] To that point, robust bullying prevention programs can help reduce conflict between youth and teach social problem-solving skills while also mending relationships that, if left unaddressed, could lead to future conflict.

The Olweus Bullying Prevention Program is a well-researched program first established in the 1990s. It focuses on creating a safe and positive school environment, with the goals of reducing existing bullying problems, preventing new ones, and creating better relations among peers. The four principles that form its base are: adults at school should (a) show warmth and positive interest in students, (b) set firm limits to unacceptable behavior, (c) use consistent positive consequences to acknowledge and reinforce appropriate behavior, and (d) function as authorities and positive role models. Researchers created a large-scale study to evaluate the effectiveness of the program from grades 3 to 11 in two different evaluations, one following 210 schools for two years and another following 95 schools for three years.[49] Over the course of the study, occurrences of reported bullying behavior declined across all grades.

Another group of researchers performed a study on a program focused on cyberbullying. Media Heroes is a program in Germany that seeks to prevent cyberbullying by promoting empathy and knowledge about internet safety and legal consequences in a single-day session. A team of researchers analyzed Media Heroes to find if there were spillover effects on traditional bullying.[50]

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[42] Kessler et al. 2022; Modestino 2019
[43] LISC 2021
[44] D.C. DHS 2022
[45] See: https://marthastable.org/sfsf/
[46] Osgood et al. 2013; Losel and Farrington 2012; Gest et al. 2011
[47] Landry 2003
[48] Cullen et al. 2008
[49] Limber et al. 2018
[50] Chaux et al. 2016

The team evaluated 1,075 adolescents from ages 11-17 and randomly assigned some classrooms to use the intervention. Those who participated in the program saw a significant decline in cyberbullying behavior compared to the control group where researchers observed an increase in cyberbullying. In addition, those who participated in the longer sessions significantly decreased traditional bullying, while the other groups did not significantly change. Both the Olweus and Media Heroes programs are just two examples of how bullying prevention programs can help target risk factors and build pro-social behaviors.

In June 2013 the District created the Citywide Youth Bullying Prevention Program.[51] From the program website: "The program works with youth-serving government agencies, District schools and youth-serving government grantees to ensure bullying prevention policies are adopted and implemented in ways consistent with the best practices adopted by the Youth Bullying Prevention Task Force." While the COVID-19 pandemic disrupted in-school implementation of the Youth Bullying Prevention Act of 2012, reports of bullying fell as students pivoted to a remote learning status. Future status reports may provide more insight into the program's effectiveness.

School-Related Protective Factors

A youth's school and classroom environment affect school attendance and performance. Developing a positive school climate can serve as a strong protective factor, leading to more pro-social behaviors.[52] Programs like in-school career academies and vocational programs can help at-risk youth develop relationships and a sense of purpose, leading to a reduction in delinquency.[53]

Classroom Behavior Management Programs

The Good Behavior Game (GBG) is one example of a classroom behavior management program. GBG seeks to create a classroom environment that benefits all students by socializing children into their role as a student and teaches them to regulate their own behavior as well as their classmates' behavior, leading to reductions in aggressive and disruptive behaviors, as well as a reduction in the likelihood of substance abuse.[54] In the GBG, students are assigned groups, and if any member of the group violates established classroom rules the entire group received a demerit. At the end of the session, groups with the fewest demerits receive positive reinforcement, and less successful groups are encouraged to try again.[55]

By randomly assigning one of three kinds of intervention programs (including GBG) to classrooms within several schools, researchers found that youth who participated in GBG experienced a decreased likelihood of developing substance use disorders or exhibiting aggressive and disruptive behavior. These effects persisted in the study follow-up with the intervention exhibiting both immediate and long-term benefits.

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[51] DC OHR
[52] Gage et al. 2018; Logan-Greene et al. 2011
[53] Kemple 2004; Tolan et al. 2014
[54] Kellem et.al. 2008
[55] AIR 2022

Another example of the effectiveness of classroom behavior management tools comes from an evaluation of the Incredible Years (IY) classroom management program.[56] The IY program is based in the United Kingdom and aims to improve teacher-student relationships as well as develop children's social and problem-solving skills by implementing proactive teacher strategies intended to reduce behavioral issues and increase social skills.[57] The research team assigned six classrooms to use the IY program and another six classrooms to teach without it. The students who were in the classroom that utilized the IY program exhibited a significant reduction in classroom off-task behavior, a reduction in negative teacher behavior towards target children, and a reduction in negative child behavior toward teachers.

Afterschool Recreational Programs

Afterschool programs can be a beneficial way for at-risk youth to gain social skills and build better relationships with adults and peers and can help fill leisure time outside of school to reduce the potential for violent or illegal activities.

Fit2Lead is a Miami-Dade County, FL afterschool park program that exemplifies this. The program runs from September to June and provides academic support, recreational activities, and life skills through workshops and other resources. Researchers identified parks that offered the program while analyzing juvenile arrest rates in the same zip code.[58] They found that after two years of program implementation, juvenile arrest rates decreased significantly in zip codes that implemented the program. In zip codes that did not implement the program, juvenile arrests remained steady or increased.

Positive Youth Development (PYD) programs are another example of afterschool programs that can help youth gain important life and social skills and carry on those skills into adolescence and adulthood. Many PYD programs follow the outcome model of the Fives C's, which are Competence, Confidence, Connections, Character, and Caring. One such program is the Sport Hartford Boys Program in Hartford, CT. The program focused on creating situations for boys from minority communities to develop an understanding of themselves. Through sport and non-sport-related activities the youth complete psychosocial tasks including developing a sense of agency, industry, or personal identity. A research team interviewed eight boys and their parents, asking them why they became involved and why they continue to be a part of the program.[59] They found that participants initially became involved because the program focused on sports related activities and that their peers were involved in the program as well. However, the participants stated that the main reason they stayed involved was because the program kept them from getting involved in at-risk behaviors.

The DC Department of Parks and Recreation (DPR) provides a wide array of youth-focused programming. District-wide recreation centers provide youth with safe spaces for structured and unstructured after-school and summer activities.

[56] Hutchings et al. 2013
[57] See: https://incredibleyears.com
[58] D'Agostino 2019
[59] Fuller et al. 2013

Educational Factors

Engagement in a positive school environment is a protective factor for high-risk youth. The District has established several taskforces and legislative actions to encourage youth engagement with the education system.

The "Student Fair Access to School Amendment Act of 2018"

This amendment was enacted August 25, 2018, and established parameters for local education agencies (LEAs) to develop school climate and discipline policies to limit out-of-school suspensions, expulsions, and disciplinary unenrollment beginning SY19-20 for K-8 and SY20-21 for grades 9-12 (D.C, Law 22-157).[60] The purpose of the law was to limit out-of-school disciplinary practices in order to encourage the development of positive school climates and prevent student disengagement, which is a risk factor for juvenile justice system involvement. Some disciplinary alternatives include:

- *Restorative Justice* – emphasizes improving students' social and emotional development and provides alternatives to suspension and expulsion.
- *Conscious Discipline Brain State Model* – an evidence-based and trauma-informed approach to integrating social and emotional learning with classroom management to modify student and teacher behavior.

Community Protective Factors

Perhaps the broadest category of protective factors is community-based protective factors. These can include the physical environment, presence of social supports, access to economic opportunities, housing stability, and other factors. The links between a youth's neighborhood and their development are well documented.[61] Community expectations for youth, safety, and the presence of strong positive role models can all act as protective factors.

Community Involvement Programs

Community involvement programs are another way for youth who are at risk of becoming justice-system involved to gain social skills while providing alternatives to illegal activities. One such program is the Communities That Care (CTC) prevention system. CTC implementation in a community follows a five-step plan over a period of 12-18 months. This process involves identifying community issues, collecting data to analyze risk and protective factors, and working together to create measurable outcomes that the community can work to achieve. The goal is to create a community prevention board made up of public officials and community leaders who work to reduce risk factors and promote protective factors.

Researchers performed a longitudinal cluster-randomized trial involving 24 communities in seven states to identify the long-term impacts of the CTC prevention system as well as perform a benefit-cost analysis.[62] They analyzed the impact of the system from grade 5 to age 23 and found that substance use decreased by 15% and that CTC led to a 20% relative improvement in college completion.

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[60] D.C. Law 22-157

[61] Brooks-Gunn et al. 1993

[62] Kuklinski et al. (2021)

Community Environment

Community environment plays a key role in childhood development and can serve as either a risk factor or protective factor. Establishing safe, community-oriented neighborhoods can reduce the likelihood of juvenile justice system involvement. The following are some District-based programs and services that operate in the community environment.

Violence Interrupters

The Office of Neighborhood Safety and Engagement (ONSE) Violence Intervention and Prevention Program and the Office of the Attorney General's (OAG) "Cure the Streets" Violence Interruption Program use individuals with credibility within their communities to help diffuse potentially violent conflicts and support individuals at high-risk of being affected by violence. The new DC Peace Academy helps provide violence interrupters with personal and professional development through a 13-week course of evidence-based curriculum.[63]

Department of Parks and Recreation (DPR) Programs

The DC DPR operates parks and recreation centers throughout the District of Columbia. These facilities provide both structured programs and unstructured environments for youth to engage with their community and learn valuable social, emotional, and behavioral skills.

Mental and Behavioral Health Protective Factors

Unaddressed mental and behavioral health challenges are risk factors for juvenile justice system involvement. Young people and their families have access to a variety of services in the District of Columbia.

Becoming a Man (BAM)©

The BAM © program provides trauma-informed school-based counseling, mentoring, and character development for male students in 7th-12th grade.[64] The program seeks to, "deliver a comprehensive counseling, mentoring, and postsecondary readiness program that empowers young men in grades 9-12 with the tools and confidence they need for personal, academic, and career success," and has recently been rolled out in some DCPS schools.[65]

Healthy Futures Program

This program operates in 24 child development centers located throughout the District and offers child- and family-centered consultation services to care providers and family members. The program aims to build participants' skills and capacity to promote social emotional development, prevent escalation of challenging behaviors, and increase appropriate referrals for additional assessments and services.[66]

Child and Adolescent Mobile Psychiatric Service (ChAMPS)

[63] See: https://www.peacefordc.org/dc-peace-academy.
[64] See: https://www.youth-guidance.org/bam-becoming-a-man/
[65] Ibid.
[66] DBH 2014

The ChAMPS emergency response service is a free, 24-hour mobile emergency service for families and children experiencing an emotional or mental health crisis in the District.[67] Depending on the circumstances, clients may receive in-home services or out-of-home care and placement.

Juvenile Behavioral Diversion Program (JBDP)
The JBDP links court-involved youth under the age of 18 with appropriate community-based mental health services and supports. Eligible juvenile status offenders have an option to participate in mental health services instead of facing prosecution.

Overview of Programs

When debating program appropriateness and efficacy, meta-analyses can provide a concise overview and comparison of options. One such meta-analysis identifies studies with delinquency, juvenile offending, or recidivism as an outcome of interest; studies that involved at-risk youth; studies that focused on selective prevention programs; and studies with experimental or quasi-experimental design.

Researchers found that effectiveness is not necessarily determined by the type of program but rather what the program teaches. All the programs in the study had statistically significant effects with a mean reduction in delinquent behavior of 13%. However, behavior-oriented programs focusing on learning positive behavior through role models, preparing behavior contracts, improving parenting skills, and family-based programs yielded the largest effect, leading to a significant reduction in offending by 30%. They also found that individual, multimodal programs, as well as those carried out in the family context, proved to be more beneficial than group-based programs.

Youth crime prevention programs are an effective way to bring about protective factors while also reducing risk factors in youth who are at risk of becoming involved in the juvenile justice system. The literature shows that each of these types of programs effectively reduces risk factors and implements protective factors. Additionally, the literature identifies the limits of the studies and cautions care when considering what types of programs to implement. Behavioral based programs seem to have the strongest effect.

Future Opportunities to Evaluate District-Specific Protective Factors

A review of existing literature demonstrates the existence of effective evidence-based programs and interventions that can reduce the likelihood of juvenile justice system involvement. The District of Columbia currently operates many of these programs, but further systemic, regularized data collection and sharing will be necessary to fully evaluate the impact on at-risk youth in the District.

Establishing data collection best practices and building collaborative relationships between District agencies and local non-profit organizations who provide services will enable future analyses to identify the specific impacts of these protective factors.

[67] See: https://www.catholiccharitiesdc.org/ChAMPS/

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Appendix A: Administrative Data

Sample and Time Frame

To examine the statistical effect of the hypothesized explanatory factors on youth crime, we drew a representative sample of youth who were born between June 1, 2001, and June 1, 2008, and enrolled in 6 – 12th grade in District of Columbia public schools (DCPS) or public charter schools (PCS) in the 2018 – 2019 school year.

We limited our sample to youth born between June 1, 2001, and June 1, 2008, to ensure that all youth in the analysis were eligible for juvenile justice system involvement at some point between May 31, 2019, and July 31, 2020, meaning they were under 18 for at least one day and over 10.5 years old at the start of the period of observation. While it is legally possible for youth under 10 to be arrested and charged in the District, it is exceptionally rare in practice, and no youth under the age of 11 was arrested during the period of examination. The justice-involvement dates were selected to allow the explanatory factors to temporally precede juvenile justice system involvement.

Our sample is further limited to individuals enrolled in DCPS or PCS because it was drawn from enrollment census data provided by the Office of the State Superintendent (OSSE), which is the state education agency for the District of Columbia. Using OSSE enrollment information as the sampling frame excludes youth enrolled in private schools from being included in the sample. However, it is not possible to include youth who are enrolled in private schools in the sampling frame because while private schools report enrollment or individual-level education data to OSSE, there is no centralized information on attendance or disciplinary involvement. Additionally, there is no data on District residents who attend schools in Maryland or Virginia. OSSE's enrollment list is, therefore, the most exhaustive listing of school age youth. The census provided by OSSE contained 32,527 youth born between June 1, 2001 and June 1, 2008. Based on population estimates (DC Office of Planning)[68], this constituted an estimated 73% of youth between ages 10 – 17 as of July 1, 2019, thus approximately 12,000 youth are not included in the sampling frame. Approximately 4,200 youth are enrolled in DC private schools;[69] the rest of the youth may be enrolled in private schools outside of DC[70], enrolled in homeschooling or adult education (GED), or not enrolled in school despite DC's compulsory school attendance law.[71]

To ensure adequate inclusion of juveniles with juvenile justice system involvement, we supplemented the original OSSE frame with a list of youth arrested by MPD from June 1, 2019 – July 31, 2020. We then matched the arrested and/or petitioned youth to the OSSE sampling frame.

In total, 3.5% of youth in the sampling frame were justice-system involved. Because this constitutes such a small proportion of the population, we used a stratified random sampling method with oversampling for youth with juvenile justice system involvement and analytical post-stratification weights. We drew random samples from within each of two mutually exclusive stratum: (1) youth who did not become involved in the juvenile justice system (96.54%) and (2) youth who were arrested (3.46%). We drew a

[68] 44,323

[69] In SY19-20, according to OSSE, there were approximately 4,700 District residents in 6 – 12th grade enrolled in private schools in the District of Columbia, which comprises approximately 13% of youth.

[70] OSSE does not track the number of DC residents enrolled in private schools outside of the District of Columbia.

[71] 3 D.C. Code §§ 38-201 – 38-213.

sample of 7% of youth without juvenile justice system involvement (N=2210), and 70% of the stratum of youth with juvenile justice system involvement (N=771) for a total sample size of 2981.[72]

The weighted sample is representative with regard to race, gender, age, school grade, school sector with no statistically significant differences between the sampling frame proportions and the sample proportions at the .05-level.

Table A.1: One Sample T-Test of Sample Proportions Compared to Sampling Frame

	% DIFFERENCE	P-VALUE
RACE/ETHNICITY		
ASIAN	-0.005	0.826
BLACK	0.038	0.287
WHITE	-0.019	0.432
AMERICAN INDIAN	0.000	0.984
HAWAIIAN/PACIFIC ISLANDER	-0.001	0.972
TWO +	0.001	0.965
HISPANIC OR LATINO (ANY RACE)	-0.014	0.596
GENDER		
FEMALE	-0.043	0.256
*AGE**		
11	0.001	0.678
12	-0.032	0.332
13	-0.027	0.381
14	-0.008	0.740
15	0.015	0.571
16	0.027	0.379
17	0.034	0.312
18	-0.010	0.679
SCHOOL TYPE		
DCPS	0.034	0.312
PCSB	-0.033	0.319
*GRADE***		
6	-0.037	0.289
7	-0.016	0.525
8	0.004	0.869
9	0.045	0.245
10	0.011	0.662
11	0.004	0.866
12	-0.010	0.695

*** AGE AS OF 6/1/2019 ROUNDED TO THE NEAREST INTEGER**
**** GRADE IN SY2018-2019**

Data and Measurements

Dependent Variable

Juvenile Justice System Involvement. Juvenile justice system involvement is a binary variable (0/1) with 1 indicating that an individual was arrested or petitioned for one or more delinquent offense between

[72] Sample sizes selected for a 2.5% margin of error at a 95% confidence interval.

June 1, 2019 and July 31, 2020. This excludes youth who were diverted pre-arrest and youth who had interactions with police that did not result in arrest. A petition is a charging document filed by the state in juvenile court alleging that the juvenile is delinquent and describing the alleged offenses committed and is comparable to a charging document in adult criminal court.

Arrest or petitioning is a commonly used measure of whether an individual has committed a crime but has substantial recognized shortcomings. This measure captures whether an individual was, at some point, suspected of committing a crime and processed by the justice system. In fact, the individual may not have committed the crime for which they were arrested or petitioned. Additionally, this measure under-reports individuals who engage in delinquent behavior who do not come to the attention of the justice system or who are not processed.

Independent Variables

Data Process. In addition to the education data and criminal justice data provided by OSSE, MPD, and DCSC, we received identified data from the Department of Human Services (DHS), the Child and Family Services Agency (CFSA), and the Department of Health Care Finance (DHCF). Because we could not share identifying information on youth in the sample with DHS, CFSA, or DHCF due to the Family Educational Rights and Privacy Act (FERPA), these agencies provided us requested information on all youth born between January 1, 2001 and January 1, 2008. Specifically, CFSA provided us data on all youth born within that date range who had a Family Assessment or a substantiated or inconclusive finding after an Investigation. DHS provided us data on all youth born within that date range who received TANF benefits between May 31, 2018 and June 1, 2019. DHCF provided us beneficiary data on youth born within those dates who were Medicaid beneficiaries from June 1, 2012 to June 1, 2019 and claims data on youth born within those dates who had mental health or substance abuse diagnoses[73] or mental health or substance abuse treatment between June 1, 2012 and June 1, 2019. We then matched the DHS, CFSA, and DHCF data to the sampled youth based on first and last name and date of birth and deleted information on youth not included in the OSSE sample.

Demographics. Age, gender, and race were derived from OSSE enrollment data with age calculated from OSSE recorded date of birth.

Table A.2: Descriptive Statistics - Age

	MINIMUM	MEAN	MAXIMUM
AGE (ON MAY 31, 2019)	11.1	14.5	17.9

In SY2018-2019, OSSE collected two categories of gender: male and female. We coded males as “0” and females as “1.” There were seven categories of race and ethnicity: Asian, Black/African American (non-Hispanic), Hispanic/Latino of any race, Native American/Alaskan Native, Native Hawaiian/Pacific Islander, Two or more races, and White. For the purposes of this analysis we collapse, Asian, Native American/Alaskan Native, Native Hawaiian/Pacific Islander, and Two or more races into one category,

[73] ICD-9 codes 290 – 312, V40 and ICD-10-CM codes F06 – F99.

"Other." These categories combined account for less than 3% of the sample and contain numbers too small to report due to privacy concerns. Thus, four race/ethnicity categories are included in the analysis.

Table A.3: Descriptive Statistics – Gender and Race

	CODING	PERCENTAGE	SOURCE
GENDER			
FEMALE	0/1	47.3%	OSSE
MALE	0/1	52.7%	OSSE
RACE/ETHNICITY			
BLACK/AFRICAN AMERICAN (NON-HISPANIC)	0/1	74.6%	OSSE
HISPANIC/LATINO OF ANY RACE	0/1	15.9%	OSSE
WHITE (NON-HISPANIC)	0/1	6.6%	OSSE
OTHER (NON-HISPANIC)	0/1	2.9%	OSSE

Economic Resources

To identify youth in low-income households, we use two proxy measures: TANF recipiency and Medicaid eligibility. Using data provided by DHS, we identified youth in the sample who received TANF benefits between May 31, 2018 and June 1, 2019. We coded youth who received TANF benefits as "1" and youth who did not receive TANF benefits as "0." Because the income threshold for TANF is lower than other benefits like the Supplemental Nutritional Assistance Program (SNAP), this measure identifies the youth from the lowest income families in the year preceding potential criminal justice system involvement.

Medicaid eligibility is determined by identifying youth in the sample who had been income-eligible for Medicaid for a cumulative 365 days or more during SY2018-19 or the preceding five years. We code youth meeting this eligibility criteria as "1" and all other youth as "0." Under the program rules for Medicaid and the Children's Health Insurance Program (CHIP), youth beneficiaries must have incomes at or below 319% of the federal poverty line to qualify based on income. Thus, we can identify youth from households that were lower income for an extended period prior to the observation period.

While the Medicaid and TANF indicators help identify low-income youth, they likely under-identify youth in addition to other shortcomings. First, these measures only identify youth from families who apply for and receive government benefits. Second, there is substantial variation in the resources available for youth near the upper limit of 319% of FPL qualification and those whose families are below the FPL.

Homelessness is a 0/1 indicator of whether a youth was verified as homeless in accordance with the McKinney-Vento (MKV) Assistance Act in the 2018 – 2018 school year using data collected by OSSE as validated by the LEAs.

Table A.4: Descriptive Statistics – Economic Indicators

	CODING	PERCENTAGE	SOURCE
TANF	0/1	15.3%	DHS
MEDICAID ELIGIBLE FOR >365 DAYS	0/1	59.0%	DHCF
HOMELESSNESS	0/1	6.5%	OSSE

Childhood Maltreatment. CFSA provided childhood maltreatment information regarding reported histories of abuse, neglect, or out-of-home placement. As the public child welfare agency in DC, CFSA is responsible for receiving and investigating reports of known or suspected child abuse and neglect. Referrals received by CFSA go through a screening process to determine whether the reported concerns reach the threshold for a response. If the concerns meet the threshold, CFSA opens an investigation. If the concerns do not meet the threshold, CFSA "screens out" the referral.

Opened investigations are referred to either the Investigation Unit (CPS-I) or the Family Assessment Unit (CPS-FA). Investigations are referred to CPS-I when there is an immediate or present danger. CPS-FA receives referrals in matters where there are no immediate safety concerns. The three outcomes of investigations are "substantiated," "inconclusive," or "unfounded."

A finding of substantiated means that there was convincing proof of abuse or neglect. Inconclusive means that they could not prove or disprove the report, and unfounded means that the investigation showed that the report was untrue.[74]

CFSA provided us information on all investigation referrals that were inconclusive or substantiated, as well as all referrals for Family Assessments. Based on the recommendation of CFSA, because we are interested in childhood experiences, we included inconclusive investigation findings and Family Assessments, in addition to substantiated findings, as all are indicative that a youth has experienced some level of childhood maltreatment, even if there was not sufficient evidence to meet the legal threshold for substantiation. Because using system involvement as the threshold already under identifies maltreatment experiences, we opted for the more inclusive measure.

Based on this data, we created two binary variables: one for neglect and one for abuse. We used CFSA's categorization of allegations as abuse or neglect, which is consistent with federal reporting requirements. We coded youth "1" for neglect if the referral resulted in a substantiated, inconclusive, or family assessment for neglect, and "1" for abuse if the referral resulted in a substantiated, inconclusive, or family assessment for abuse.

In addition to abuse and neglect, we included a binary variable coded "1" if CFSA documented the outcome of any referral as the youth being removed from their home due to maltreatment and "0" if there was no report of removal.

Table A.5: Descriptive Statistics – Childhood Maltreatment

	CODING	PERCENTAGE	SOURCE
REMOVED	0/1	5.9%	CFSA
CHILDHOOD ABUSE	0/1	16.2%	CFSA
CHILDHOOD NEGLECT	0/1	25.5%	CFSA

Educational Experience. We included multiple variables to examine the impact of a youths' educational experience on criminal justice system involvement: attendance, discipline, special education eligibility, and grade-level retention.

We measured student attendance as a count of both excused and unexcused absences. Although both represent missed days of school, conceptually they reflect different levels of engagement. Excused

[74] CFSA 2010

absences are missed days for which a youth has a valid, documented reason, while unexcused absences are for undocumented or invalid reasons. To correct for outliers, we log-transformed these counts for use in our models.

We measured student discipline by counting the number of times a student was suspended as well as the number of days a youth was excluded from school for disciplinary reasons. Including both allows us to measure the individual impacts of both the number of incidents and the number of days of school missed. These variables were log-transformed for modelling purposes as well.

Table A.6: Descriptive Statistics – Educational Factors

	MINIMUM	MEAN	MAXIMUM	SOURCE
EXCUSED ABSENCES	0	6.5	109	OSSE
UNEXCUSED ABSENCES	0	16.0	170	OSSE
NUMBER OF SUSPENSIONS	0	0.4	14	OSSE
NUMBER OF DAYS EXCLUDED (IF SUSPENDED)	1	5.9	33	OSSE

We measured school performance through a binary grade retention variable. This indicates whether a youth had been grade retained in the previous school year and was in the same grade level in SY2018-19 as they were in SY2019-20. Grade retention indicates that a youth did not meet the minimum performance requirement necessary to advance. We use grade retention rather than test scores or GPA to measure performance because of variations in timing and school-specific standards and practices. In addition, grade retention allows us to identify youth who struggled the most academically. We coded this variable "1" if a youth was grade retained and "0" if promoted or not enrolled in a DC school in SY2019-2020 which may potentially under-identify the percent of students who were retained.

Table A.7: Descriptive Statistics – Grade Retention

	CODING	PERCENTAGE	SOURCE
GRADE RETAINED	0/1	13.2%	OSSE

Mental Health Diagnoses. DHCF provided Medicaid claims data for youth born in the date range of interest (January 1, 2001 through January 1, 2008) where there was a mental, behavioral, and neurodevelopmental disorder diagnosis or mental health or substance abuse treatment.[75] This claim-level data allows us to identify youth in the sample who received medical treatment for their diagnoses through Medicaid. Because this does not capture youth treated under private insurance or other non-Medicaid billing or youth with undiagnosed or treated conditions, the data likely underestimated the effects and prevalence of mental health and substance abuse disorders.

As with the previous iteration of this report, we included indicators for the following: internalizing disorders, externalizing disorders, internalizing-externalizing comorbidity, psychiatric disorders, specific learning disorders, and specific developmental motor disorders.

[75] ICD-10-CM category codes F06 – F99.

We based our disorder indicators on ICD-10-CM diagnoses categories and codes. Since the diagnosis data included both ICD-9 and ICD-10-CM codes we cross-walked the ICD-9 codes using the CDC's FY 2016 General Equivalence Mappings.

We included three dichotomous variables to measure whether youth have disorders in the internalizing and externalizing domains. We code youth as having internalizing-externalizing comorbidity "1" if they have both internalizing and externalizing disorders or Disruptive Mood Dysregulation Disorder (DMDD); "0" if else. We code youth as being internalizing-only "1" if they only have one or more internalizing disorder and no externalizing disorders. They are coded as externalizing-only "1" if they have one or more externalizing disorder and no internalizing disorders.

The internalizing domain represent disorders with prominent anxiety, depressive, and somatic symptoms.[76] We included the following diagnosis categories as internalizing disorders: major depressive disorders (F32 and F33), persistent and unspecified mood disorders (F34 and F39) with the exception of disruptive mood dysregulation disorder (F34.81) (DMDD), phobic and other anxiety disorders (F40 and F41), obsessive-compulsive disorder (F42), reaction to severe stress and adjustment disorders (F43), dissociative and conversion disorders (F44), somatoform disorders (F45), eating disorders (F50), emotional disorders with onset specific to childhood (F93), manic episode (F30), and bipolar disorder (F31). These general categories subsume the common stress-related disorders and mood disorders subcategories consistently found to be internalizing such as generalized anxiety disorder, somatic disorders, panic disorder, separation anxiety disorder, and dysthymia. Consistent with emerging research, the internalizing disorder indicators also includes post-traumatic stress disorder.

The externalizing domain represent disorders with prominent impulsive, disruptive conduct, and substance use symptoms. We included as externalizing disorders impulse disorders (F63), attention-deficit hyperactivity disorders (F90) (ADHD), conduct disorders (F91), and substance use disorders (F10 – F19). These general categories subsume the commonly found externalizing disorder subcategories including oppositional defiant disorder and intermittent explosive disorder. Consistent with Kimonis and Frick (2015), we also include ADHD as an externalizing disorder.[77]

Internalizing-externalizing comorbidity occurs when individuals have disorders in both the internalizing and externalizing domains. We therefore coded youth with both internalizing and externalizing disorders as comorbid. We also coded youth with DMDD as comorbid as DMDD is associated with both internalizing and externalizing disorders.

We also included a dichotomous variable to measure whether a youth has a psychotic disorder, which includes schizophrenia (F20), schizotypal disorders (F21), delusional disorders (F22), brief psychotic disorders (F23), shared psychotic disorders (F25), schizoaffective disorders (F25), and other and unspecified non-organic psychotic disorders (F28 and F29). We coded youth as a "1" if they had a psychotic disorder diagnosis and "0" otherwise.

We include two dichotomous variables to measure whether a youth as a specific developmental learning disorder (F81) or whether a youth has a specific developmental motor disorders (F82). Specific learning disorders include specific reading disorder (F81.0) and mathematics disorder (F81.2). Specific motor

[76] Achenbach et al. 2016
[77] Kimonis and Frick 2015

disorders include developmental coordination disorder, stereotypic movement disorder, and tic disorders. For each variable, we coded youth with the disorder "1" all others "0."

Individualized Education Program (IEP). We included a binary variable to measure whether a youth had an Individualized Education Program (IEP) in place during the SY2018-19. An IEP is a legal document that specifies special education accommodations for youth who qualify under the Individuals with Disabilities Education Improvement Act of 2004 (IDEA). Students can qualify for an IEP if they have mental, physical, behavioral, or emotional disabilities. Specifically, the IDEA defines a "child with a disability" as a child with "intellectual disabilities, hearing impairments (including deafness), speech or language impairments, visual impairments (including blindness), serious emotional disturbance …, orthopedic impairments, autism, traumatic brain injury, other health impairments, or specific learning disabilities." Our data do not distinguish between IEP reasons; for example, individuals with orthopedic impairments are indistinguishable from those with emotional disturbance.[78] We code all individuals with IEPs as "1" and all without IEPs "0."

Mental Health Diagnosis and IEP Interaction. Because IEPs are put into place to provide services to youth with legally defined disorders, including the disorders in this analysis, when they impair educational performance, we include interaction variables between IEP and each included diagnosis category to examine whether the effect of IEPs is conditioned on particular types of diagnoses. This allows us to begin disentangling the effect of IEPs in light of different mental health conditions.

Table A.8: Descriptive Statistics – Mental Health Diagnoses and IEP

	CODING	PERCENTAGE	SOURCE
INTERNALIZING ONLY	0/1	7.7%	DHCF
EXTERNALIZING ONLY	0/1	4.8%	DHCF
COMORBID	0/1	9.1%	DHCF
PSYCHOTIC DISORDER	0/1	3.6%	DHCF
SPECIFIC LEARNING DISORDER	0/1	9.5%	DHCF
SPECIFIC MOTOR DISORDER	0/1	3.2%	DHCF
IEP	0/1	25.4%	OSSE

Proximity to Crime. Based on a youth's residential address as obtained from OSSE records, we include a violent gun crime hot blocks variable. Previous analysis found that proximity to violent crime, in general, and property crime had no significant effect on youth criminal justice system involvement. We identified the 25 blocks with the most violent gun crime incidents and created a binary variable coded "1" if the youth's residence was on one of the blocks and "0" otherwise.

Table A.9: Descriptive Statistics – Proximity to Crime

	CODING	PERCENTAGE	SOURCE
RESIDENCE ON A HOT BLOCK	0/1	8.4%	MPD

[78] Updated language refers to this as "Emotional Disability." However, in this report we are using the language consistent with 2018-19 standards.

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Appendix B: Multivariate Models

Model Estimation

We use STATA 16 to estimate a multi-variate logistic regression model to identify the factors that are statistically associated with involvement in the juvenile justice system. Because our stratified sample included an oversample of youth with criminal justice system involvement, we use the 'svyset' function to assign probability weights and calculate a linear variance estimator. We then use the 'margins' function to calculate estimated average marginal effects and predicted probabilities.

Model Results

Table B.1 presents the results of the logistic model where the dependent variable is criminal justice system involvement – as measured by being arrested or petitioned for one or more delinquent offenses.

Table B.1: Logistic Regression Results

		COEFFICIENT	STANDARD ERROR
DEMOGRAPHICS	**Female**	**-1.355**	**.186**
	Black	**.618**	**.378**
	Hispanic	.255	.356
	Other	.075	.448
	Age	**5.350**	**1.183**
	Age-squared	**-.172**	**.039**
ECONOMIC RESOURCES	TANF	.339	.234
	Medicaid >=365 Days	.180	.412
	Homelessness	.499	.294
CHILDHOOD MALTREATMENT	**Removed from Home**	**.844**	**.307**
	Abuse	**.554**	**.225**
	Neglect	**.421**	**.204**
EDUCATIONAL EXPERIENCE	Excused Absences (log-transformed)	-.001	.088
	Unexcused Absences (log-transformed)	**.225**	**.072**
	Suspensions (log-transformed)	**.762**	**.206**
	Days Excluded (log-transformed)	.670	.199
	Grade Retained	**.929**	**.253**
MENTAL HEALTH DIAGNOSIS AND IEP STATUS	Internalizing Only	1.019	.827
	Externalizing Only	**1.742**	**.825**
	Comorbid	**.774**	**.824**
	Psychotic Disorder	.067	.976
	Specific Learning Disorder	.323	.501
	Specific Motor Disorder	3.223	.980
	IEP	.428	.274
INTERACTIONS	Internalizing*IEP	.970	.934
	Externalizing*IEP	.971	.952
	Comorbid*IEP	-.526	.659
	Psychotic Disorder*IEP	.575	.274
	Learning Disorder*IEP	-.267	.548
	Motor Disorder*IEP	-.348	1.074
PROXIMITY TO CRIME	Gun Violence Hot Block	.508	.266
CONSTANT		**-48.498**	**9.022**
	Number of Observations	2980	
	Prob>F	.000	

Testimony of Laura Furr
On “Safer Stronger Amendment Act”
To the Committee on Public Safety and Judiciary

Delivered June 27, 2023

Good afternoon. My name is Laura Furr, I am a resident of Ward 6. I am here in my personal capacity. I’ve served for more than four years as the Chair of the Mayor’s Juvenile Justice Advisory Group and have worked for 20 years with juvenile justice system partners and youth in the system both here and across the country. I am here to testify against this “Safer Stronger Amendment Act.”

This is a performative, political and paternalistic bill, and the Mayor’s office does not have evidence in favor of increasing detention for youth. There are in fact dozens of studies that show that detention *by itself* increases the risk youth will re-offend and re-offend more seriously when released. Caging youth makes us less safe.

The Criminal Justice Coordinating Council’s data analysis shows that our city is more likely to put a Black child in the juvenile system, separate from all other factors. Making cages the default for more youth brought into the system means making cages the default for more Black youth.

The bill also allows the court to use a young person’s potential risk to themselves as a reason to detain. I have a young person’s express permission to share her experiences being jailed “for her own protection” with you today.

A few years ago, when she was a teen, K. was arrested, charged, and detained at YSC for a status offense. Adults in the system and services who should have helped, instead targeted kids in detention and trapped K. in a spiral of sexual exploitation and trauma. It took K. multiple years to fight her way out of the sinkhole opened by that single detention.

In addition to actively harming youth like K., this bill misplaces accountability. Adults in power have failed to follow through on implementing reforms that should have strengthened our communities and services for youth and to adequately respond to the trauma and additional needs youth experienced during the pandemic. Those same leaders are now blaming youth for the impact of their failure to implement what works.

And it’s not for lack of knowing what works. For example, the Mayor’s Juvenlie Justice Advisory Group submitted a report to the Mayor over 3 years ago detailing evidence-based recommendations for a robust continuum of services in the community and removal of youth charged with status offenses from the courts. The Mayor’s office has done nothing to act on those recommendations.

I appreciate the opportunity to testify here today. But I am also angry that I and dozens of other dedicated Washingtonians have worked hard to provide advice and support to the Mayor's office as members of advisory groups only to be ignored. Follow the ample evidence of what works and the JJAG's recommendations; give our kids the healing and services they need in the community, don't just lock them away.

I appreciate your time and am happy to answer questions.

Testimony on "The Safer Stronger Amendment Act of 2023"

by

Lenwood O. Johnson

Good afternoon Chairwoman Pinto and others. I am Lenwood Johnson, a resident of Ward 8. I am also a member of CRAV (Concerned Residents Against Violence) and a supporter of the MAGA Movement--Make America Great Again movement.

Six things need to happen in this city, in order for D.C. society to bring violent crime under control.

First, the residents must start electing city councilors who are interested in protecting and providing for the law-abiding, hardworking residents of D.C. We residents must stop putting into office councilors who are soft on crime and who care only about protecting and preserving the well-being of the violent criminals that all of us are subjected to on a daily basis.

Second, D.C. needs to institute a death penalty. Anyone age 13 and older who commits murder can be considered for the death penalty.

Third, there needs to be a mandatory minimum sentence of three years for anyone age 13 and older who is convicted of using a firearm in the commission of a crime.

Fourth, all juveniles charged with a gun crime must be tried as adults.

Fifth, individuals who are sentenced while juveniles will have their sentences rolled over into "adult" incarceration so that they can serve a longer sentence, and

Sixth, the city council must pass a law providing for D.C. voters to elect our prosecutors and Superior Court judges.

Thank you, Chairwoman Pinto, for receiving my opinion.

June 27, 2023

Judiciary and Public Safety Committee Hearing

Council of the District of Columbia

John A. Wilson Building

1350 Pennsylvania Ave., NW

Washington, DC 20004

Subject: Official Testimony against the Proposed Safer Stronger Amendment Act of 2023

Dear: Judiciary and Public Safety Committee,

I, Leonard Eugene Bishop, Advisory Neighborhood Commission (ANC) Commissioner for Single Member District 7F08, submit this testimony to formally express my profound concerns regarding the proposed amendments to the Incarceration Reduction Amendment Act (IRAA), encapsulated in Bill B25-291, the Safer Stronger Amendment Act of 2023. This testimony seeks to underscore the imperative for a balanced and holistic approach to justice reform, emphasizing rehabilitation and community-based preventative measures over stringent punitive actions. Leveraging my extensive personal experiences, professional insights, and a deep understanding of the unique challenges and strengths of our community, I wish to convey that the proposed amendments, while ostensibly designed to bolster public safety, may inadvertently engender a cycle of recidivism and social exclusion, thereby undermining the very fabric of our community's social cohesion, trust, and collective prosperity. Instead, I advocate for a more comprehensive, equitable, and legally sound approach that recognizes the potential for transformation, fosters sustainable societal change, and truly aligns with our shared vision of a safer, stronger Washington, DC.

As a native of the 7th ward of Washington, DC, and currently serving as the ANC Commissioner for Single Member District 7F08, my life story is deeply intertwined with the narrative of our city's ongoing battle against crime, poverty, and systemic injustice. At 19, I found myself on the receiving end of a wrongful conviction and a harsh sentence that would see me spend my formative years within the confines of the criminal justice system. This experience, as painful and life-altering as it was, has provided me with an invaluable perspective on the profound implications of our criminal justice policies. Consequently, I can attest firsthand to the rippling effects these policies have, not only on those directly involved but also on our community as a whole. As a community leader, I urge the committee to reflect on the wider impact of these policies, taking into account the lives they touch and the futures they shape. Only through such meticulous consideration can we create a justice system that is equitable, humane, and truly serves the interest of our community.

The Incarceration Reduction Amendment Act (IRAA), as it currently stands, represents more than just a statutory provision - it symbolizes a commitment to empathy, understanding, and belief in the capacity for change. Specifically, its provision for sentence reductions for crimes committed under the age of 25 underscores a nuanced grasp of the dynamics of juvenile development and the potential for reform. This legislation acknowledges the reality that systemic adversities can lead young individuals into errors, yet those errors, committed during a stage of life when impulse often overrules judgment, should not irreversibly dictate the course of their existence. In my own journey, and for many others who once stood where I did, the IRAA has served as a beacon of hope, testifying that a youthful mistake does not have to culminate in a lifetime of lost potential. By holding this stance, the IRAA promotes justice that is not just punitive, but restorative - paving the way for personal growth, redemption, and ultimately, a second chance.

I request the Committee to meticulously assess the potential ramifications of Bill B25-291 on our community, particularly in the light of the chilling lessons from the 1994 Crime Bill. The latter legislation, with its rigorous punitive ethos, led to a sweeping and disproportionate incarceration of marginalized individuals, a scenario which reverberated powerfully, magnifying existing socio-economic challenges and creating new, systemic hurdles that we are still grappling with decades later. It is essential to remember that laws have long-term consequences that extend beyond immediate penal objectives, shaping community dynamics, influencing socio-economic structures, and impacting individual lives. Thus, it is our responsibility, as stewards of justice, to ensure that we are not repeating the mistakes of the past, but learning from them to form a more balanced, humane, and ultimately effective approach to criminal justice.

I acknowledge and respect Mayor Bowser's commitment to a safer, more secure DC. However, I firmly believe the proposed amendments to the IRAA represent a dangerous shift toward retrogressive policies that could undermine the very security we strive for. Introducing the nature of offence as a deciding factor for sentence reductions not only undermines the principle of rehabilitation - a cornerstone of a progressive justice system - but also inadvertently promotes a punitive, binary approach to justice. Further, mandating an admission of guilt through the acceptance of responsibility as a prerequisite for early release jeopardizes the possibility of justice for those potentially wrongfully convicted. This stipulation may lead to coerced false confessions, paradoxically heightening the risk of miscarriages of justice, a scenario which could erode public trust in our justice system. This unintended consequence underlines the imperative for careful, meticulous policy making that considers every angle of potential impact.

I urge the Committee to appreciate that an effective strategy for enhancing public safety should embrace a comprehensive approach, one that acknowledges the importance of proactive violence reduction initiatives. For true progress, such initiatives ought to incorporate all stakeholders in our diverse city. ANC Commissioners like myself are pivotal conduits between the District's administration and our communities, and our voices can provide valuable insights into grassroots realities. Inclusive dialogue can help sculpt policies that not only respond to crime but also address the root causes of it, such as socio-economic disparities and systemic injustice. The goal is not merely to react but to prevent, creating an environment where all residents feel secure, supported, and confident in the justice system's capacity for fairness and redemption.

It is crucial to understand the invaluable contribution of returning citizens in violence reduction, based on my own experiences and observations. The individuals who have been granted a second chance through the IRAA often transform their lives and contribute significantly to improving their communities. They embody the concept of rehabilitation, using their experiences to mentor, guide, and positively influence at risk youth. This capacity for positive change highlights the human potential that punitive policies risk overshadowing. Therefore, incorporating such individuals in community-based Violence Reduction Initiatives is not just a desirable option—it's a necessary one. We must leverage their lived experiences and newfound commitment to promote peace and discourage the cycle of crime within our communities. Their stories of redemption, backed by the IRAA, are a testament to the transformative power of empathy, understanding, and second chances.

Understanding the potential for impactful change by returning citizens, I strongly advocate for the implementation of a permanent Violence Reduction Program within the Department of Corrections (DOC), alongside more rehabilitative programs. Can be a powerful tool for violence prevention and rehabilitation. Residents of the DOC, especially returning citizens, possess unique insights gained from personal experiences that can be transformative. By harnessing these insights, they can play an active role in positively shaping the mindset of young first-time offenders, providing guidance, and leading efforts in conflict de-escalation. This would not only foster a more peaceful environment within the DOC but also ensure a sustainable peace outside the confines of carceral institutions. This proactive measure would maximize the rehabilitative impact of incarceration, reaffirm our commitment to restorative justice, and ultimately contribute to safer communities.

It is pertinent to mention here that public safety is not an isolated responsibility but a collective effort, inextricably linked to the participation and commitment of all community stakeholders. The effectiveness of any public safety strategy is predicated upon the integration of the valuable contributions from every community member, especially returning citizens and ANC Commissioners. It is their diverse perspectives, experiences, and active roles in the community that can truly bring about our shared vision of a safer, stronger DC. These contributions should not merely be acknowledged, but actively sought and integrated into our strategic planning. They are the vital threads that weave the social fabric of our community. Therefore, policies and amendments proposed must reflect this collective ethos, providing spaces for redemption, growth, and improvement for all community members. The success of a city lies not in punitive measures, but in nurturing a community that values each individual and their potential to contribute positively to the overall health and safety of our city.

As an ANC Commissioner and an individual with personal experience of incarceration, I bring a unique perspective to the discussion on criminal justice reform. It is through the integration of diverse insights that we can develop comprehensive, equitable, and compassionate policies. Thus, I implore this esteemed committee to carefully reconsider the proposed amendments to the Incarceration Reduction Amendment Act. These amendments deviate from our shared objective of creating a safe, inclusive, and thriving Washington, DC. Instead, let us focus on enacting measures that prioritize rehabilitation, second chances, and community reintegration, ensuring that our justice system reflects the values of fairness, redemption, and genuine rehabilitation.

As an alternative to the proposed amendments, I strongly advocate for an enhanced focus on violence reduction initiatives and the provision of comprehensive rehabilitative services for individuals incarcerated within our justice system. This approach embraces a paradigm shift towards a culture of reconciliation, restoration, and transformation, rather than perpetuating a cycle of punishment and social exclusion. It recognizes that public safety is an intricate and multifaceted construct influenced by various societal factors, demanding a holistic and inclusive response. By addressing the underlying determinants of crime and investing in evidence-based programs that promote healing, education, skill development, and community integration, we can foster long-term positive outcomes for individuals and society as a whole.

The proposed Safer Stronger Amendment Act of 2023 demands careful consideration of its long-term implications, as it extends beyond the realm of the incarcerated and the criminal justice system, permeating the very fabric of our communities. We must recognize that sustainable peace and social stability can only be achieved by fostering a culture that acknowledges the potential for personal growth, redemption, and reintegration. By providing individuals with meaningful opportunities for rehabilitation, education, and community engagement, we empower them to become productive, law-abiding citizens.

In conclusion, as the elected Commissioner representing Single Member District 7F08, I firmly believe in the power of second chances, acknowledging the capacity for personal growth and transformation in each individual, regardless of their past mistakes. It is with sincere hope that these concerns and recommendations find attentive ears during your deliberations on the proposed Safer Stronger Amendment Act of 2023. By fostering a compassionate and forward-thinking approach to criminal justice, we can forge a safer, stronger, and more equitable future for all residents of our beloved City.

I am confident that through thoughtful dialogue and considerate policy-making, we can construct a framework for public safety that serves the best interest of all residents of Washington, DC.

Thank you for your time and consideration.

Sincerely,

Leonard Eugene Bishop

Advisory Neighborhood Commission (ANC)

Commissioner for Single Member District 7F08

Washington, DC

GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF THE DEPUTY MAYOR FOR PUBLIC SAFETY AND JUSTICE

Public Hearing
on
B25-0291, the "Safer Stronger Amendment Act of 2023"

Testimony of
Lindsey Appiah
Deputy Mayor for Public Safety and Justice

Before the
Committee on the Judiciary and Public Safety
Council of the District of Columbia
The Honorable Brooke Pinto, Chairperson

June 27, 2023
12 PM
Room 500

Good afternoon, Chairperson Pinto, members, and staff of the Committee on the Judiciary and Public Safety, I am Lindsey Appiah, Deputy Mayor for Public Safety and Justice, and I am here to present the Executive testimony in support of B25-0291, the "Safer Stronger Amendment Act of 2023."

Councilmember Pinto, thank you for holding this hearing in a timeframe that demonstrates the urgency that the current state of public safety in our city demands. We are committed to partnering with you to reduce crime and advance policies that will help us to increase and enhance safety across the District.

I also want to acknowledge all the public witnesses who shared their perspectives in written testimony or by testifying at today's hearing. We recognize that there is no one solution to ending violence and that the diverse perspectives and opinions represented today are a credit to our city. While we may not perfectly agree on how to best increase safety, it is clear that we align in our collective desire to see our youth excel, families thrive, and communities in all eight Wards both be and feel safe.

Samya Gill, Kevin Mason and Demarcos Pickney, Arianna Davis, Robert Cunningham, Christy Bautista. These are the names of several beloved people who have been the victims of crime in our city this year. I begin my testimony by saying their names. By orienting us to the sober, urgent nature of the moment we find ourselves in. By remembering and uplifting them and the thousands of other Washingtonians who have unfortunately been victimized by crime. Their experiences are but some of the evidence that the status quo is not working.

Throughout the course of this year, Mayor Bowser has led us in conversations with a variety of stakeholders across our city to discuss public safety, and more specifically to ask the question of how we can partner to reduce crime and increase conditions by which everyone in our city can thrive. We have met with principals and school leaders, ANCs, criminal justice system partners, business leaders, community-based organizations, and residents in all eight wards. We have listened and learned and have asked everyone to be introspective about how we can work together and what must change. People have offered a host of ideas of how they can contribute to the safety

of our city, but they have also been clear that accountability for everyone, including those who do harm by committing crime, must be prioritized. We have heard a common refrain – people do not currently feel safe. And as those tasked with the most foundational responsibility of government – ensuring the safety of our residents and visitors – we must urgently respond to their legitimate fears.

Just as we've asked all partners to make changes, Mayor Bowser has tasked the whole of the Executive with critically evaluating the entirety of our public safety and justice ecosystem – which we believe consists of the whole of government – and making difficult but necessary adjustments to interventions that are not yielding the results that they must if we are to make safety gains. And now we come to you, the policy makers to ask for the same introspective, urgent action that so many across our city are putting forth to ensure that the hard-fought gains we have made over time in making our city safe and a place that people want to live, raise families, work, shop, visit are not reversed but instead we continue to move forward. Because the status quo is not working.

In the District, we are leaders in systemic reform; this is certainly true in the criminal justice space, where we lead in pushing the bounds of what is possible to achieve equal justice for all under the law. We can and should be proud of our progress. But we must not be so proud that we are unwilling to critically evaluate our reforms and adjust when unintended consequences are leading to harmful outcomes for those we serve. While we are a city that often leads the nation in instituting forward thinking reforms, we must never lose sight that we are first and foremost a local city and that our solutions must be tailored to the specific realities that we face.

While it is true that over time we have seen significant reductions in crime in our city through investments across our public safety and justice ecosystem, we are currently seeing unacceptable increases in crime - as of June 26, 2023, we have had 112 homicides, an increase of 8.7% as the same time as last year; we have 497 people shot this year, in 399 separate incidents, 358 incidents of robbery (up 35% over the last year) and 1,770 car thefts (up 112% from last year). We know these numbers are not just numbers, but are representative of real people – our families, friends, and neighbors – harmed in our city. These unacceptable crime increases are occurring amidst the

backdrop of significant decreases in MPD sworn staffing and despite historic and unmatched investments in violence intervention and prevention. It's time to pivot.

The Safer Stronger Amendment Act is a set of commonsense policy proposals aimed at providing additional tools across our system to combat crime, including against some of the most vulnerable in our city, increase systemic accountability and transparency, consider the community in critical criminal justice processes, and uplift the voices and experiences of victims across all parts of a case.

We recognize that there are those who are concerned that this set of policy proposals will not substantially reduce crime and will instead turn back the clock to the bygone era of tough on crime rhetoric and practices and mass incarceration. This is not the case. We are vehemently opposed to perpetuating those past policies which we know do not work. This is not about making a political statement but honestly evaluating the impacts of our current policies and making pragmatic, necessary adjustments where we are seeing harm and believe that change can reduce crime. Our position remains the same as it has always been throughout the Mayor's tenure – we are a second chance city that firmly believes in justice and equality for all, including respect for the constitutional rights of those accused of crime, that no person is the sum total of their worst decision, that positive life change is possible and we are here to provide support and opportunity to those who wish to take a different path, that restorative justice is the correct model but that accountability is a critical part of restoration. We also believe that as leaders, we have a duty and responsibility to do everything in our power to protect our communities from those who choose to engage in repeated violent offenses.

I now turn to briefly discuss some specific parts of the proposed legislation. First, Mayor Bowser has advanced two proposals related to pretrial detention – one aimed at adults and another at youth. For adults, we propose adding one additional category of consideration for pretrial detention to the current rebuttable presumption statute for those defendants arrested for a crime of violence who have previously been convicted of a violent crime. We recognize that everyone is innocent until proven guilty and that in general, District law presumes that arrestees should be released pending trial. The proposal does not mandate automatic detention but rather provides the Court with

additional discretion to consider whether detention is appropriate for those allegedly engaged in repeated violent offenses. We have faith in the judgment of the Court to decide the risk to the public based upon the evidence presented.

For juveniles, we propose removing the requirement that a youth possess a firearm in order for the Court to determine if secure detention is appropriate for youth who commit a crime of violence or dangerous crime. We also propose restoring the ability of the Court to consider whether youth charged with a crime of violence or dangerous crime are themselves at significant risk of harm such that detention is appropriate. As adults, we have a responsibility to keep young people safe. The existence of a juvenile justice system is an acknowledgment of the inherent difference in young people when compared with adults and we must consider how to safeguard and provide for the mental, emotional, and physical needs of youth, including those charged with serious crimes.

To date there have been 65 juveniles shot in the District, compared with 32 youth at this same time last year and 22 in 2021. These massive increases are not acceptable. Retaliatory violence amongst our youth is driving harm to both them and others and we must act. We must ask ourselves, "What does love look like in policy when it comes to protecting children?" Creating necessary boundaries is loving. We do not want young people to be in secure detention, and we are working to find ways in a challenging system to identify and provide rehabilitative services and supports to more at-risk youth over whom the Executive has no legal nexus. But we cannot fail to act on our current reality in which our youth are being shot and killed. We cannot provide them with the services they need if they are not alive, and no group is at higher risk of harm than those engaging in the most risky and dangerous criminal activity. We must do everything we can to ensure that our youth live and that includes giving Courts the ability to consider risks mitigating against their safety and the corresponding safety of the public as a result.

Additionally, we have proposed several new offenses and penalty enhancements, including for gun offenses, strangulation, crimes against vulnerable populations, and those committed against those in safe spaces, like on transit and in our recreation facilities. There are far too many illegal guns and those willing to use them. There is an unacceptable increase in violence in safe spaces – on Metro trains and buses, in DPR recreation centers, and during rideshares. Domestic violence has

also increased significantly in the past few years since the pandemic. We must act to have tools in our system to address these realities.

We often hear that it is not lengthy sentences that reduce crime but rather surety of consequence. We agree and are not proposing lengthy sentences. Instead, we are proposing appropriate sentences considering the serious nature of the offenses and providing prosecutors with tools to help bolster surety. For example, we are proposing stronger penalties for some of the most dangerous guns: ghost guns, machine guns, and sawed-off shotguns, as well as tools to deal with trafficking firearms. The impact of these weapons is immeasurable in our city. Last week, I visited the Department of Forensic Sciences where I saw the bullet-riddled car from the incident in which two people used automatic weapons during the middle of the day to take the life of pregnant Samya Gill. Her life, and all the lives of the victims of crime in the District, are invaluable, and it is our duty to ensure that those who would use weapons in our city are held accountable.

And so, I end where I began – with a focus on those impacted by crime in our city. Percents and numbers provide critical context; however, we can never lose sight that each statistic on a website or read during a hearing is more than a number. It's someone's son, daughter, sister, brother, mother, best friend, or neighbor. The reality is there are no victimless crimes. We recognize the harm and trauma so many have experienced. We acknowledge our responsibility to respond soberly and urgently. We vow to work together to move forward this legislation and other proposals that will help to make our city safe, stronger, and a place of collective flourishing.

Thank you for this opportunity and I appreciate Interim Chief of Police Ashan Benedict for joining me to answer questions about the subtitles of Mayor Bowser's proposed legislation.

Supplemental Written Testimony

Title I: Sentencing Commission Representation. Currently, the Commission is heavily slanted toward the federal agencies – yet another instance of the District's voice being lost in these debates. Of 12 voting positions, only three represent District voters, while six are appointed by the Court alone. As the Commission makes critical decisions about the range of sentences for individuals

convicted of crimes, it is important that its membership reflects the interests of District residents. This provision increases the number of District residents on the commission from two to four and includes the Chief of Police (who is also required to be a District resident). Simply put, more local representation will result in recommendations that robustly reflect District values, with consideration of the impact on District residents informed by District residents.

Title II: Safe Schools and Safe Students: This title enhances protection for youth in the District in two primary ways. First, Subtitle A expands protections for students in the District by including consultants and contractors as individuals determined to have a "significant relationship" to the student, which is a requirement in the law for the USAO to bring charges of sexual abuse against a minor. This would close a gap that would cover thousands of contractors and consultants who have access to students as schools. This provision is about protecting children, and enabling the criminal justice ecosystem to go after perpetrators that harm our children will result in more accountability for those who operate in and around schools.

Next, Subtitle B would give a judge the ability to detain a child if the judge determined detention could protect the child from any kind of harm to themselves, or from the community. Additionally, it shifts the rebuttable presumption to detention of a child, if the judge finds by substantial probability the child committed a dangerous crime or crime of violence. This subtitle removes the requirement that the child was armed while committing the crime of violence or dangerous crime and removes exceptions to use detention in the cases of felony drug possession or distribution, burglary, and prostitution.

Subtitle B is a proposed solution for the retaliatory violence we are seeing committed by youth, often fueled by social media disputes. No one wants to lock up kids, but we need to connect these kids, whose support systems like parents, grandparents, and church, have collapsed during the pandemic, to the services they so desperately need. And they need to be safe and alive so we can do that. They have fallen through the cracks and are being connected to multiple dangerous crimes and crimes of violence.

Title III: Illegal Discharge of Firearm and Ammunition Penalties: Addressing violence in DC means we need to address illegal guns, and the fact that people using illegal guns are creating havoc in our neighborhoods. Fatal shootings, this year-to-date, have increased by 12 percent when compared to 2022 and increased by 38 percent when compared to 2021. The total number of gunshot wound victims, across all offenses, has increased 20 percent versus 2022 and increased 32 percent since 2021.

This legislation helps in a few ways. One, it creates stronger penalties for some of the most dangerous guns: ghost guns, machine guns, and sawed-off shotguns. Last year, 17% of guns recovered were untraceable, privately made guns, or ghost guns. The number of guns recovered with Glock switches, which converts them to fully automatic weapons, went from 66 in 2021, to 127 in 2022, nearly doubling. Furthermore, we need better tools for the criminal justice ecosystem to go after gun traffickers. This title creates penalties to address possession of stolen guns or guns in which the serial number was obliterated, removed, or altered – scenarios which are hallmarks of gun trafficking, and enable prosecutors to bring charges in the Superior Court instead of the District Court, which increases the chances the case goes to trial.

Title IV: Penalty Enhancements: This title enhances penalties for violent crimes that victimize or target vulnerable residents with physical or mental impairments, as well as expanded protections for transit and for-hire vehicle employees, transit passengers, and people at recreation centers**.** The Executive will not tolerate crime that impacts our residents' livelihoods, like their ability to move about the city, to take care of their families, to go to school, or to work.

Title V & VI: Rebuttable Presumption, GPS Data for Prosecution, GPS data for persons under supervision: These titles can be easier explained together. Title V would create a rebuttable presumption that someone is dangerous if someone has previously committed a crime of violence,[1]

[1] DC Official Code § 23-1334(3): The term "dangerous crime" means: Any felony offense under Chapter 45 of Title 22 (Weapons) or Unit A of Chapter 25 of Title 7 (Firearms Control); Any felony offense under Chapter 27 of Title 22 (Prostitution, Pandering); Any felony offense under Unit A of Chapter 9 of Title 48 (Controlled Substances); Arson or attempted arson of any premises adaptable for overnight accommodation of persons or for carrying on business;
Burglary or attempted burglary; Cruelty to children; Robbery or attempted robbery; Sexual abuse in the first degree, or assault with intent to commit first degree sexual abuse; Any felony offense established by the Prohibition Against Human Trafficking

and they are being charged again for crime of violence. The defendant would need to demonstrate to the judge why they should be released to the community pending trial. Currently, there are a few scenarios in the law where there is a presumption that someone is dangerous and cannot be released because any condition of release would endanger the community.[2] But right now, being convicted of a crime of violence, and being charged for another crime of violence does not trigger this rebuttable presumption of detainment. The Executive believes this is a gap, and if closed, would have an immediate impact on community and resident safety by giving judges the discretion to detain individuals who are likely to endanger the community even while they are pending trial. Title V and VI would also empower MPD to utilize GPS data from a device an individual is required to wear, in any criminal trials, or as a condition of release. This would close information gaps for MPD and allow for better coordination amongst our criminal justice ecosystem partners to monitor persons of interest to the Court.

Title VII: Strangulation: This title is an unacceptable gap in current law that needs to be amended, and frankly, should have been passed into law when the Mayor first introduced it in

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Amendment Act of 2010 [D.C. Law 18-239; § 22-1831 et seq.] or any conspiracy to commit such an offense; or Fleeing from an officer in a motor vehicle (felony).
DC Official Code § 23-1331(4) The term "crime of violence" means aggravated assault; act of terrorism; arson; assault on a police officer (felony); assault with a dangerous weapon; assault with intent to kill, commit first degree sexual abuse, commit second degree sexual abuse, or commit child sexual abuse; assault with significant bodily injury; assault with intent to commit any other offense; burglary; carjacking; armed carjacking; child sexual abuse; cruelty to children in the first degree; extortion or blackmail accompanied by threats of violence; gang recruitment, participation, or retention by the use or threatened use of force, coercion, or intimidation; kidnapping; malicious disfigurement; manslaughter; manufacture or possession of a weapon of mass destruction; mayhem; murder; robbery; sexual abuse in the first, second, or third degrees; use, dissemination, or detonation of a weapon of mass destruction; or an attempt, solicitation, or conspiracy to commit any of the foregoing offenses.

[2] Other rebuttable presumptions in DC Official Code § 23-1322: No condition of release will reasonably assure the safety of any other person and the community if probable cause that the person:

1. Committed a dangerous crime or a crime of violence while armed with a pistol., firearm, imitation firearm, or other deadly or dangerous weapon;
2. Threatened, injured, intimidated a LEO, officer of the court, prospective witness;
3. Committed a dangerous crime or a crime of violence and has previously been convicted of a dangerous crime or crime of violence while on release pending trial;
4. Committed a dangerous crime or a crime of violence while on release pending trial;
5. Committed 2 or more dangerous crimes or crimes of violence in separate incidents that are joined in the case before a judge;
6. Committed a robbery in which the victim sustained aa physical injury;
7. Violated CPWL, possession of a firearm during the commission of a crime of violence or dangerous crime; unlawful possession of a firearm; or

Violated gun offender registry while on probation, supervised release for committing a dangerous crime or crime of violence and while armed with or having available a firearm or other dangerous weapon.

Council Period 23[3] and 24.[4] Strangulation is charged as a felony criminal offense in all 50 states.[5] This legislation is critical because strangulation is among the most lethal forms of domestic violence. In addition, it is one of the most common. Of women at high risk, according to the Family Justice Center Alliance, between 68-80% will experience near-fatal strangulation by their partner. One of the complicated factors of strangulation is that oftentimes, even in fatal cases, there may be no external signs of injury, making these cases even harder to prove. This legislation will be another tool that responding officers can use to intervene when responding to calls and prosecutors can use to get convictions for longer sentences. We hope this necessary change will mean better case results for domestic violence survivors.

Title VIII: Private Security Camera Incentive Program: The Private Security Camera Incentive Program, administered by the Office of Victim Services and Justice Grants (OVSJG), encourages residents, businesses, non-profits, and religious institutions to install security camera systems on their property and register them with MPD. This program is intended to help deter crime and assist law enforcement with investigations. This title would allow OVSJG to make changes to the program through rulemaking, instead of the legislative process, which is much longer, and requires congressional approval. If enacted, OVSJG would be able to update the prices of rebates and vouchers to better reflect the market prices of cameras and give residents the ability to choose from a wider selection of cameras that better suit their public safety needs. Additionally, as OVSJG thinks through potential expansions of the program to other types of cameras, rulemaking would allow for faster implementation of new programming, while still providing feedback and community participation through the comment period.

Title IX: Criminal Justice Coordinating Council: In 2001, the Statistical Analysis Center for the District of Columbia (DC SAC) was established by a Mayoral Executive Order to provide a division dedicated to the collection, analysis, and dissemination of criminal justice system information. The DC SAC was originally a unit of the Office of Research, Analysis, and Evaluation under DMPSJ. In March 2006, a transfer occurred that organizationally realigned the DC SAC to

[3] B23-607, January 9, 2020.
[4] B24-116, February 26, 2021.
[5] https://www.familyjusticecenter.org/resources/strangulation-intimate-partner-violence-fact-sheet/

be housed as a unit within the Criminal Justice Coordinating Council (CJCC),[6] an independent District agency. The CJCC's mission is to serve as the forum for identifying and addressing juvenile and criminal justice issues while working collectively with all components of the District of Columbia's criminal justice system. The DC SAC, as the research arm of the CJCC, provides the data, research and analytical support needed by the CJCC to inform their activities and support decisions. The DC SAC also provides statistical information and technical support to District agencies. The changes to this title are designed to leverage the unique position of the CJCC to help residents navigate the reality that the criminal justice system of the District is a complicated, interwoven minefield of jurisdiction, programming, and authority. It is complicated for government officials to navigate and nearly impossible for residents to access the information they need in a centralized location. With this thought in mind, the Mayor wanted an empowered, centralized authority, one that would have access to information on programming and outcomes for all the major actors in the District's criminal justice ecosystem and would be able to compile a centralized report for this information. District agencies are a piece of the puzzle, and full transparency is needed to determine what is working and what is not.

Title X: DNA Sample Collection: Based on RAINN survey (2020) of states: 31 states and the federal government collect DNA either at arrest or at a probable cause hearing and then enter the information into the Combined DNA Index System (CODIS). This bill would limit the collection to those charged with the most serious sexual assaults because sexual violence too often escalates, and they are difficult crimes to get a conviction. When a survivor has taken the very difficult step of reporting a sexual assault, we need to be doing all we can do to try to solve it. By identifying the true perpetrator quickly, DNA identification will help law enforcement focus their investigations—saving time, manpower, money, and lives. The process is simple and no more invasive than fingerprinting or photographing arrestees. Fingerprints aren't always intact or present. The chances of finding material with DNA is far greater. Along with Maryland and Virginia, the District should pass this title to enhance protections for rape survivors and help prevent serial rapists from remaining free to terrorize our community.

[6] DC Code 22-4233

Title XI: Incarceration Reduction Amendment Act: The title will allow or require judges to consider important factors before deciding whether to grant the petition for early release, such as the nature of the crime, whether it was brutal or cold-blooded, and whether the defendant shows remorse, which a crucial part of accountability and rehabilitation.

It is crucial that the statute expressly requires the court to consider the nature of the offense. The only reason that a defendant is incarcerated at all is because of the "nature of the offense" that the defendant committed. It is only the most serious violent crimes in the District that would have received sentences of more than 15 years – murder, violent sexual assaults, or other violent crimes such as assault with intent to kill while armed and kidnapping while armed – and may involve either single victims or multiple victims. Although other factors such as a defendant's rehabilitation, remorse, and maturity are important factors that a court should consider, a second look takes place in a vacuum if the nature of the offense is not considered. Additionally, remorse is a crucial part of accountability, growth, rehabilitation, and maturity. The court should be directed to consider whether a defendant has accepted responsibility for their actions that harmed another person because remorse is an essential component of whether the defendant has been rehabilitated and is fit to reenter society. The IRAA statute provides that a court shall consider a victim impact statement from a victim or a victim's family member provided pursuant to D.C. Official Code § 23-1904. That section of the Code also allows a "representative of a community affected by the crime of which the defendant has been convicted" to submit a statement prior to imposition of sentence. This title clarifies that the IRAA also includes consideration of **any community impact statement** submitted, which ensures that voices of victims *and* the community receive proper consideration, as well as the opinion of the USAO. Why does this title matter?

In 1992, Kristen Hubbard (18-year-old student at the time) and a close friend parked near a nightclub in Southeast. As she got out of the car, she noticed someone pointing a gun in the passenger side window at her friend's face and felt an object pressed into her own head. Two teenagers took her and her friend hostage at gunpoint, repeatedly beating and sexually assaulting the women overnight at a Maryland motel. These women were forced to dig graves for themselves but were ultimately released. Joshua Haggins, 16 at the time of the attacks, pleaded guilty to several crimes, including armed rape and armed kidnapping, and was sentenced to 34 years to life in the

District and 30 years in a separate case in MD. This year, the Superior Court heard arguments on whether Mr. Haggins deserved to be released early under IRAA. (The case has since been reassigned to a new judge because the first judge was visibly disturbed during the proceeding.) The survivor, Ms. Hubbard opposed the possible release, stating "it is not fair at all that we have to be here, all these years later, reliving that nightmare because he now says he's a changed person. The young women that we would have been is gone, where is our resentencing? Who will speak for us?"[7]

[7] https://www.washingtonpost.com/dc-md-va/2023/02/02/rapist-sentence-reduction-dc-judge/

The Committee on the Judiciary and Public Safety
Councilmember Brooke Pinto,
B25-291 Safer Stronger Amendment Act of 2023
Public Hearing
Tuesday, June 27, from 12 p.m. – 6 p.m.

Good afternoon, Councilwoman Brooke Pinto and Members of the Committee on the Judiciary and Public Safety. My name is Loughton B. Sargeant, Executive Director of DC Caribbean Carnival, Inc., a current Business at 1212 Emerson Street NW, Washington, DC 20011 in Ward 4. Telephone number 3013469635.

I'm submitting my writing testimony in support of bill **B25-291 Safer Stronger Amendment Act of 2023**

There is nothing more important than the safety of every DC resident and Mayor Muriel Bowser has set clear priorities for reducing crime, gun violence, and juvenile crime. This means ensuring all residents are safe, victims of violent crime experience justice, and those that harm our community are held accountable.

· I believe in second chances in our city, I also believe in accountability.

· In May, Mayor Bowser introduced The Safer Stronger Amendment Act of 2023 to address gaps in the District's public safety and justice ecosystem that are necessary to build a safer, stronger DC.

· Everyone in our community must take a critical look at the things we are doing and ask what we can do differently for improved outcomes in crime reduction. · We know there is no one solution to ending violence; public safety is a community-wide effort.

· The Metropolitan Police Department (MPD) maintains its lowest sworn staffing numbers is more than 50 years with approximately 3,335 officers. Mayor Bowser's Safer Stronger Amendment Act of 2023 is commonsense legislation that will:

· Enhance penalties for violent crimes that victimize or target vulnerable residents with physical or mental impairments as well as expanded protections for transit and for-hire vehicle employees, transit passengers, and people at rec centers.

. · Increase penalties for illegal gun possession. DC Current Proposed

- Make strangulation a type of felony assault (strangulation is a key indicator that domestic violence will become deadly). o According to the United States Attorney's Office, every state in the country already has provisions to support prosecuting strangulation as a felony.
- Strengthen provisions that allow individuals to petition for early release to ensure the voices of victims and community receive proper consideration.
- Provide greater discretion for the Courts to determine who should be held pre-trial, including defendants previously convicted of a violent crime while they Tuesday, June 27, 2023
- Good afternoon, Councilwoman Brooke Pinawait trial for a new violent crime.
- Increase the reimbursement for the District's popular Private Security Camera System Incentive Program which strengthens public safety by increasing the network of cameras available to assist MPD in solving crimes and closing cases. o Videos are extremely helpful in closing or identifying leads for crimes. In one analysis of homicides, MPD found that video footage, when available, helped to advance the investigation in 71% of the cases, and helped to close it in 36% of the cases.
- Require the Criminal Justice Coordinating Council to report more data on process and outcomes.
- Collect DNA earlier in the process for First Degree sexual offenses after the probable cause hearing.
- Require supervisory agencies to provide MPD with location and identification data collected from any detection device necessary in conducting a criminal law enforcement investigation.
- Expand the District's representation on the DC Sentencing Commission.

Thank-you for your time Councilwoman Pinto.

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Council of the District of Columbia
Committee on the Judiciary and Public Safety
Brooke Pinto, Chair
Testimony of Luis Villafane
Public Hearing
The Safer Stronger Amendment Act of 2023
Tuesday, June 27, 2023
Room 500
Wilson Building 1350 Pennsylvania Ave NW Washington DC

Good afternoon Chairwoman Pinto and members of the Committee,

Thank you for this opportunity to testify. My name is Luis Villafane and I am a recipient of the Incarceration Reduction Amendment Act. I am a member of Free Minds Book Club & Writing Workshop, which builds community to foster personal development and systems change for justice-involved youth and adults through the literary arts, workforce development, trauma healing, peace-building, and member-led advocacy.

Ladies and gentlemen, quite frankly, without IRAA and its amendments, I would not be here today. I would still be in federal prison serving another 9 years on a 30-year sentence I received when I was 19 years old. My life would be on a completely different trajectory. Getting out at the age of 39 versus 48 allowed me to plan and achieve so many different things that would be denied to me had IRAA not been enacted. I have been home for approximately 6 months and in that time, I have secured not one, but two jobs. I have acquired for the first time in my life, my own one-bedroom apartment with the help of several non-profit organizations including Who Speaks For Me? and Voices For a Second Chance, not to mention the great people at Free Minds. I have gathered all of my vital documents, including an original copy of my birth certificate from Puerto Rico, and my learner's permit. I have embarked on my educational journey, complete with setbacks and restarts. My legal team at PDS did an amazing job of getting me home, but that was only the first step in a long process. They are still hard at work, trying to get many more people like me home, so they can have their chance at success. Some of us will fail. We will fall short of the tremendous dreams and aspirations we have for ourselves and our lives. Don't hold that against us.

Please, give us the opportunity to try, and you will be amazed at the things we can achieve when given the chance. Thank you.

2023 City Council Statements

I am a young professional living and working in DC. I use public transportation for my daily commute and to navigate the city on the weekends. There is not just a perception that the DC public transportations systems are unsafe. I know from personal experience that it is. Here are four recent incidences that have that have made me concerned for my safety and wellbeing.

Spring 2023 7:30 PM Noma Metro Station

- Passenger started to seize and collapsed on the floor of the train. I called 911 for assistance. Teenage kids approached the man collapse on the floor of the metro after a few minutes and began to kick him.

Fall 2022 8 AM 14th & U St Bus

- Shortly after I boarded the bus, a woman came running on board, yelling in gibberish and started to strike me in the head from behind repeatedly. I slowly turned around, she spat in my face. Only after these things happened did the bus driver make her leave the bus.

Spring 2023 – In transit on 90 bus

- The bus was silent in the morning commute. Suddenly, a woman yelled "Ma'am are you okay?" I turned around to see what was wrong and if someone needed help. I made eye contact with the same woman. The rest of the ride, she kept yelling that she would "come up there and kill me" and several other profanities.

Fall 2017 – Gallery Place

- Morning commute again. I boarded the metro at Gallery Place with a police officer. We were immediately hit with a strong odor. There was one other person in the car. This gentleman was naked aside from a loosely tied fuzzy bath robe and shower cap. The police officer stepped out of the car and the doors closed, leaving me alone in the car with this man. His skin had deep open sores and he was intensely scrubbing his open wounds with a bath loofa. I got off the train at next stop.

sahiyo
United Against Female Genital Cutting

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United States
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Council of the District of Columbia
Councilmember Brooke Pinto, Chairwoman
Committee on the Judiciary & Public Safety
1350 Pennsylvania Avenue, N.W.,
Washington, D.C. 20004

June 27, 2023

Dear Chairwoman Pinto,

Thank you for reading my enclosed written testimony regarding the occurrence of female genital cutting (FGC) in the United States. I have been working on gender violence issues, including the topic of FGC for over a decade and I have completed extensive research on female genital mutilation/cutting or FGM/C or FGC. I have also provided cultural competency to frontline professionals who come in contact with women who have undergone it. And in 2015, I co-founded an organization, Sahiyo, to use storytelling methods to elevate the conversation that FGM/C happens in the U.S. and globally.

One of Sahiyo's projects called Voices to End FGM/C, is a digital storytelling project involving collecting stories from those impacted by this harmful practice. This project has been occurring since 2018 and to date, we have over 60 videos, including from survivors in the U.S. This project seeks to bring survivors together to share their stories of undergoing FGC in order to heal, feel less alone, and to create digital stories that will allow the world to know this is a global issue affecting those in over 92 countries.

There is a misconception that FGC ONLY affects immigrant communities, however, our Voices project highlights FGC occurring to American-born individuals, including myself. I was born in the United States and on a family trip to India, was taken to have FGC performed on me. A few years later, family and friends of mine went through FGC, here on U.S. soil. If you have heard of the 2017 Michigan case involving FGC - all the girls involved in that case come from the same religious, ethnic, community that I grew up in, and they too underwent FGC here in the United States.

FGC does not discriminate, it can occur to girls of all different backgrounds, socioeconomic statuses, educational levels, citizenship statuses.

The fact is FGC is NOT a new occurrence in the United States, but somehow the continuation of FGC amongst American communities is relatively unknown. Up until the 1960s, clitoridectomy,

a form of FGC was a practice recommended in medical books to treat women who had undergone “hysteria” or “mental illness” or to treat “lesbianism.” A few years ago, one woman, who attended one of Sahiyo’s Voices to End FGM/C workshops, shared her story of being a survivor who came from a white, mid-west background and in the 1950s underwent FGC at 3 to stop masturbation. Since sharing her story, other women, from similar backgrounds and much younger than her have also shared their stories of undergoing FGC here in teh U.S. with our Voices project.

The Center for Disease and Control has estimated that half a million women and girls in the U.S. have undergone or at risk of undergoing FGC. Yet, when you consider how these numbers have been calculated, you’ll see that myself, the girls in Michigan, the women I mentioned who took part in my Voices workshop are actually not included in the number of those who have been affected by FGC. Only women with backgrounds coming from 32 countries mostly from one region in the world - Africa are included. This means, that this number of half a million women and girls in the U.S. who have undergone FGC is most likely much higher.

When I underwent FGC, there was no federal law in place banning the practice. That law would not pass until 1996. The federal law was contested after a U.S. District Judge struck down the 1996 federal law on technical grounds, and though a new Federal bill was signed into law in January 2021. When the U.S. District Judge contested the original 1996 law, he opined "***As despicable as this practice may be, it is essentially a criminal assault" and FGM/C was “local criminal activity” to be regulated by the States.*** His remarks shows there is an urgency to pass such a law in Washignton DC so that we can ensure we are protecting ALL girls from this harm. Forty states in the U.S. have a law — I believe Washignton D.C. should as well.

FGC is a form of gender violence. It is learned behavior that occurs from one generation to the next, much like how we know family violence is learned behavior. There are laws against domestic violence and sexual assault, and at one point in our country’s history, these forms of violence were also considered “private” and “culturally acceptable.” But we know better today.

My hope is that we can also understand that FGM/C is another learned form of violence that must not be accepted.

I support this bill because I believe it is a holistic bill that not only makes clear that FGC should be made illegal but also point to the need for community education and support.

Thank you again for considering my testimony in you decision regarding the passage of Bill 25-247, the Female Genital Mutilation Prohibition Act of 2023. If you should need additional follow-up information, please do not hesitate to reach me at mariya@sahiyo.org or by phone at 661-496-6976.

Sincerely,
Mariya Taher
Sahiyo Co-founder & U.S. Executive Director
Steering Committee of the US Network to End FGM/C

PUBLIC HEARING ON B25-291, THE SAFER STRONGER AMENDMENT ACT OF 2023
BEFORE THE COMMITTEE ON THE JUDICIARY AND PUBLIC SAFETY
COUNCIL OF THE DISTRICT OF COLUMBIA

Testimony of Mark Jordan

Executive Director, Office of Independent Juvenile Justice Facilities Oversight

JUNE 27, 2023

Good afternoon, Chairperson Pinto, and members of the Committee. My name is Mark Jordan, and I am the Executive Director of the Office of Independent Juvenile Justice Facilities Oversight. The Office of Independent Oversight was created in 2021 pursuant to a settlement agreement that ended the 35-year-old Jerry M. class action lawsuit, which pertained to the conditions of confinement for youth housed in Department of Youth Rehabilitation Services ("DYRS") secure facilities.

I am here today to testify regarding B25-291, the Safer Stronger Amendment Act of 2023 as it relates to DYRS's secure facilities, particularly the Youth Services Center ("YSC"), DYRS's secure facility for detained youth. My testimony is not intended to take a position on the merits of the policies that would be effected through the legislation. Rather, my testimony is intended to address a potential consequence of the legislation that must be considered carefully, and, if the legislation is passed, managed deliberately in order to avoid detention center overcrowding and deteriorating conditions of confinement like those that existed during many years of Jerry M.

Title II, Subtitle B of the bill would amend the District of Columbia Code to allow for the detention of a child alleged to be delinquent in order to protect the child's person or property from significant harm and would add a rebuttable presumption of detention for children who a judicial officer finds a substantial

probability of having committed a dangerous crime, a crime of violence, or the crime of carrying a pistol without a license. One potential, if not likely, effect of these changes to the Code would be to increase the percentage of youth alleged to be delinquent ordered to be securely detained pending a hearing. This, in turn, would likely result in more youth being admitted to the YSC, which, all other things being equal, would cause the population of the YSC to grow.

It is this potential for increases in the YSC population and the associated consequences of facility overcrowding that I would like to focus on today. The YSC is an 88-bed facility, which opened in December 2004. For much of its history, the YSC was prone to precipitous changes in population levels and overcrowded conditions, that is, housing more than 88 youth in the facility. At its peak in 2009, the YSC housed 156 youth, 77 percent more than its designed capacity. More frequently, however, when the facility was overcrowded it housed between 90 and 120 youth.

Beginning in June 2017 there was a sustained reduction in the population of the YSC, and until very recently, which I will discuss momentarily, June 18, 2017 marked the most recent date the YSC's population exceeded its 88-bed capacity. In fact, for the period from mid-2017 through the beginning of 2023, the facility's population generally remained below 60 youth.

During a February 2023 DYRS oversight hearing, I stated the following:

> I am pleased to report that population levels at the YSC have not exceeded the facility's 88-bed capacity since June 18, 2017. Over the past six months, the average daily population at the YSC has been 50 youth….While DYRS has been able to operate its facilities below capacity for a sustained period, historical population trends, at the YSC in particular, caution against complacency. The YSC population is prone to rapid and significant changes, influenced not only by arrest rates, but as importantly by prosecutorial and judicial decision-making practices. DYRS and its partner agencies should closely monitor population trends to identify population pressures *before* they result in facility overcrowding.

In fact, shortly after that hearing the YSC population began to grow steadily. From a baseline in the mid-40s in January 2023, the population rose to over 60 by mid-March, to over 70 consistently by mid-April, and to over 80 by late-May. On May 29, the population of the YSC exceeded its 88-bed capacity for the first time since June 2017 and peaked at 91 two days later before dropping. Much of the growth of the population during this six-month period was attributable to youth with detention orders. Whereas in the beginning of 2023 there were generally 20 to 25 youth with detention orders housed at the YSC each day, by late-May that number had increased to the mid-40s.

Fortunately, since the late-May peak, YSC's population has declined to 68 youth as of yesterday, in large part due to DYRS's efforts to move committed youth to alternative placements. Notwithstanding this very recent population retrenchment, the risk of facility overcrowding remains greater now than it has been over the past several years.

There is a long and well documented history of the consequences of overcrowding at the YSC in the record of the Jerry M. lawsuit. When the facility exceeds its capacity, youth are housed in makeshift dormitories, often in areas that are otherwise used for facility programming. Critical incident and assault rates tend to rise as there are more youth interactions and fewer options to separate youth into smaller groups. More staff are required to operate the facility, as more youth require more staff to supervise additional areas of the facility, to conduct more internal escorts, and to transport youth to outside appointments. The quality of programming suffers, including education and health services as the demands of the programs exceed the designed capacity and staffing levels the services were intended to serve.

Perhaps more now than ever, the effects of an overcrowded YSC would be amplified due to current staffing shortages at the facility. The YSC staffing complement is at historically low levels and, consequently, the number of staff available to fill posts is greatly reduced compared to pre-pandemic levels. Areas of the facility that historically would be supervised by two YDRs are now frequently supervised by one YDR, creating safety risks to youth and staff alike. If the facility were to exceed it's 88-bed capacity regularly it would cause sustained and acute operational strains on facility staff.

Low staffing levels are an independent problem from facility population levels that require a different set of management solutions which I encourage be undertaken. Nonetheless, the potential for overcrowding must be considered in the context of current staffing levels.

Under any circumstances, juvenile justice stakeholders must be purposeful about the population of individuals who are subject to detention and aware of the conditions that those individuals experience. The long history of Jerry M. underscores that maintaining appropriate facility population levels and preventing overcrowding is central to ensuring the safety and health of both youth and staff. Whether to enact Title II, Subsection B of the Safer Stronger Amendment Act of 2023 is a decision for policymakers that I nor my office take a position on. However, regardless of what decision is made, juvenile justice stakeholders from all three branches must collaborate to ensure that that there are sufficient, safe resources to manage the population of securely confined youth in the District of Columbia and that conditions at the YSC do not revert back to the conditions that characterized the facility prior to the termination of Jerry M.

Thank you for the opportunity to testify today and I would be pleased to answer any questions you may have.

ahafoundation

BREAKING THE SILENCE
PROTECTING LIBERTY
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TESTIMONY IN SUPPORT OF Bill 25-247: END FEMALE GENITAL MUTILATION IN WASHINGTON D.C.
SUBMITTED TO THE COMMITTEE ON JUDICIARY AND PUBLIC SAFETY ON JUNE 27, 2023

Chair Pinto and Distinguished Committee Members:

AHA Foundation thanks Chair Pinto and Councilmembers Frumin, Henderson, Nadeau, Allen, and Gray for introducing Bill 25-247 and the Committee for prioritizing a hearing on this important legislation. At the forefront to end female genital mutilation (FGM) throughout the United States, AHA Foundation is in strong support of this bill. Forty-one states have passed laws criminalizing FGM to protect girls from this human rights violation.

Background

FGM is defined by the World Health Organization as the partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons. FGM is a form of gender-based violence that is internationally recognized as a violation of women's and girls' fundamental human rights. The practice of FGM is generally motivated by beliefs about what is considered proper sexual behavior and cultural ideas of femininity and modesty. This includes the notion that girls are "clean" and "beautiful" after the removal of body parts that are considered "male" or "unclean." FGM is also considered a way to reduce a female's libido, safeguarding virginity and marital fidelity. Communities that practice FGM often believe that it will ensure a girl's marriageability, virginity, beauty, and family honor and families can face immense societal pressure to conform to social standards and subject girls to FGM.

FGM is most commonly inflicted upon a girl between infancy and 15 years of age. The procedure is typically carried out by traditional practitioners, without anesthesia or antiseptics, using a knife, razor blade or other objects such as scissors or broken glass. FGM has no health benefits. Many girls who undergo FGM face lifelong physical and psychological consequences. During and immediately following the procedure, girls may experience severe pain, shock, hemorrhage, tetanus or sepsis, urine retention, open sores in the genital region and injury to nearby genital tissue. Over the course of her life, a survivor may experience recurrent bladder and urinary tract infections, cysts and infertility. Survivors also face an increased risk of complications during childbirth, including maternal and newborn deaths. If a girl is forced to undergo infibulation, where the vaginal opening is sewn almost completely closed following the cutting away of most of the external genital tissue typically, she will likely undergo numerous surgeries throughout her life to open the scar tissue for sexual intercourse and childbirth. These surgeries put a survivor at further risk and are also sometimes done with a knife or razor blade without anesthetics or antiseptics. The practice of FGM can indirectly or directly lead to death.

A 2016 report by the Centers for Disease Control and Prevention estimates that there are as many as 513,000 women and girls in the U.S. who are at risk of or have undergone FGM. According to the Population Reference Bureau, an estimated 3,808 of those at-risk women and girls live in the District of Columbia (D.C.) and in the Washington metropolitan area

(Washington-Arlington Alexandria), 51,411 women and girls are estimated to be impacted by FGM, making it one of the largest at-risk populations in the U.S. Globally, FGM is largely concentrated in 30 countries in Africa, the Middle East, and Asia where UNICEF estimates that 200 million women and girls have undergone the procedure. In the U.S. the procedure is most common among those coming from practicing countries.

Although 41 states have passed laws criminalizing FGM, D.C. as well as 9 remaining states, have yet to take steps to protect girls from this harmful practice. Comprehensive legislation is particularly important for the District because it is completely surrounded by states that have already banned the practice. As it stands, D.C. is vulnerable to being a destination for FGM.

Importance of Passing B25-247

B25-247 would create a robust anti-FGM law in several ways. First, the bill creates a specific criminal felony offense for FGM. The felony would apply to a person performing FGM, a parent or guardian who consents to, permits or facilitates FGM, or a person who knowingly removes or facilitates the removal of a person under care from the District for the purpose of facilitating the female genital mutilation of the person under care. Importantly, the statute of limitations is tolled until ten years from a survivor turning 18 years of age.

The bill sends a strong message to those who would organize, and subject girls to, FGM, that FGM is not tolerated in the District and they will be held accountable. Notably, B25-247 not only provides prosecutors with the tools they need to bring perpetrators to justice, but it also aids in prevention of the practice as it provides families with justification to resist cultural and familial pressure to cut their daughters. We know anecdotally through our work with survivors and at-risk individuals that families on the fence about whether or not to cut their daughters, but who may be facing pressure from family or communities, have used the existence of legislation as an excuse for why they will not go ahead with the procedure. Given the high estimates of girls at risk in the Washington metropolitan area, we also do not want D.C. to become a destination site where girls are subjected to FGM.

These provisions are also important as we also do not want vulnerable girls being trafficked out of the District so they can be subjected to FGM. We have seen girls trafficked from states with anti-FGM legislation to states with no anti-FGM legislation to underdo FGM. Trafficking a girl out of the country for FGM is a crime federally, and it is important to have clear state protections as well.

Second, under the bill, a robust definition would be used to define FGM in the law. AHA Foundation believes use of this robust definition is best practice. There are various types and degrees of FGM; using the most comprehensive definition of FGM as this bill does ensures that no form of FGM is deemed to be “acceptable” or is overlooked.

Third, the bill asserts that neither religion, custom, ritual, or other standard practice, nor the consent of a parent, guardian or custodian, shall be a defense to prosecution. FGM is a harmful traditional practice that is not particular to any religious group nor prescribed by any faith.

Notwithstanding, often cultural or religious justifications are used by those who are proponents of the practice. By using this language, the District will clearly signal to those who would subject girls to FGM, that FGM is a serious crime that will not be tolerated here under any circumstances.

Fourth, the bill adds FGM to the definition of a neglected child under District law. This is important for reasons including that it makes clear under the mandated reporting laws that instances where someone has been subjected to, or is in imminent danger of being subjected to, female genital mutilation, must be reported. This ensures that FGM is treated in line with requirements for any other form of child abuse or neglect.

Fifth, the bill creates a civil cause of action for an FGM survivor, under which the court may award the payment of actual, compensatory, and punitive damages, and any other appropriate relief. The civil protections included in this bill work to ensure that survivors of FGM are able to advocate for themselves in a court of law and seek damages.

Sixth, the bill mandates education for community members and mandated reporters. Education and outreach programs are an important component of addressing social norms; B25-247 ensures such programs target communities and professionals likely to encounter cases of FGM to provide education on the health risks and emotional trauma caused by the procedure as well as the criminal penalties for committing or allowing FGM on a minor. Professionals would be taught the risk factors associated with FGM, signs that an individual may be a victim, and best practices for responding to and reporting suspected cases. Crucially, an outreach program can start an important dialogue in vulnerable communities about the underlying social norms that compel families to perpetuate the practice.

B25-247 is common sense legislation that would add safeguards for vulnerable girls and survivors of FGM. AHA Foundation urges the Committee to create these protections for survivors and girls at risk of FGM, join the 41 states that have already enacted anti-FGM laws, and vote **YES** to advance Bill 25-247 favorably out of Committee.

About AHA Foundation

AHA Foundation is a 501(c)3 non-profit founded by women's rights activist and FGM survivor Ayaan Hirsi Ali, and is the leading organization working to end honor violence that shames, hurts or kills thousands of women and girls in the U.S. each year, and puts millions more at risk. We ensure that women and girls of all races, cultures, religions, beliefs and backgrounds who are facing female genital mutilation, forced marriage, child marriage, or honor violence have a way out, and that survivors get the help they need to thrive.

Since 2010, the focus of the Foundation's programs includes: 1) compiling data on these crimes, which are not currently tracked by U.S. law enforcement or government agencies, 2) publishing reports and articles and organizing conferences about the continued oppression of women and girls in the U.S., 3) educating and outreach to expand and strengthen state and national legislation for the protection of women and girls, 4) training of law enforcement and

service providers, and 5) connecting women and girls in crisis to appropriate services. AHA Foundation has trained over 3,500 frontline service providers on responding to cases of female genital mutilation, honor violence, and forced marriage, and partnered with Crisis Text Line to create America's first honor violence and forced marriage helpline.

Testimony by
Michele Molotsky, Program Director
Logan Circle Main Street, District Bridges
Before the
DC Judiciary & Public Safety Public Hearing
June 27, 2023

Designated in 2019, the Logan Circle Main Street (LCMS) supports approximately 180 small businesses and community members in the 14th Street Corridor between Thomas Circle and T Street NW predominantly in Ward 2. The businesses along 14th Street include local and national stylish home-decor stores, hip restaurants, LGBTQ bars, craft beer and cocktail bars. It is one of six DC Main Street programs managed by District Bridges, a DC-based community ecosystem development nonprofit. Established in 2005 by neighbors and business owners in the Columbia Heights neighborhood, District Bridges' mission is to enrich neighborhood vitality by bridging community engagement and economic development opportunities so individuals, businesses, and organizations can thrive together. Collectively, District Bridges' Main Street programs represent 1,500 businesses in Wards 1,2, 3 and 4.

Thank you for the opportunity to testify today on the The Safer Stronger Amendment Act of 2023. I am speaking today in support of the improvements to the private security cameras incentive program. I have one example where more cameras would have greatly benefited Logan Circle. I also have experience working with small business owners and have suggestions to improve the program.

Last winter in December, January and February, there was a spate of attacks on businesses where storefront windows were smashed. At least ten businesses in the Logan CIrcle/U Street area had windows broken including: Barrel House Liquors, Coldwell Banker, Cork Market and Wine Bar, Filson, Lululemon, Madewell, Silver Cycles, Soul Cycle, Wells Fargo and a bus stop at 14th and R Street.

This vandalism cost at least $15,000 in window replacements alone. Other indirect expenses include delayed openings, hiring additional security and the staff's lost sense of safety. The Main Street provided financial aid to two businesses although we would have preferred allocating funds toward a project that could have fostered business growth. have fostered business growth. The culprit was only captured on surveillance footage at Coldwell Banker. If other businesses had surveillance cameras in place, there is a chance that the vandal would have been caught earlier.

Despite the availability of the District's camera rebate program, few small businesses have participated in the program. The progress is a bit cumbersome for busy small business owners. The business owner has to purchase the equipment, register with MPD, apply for the rebate, have the camera installed and ensure there's adequate wifi and purchase a subscription.

When I started as the Logan CIrcle Main Street manager in 2020, I worked on a program that would allow merchants to buy cameras at Logan Hardware and the Main Street would pay for the installation. Still, we did not have any business participating.

So along with increasing the rebate amount, I suggest the District streamline the process and create a one stop shop which the Main Street could coordinate. Fronting the expenses, would ensure more businesses participate in the program.

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Statement on behalf of the
American Civil Liberties Union of the District of Columbia
before the D.C. Council Committee on the Judiciary and Public Safety
Public Hearing Regarding
Bill 25-0291, the Safer Stronger Amendment Act of 2023
by
Monica Hopkins, Executive Director
June 27, 2023

Good afternoon Chairperson Pinto and members of the Committee on the Judiciary and Public Safety. I am Monica Hopkins, Executive Director of the American Civil Liberties Union of the District of Columbia and today, on behalf of the ACLU of DC and our over 14,000 members in all 8 wards, I am pleased to submit testimony regarding Bill 25-0291, the Safer Stronger Amendment Act of 2023.

The ACLU of DC strongly opposes this legislation and urges the Committee not to move it forward. Every District resident deserves safety and security and the ACLU of DC recognizes the need to address crime in the District and the importance of public safety. However, we must not further the self-perpetuating and unjust cycle of over-policing and mass incarceration that has plagued our criminal justice system for far too long. We must have a comprehensive public safety approach that includes preventative, community-based interventions to violence and access to appropriate, non-police, responses to people in need of assistance. Above all, any approach to public safety that is true to our values as a District must respect District residents' civil rights and civil liberties rather than trading them away for a false sense of security. We can increase equality, justice and public safety without resorting to further criminalization, surveillance, and deprivation of liberty.

This legislation fails on all of these metrics. Far from being comprehensive, it is a collection of piecemeal measures that, in many cases, bear no relationship to one another. To the extent that there is a common thread that ties elements of this bill together, it is a reliance on increased criminalization, surveillance and depravation of liberty, which we know disparately impacts Black and brown District residents. It suggests incarceration of adults and children, who are presumed innocent and many whom may be proven innocent, will achieve the goal of public safety. It has been said, "Insanity is doing the same thing over and over expecting different results." This legislation recycles a "tough on crime" approach to public safety that, for decades, has destroyed lives and communities, allowed discriminatory use of law

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enforcement power, and fueled racially disparate mass incarceration. In short, this legislation takes the same approach that has failed to prevent the challenges that we confront today.

The Legislation is Not the Public Safety Solution the District Needs

Our testimony today will focus on pre-trial detention, GPS tracking and collection of DNA evidence. We know that other witnesses will highlight, in detail, problems with adding MPD to the Sentencing Commission and creating barriers to sentencing revisions. We support their testimony while noting the following:

- While framed as improving citizen representation on the Sentencing Commission, Title I adds the Metropolitan Police Department to the Commission's voting membership.[1] It is inappropriate for MPD, which is responsible for investigating potential crimes and making arrests, to also have a direct role in shaping sentencing policy. Sentencing policy should be left to the Court, individuals and entities that practice before the Court, and representatives of the community who can speak to the effects of sentencing policy at the community level.

- Title XI adds unnecessary barriers to sentencing revisions under the Incarceration Reduction Amendment Act.[2] The IRAA's process for reviewing the sentences of incarcerated individuals convicted for acts committed before age 25 is based on a modern understanding of brain development and decision-making in young people. It was enacted after robust analysis,[3] as well as debate and consideration of amendments. In fact, one of the bill's proposed changes was considered by the Council when it passed the Second

[1] Bill 25-0291, Safer Stronger Amendment Act of 2023, Title I (2023), available at: https://lims.dccouncil.gov/downloads/LIMS/53020/Introduction/B25-0291-Introduction.pdf?Id=161560

[2] *Id*. at Title XI.

[3] For discussion of the Council's reasoning for recent amendments allowing for sentencing review regarding acts committed before age 25 (as opposed to 18), *see*, Charles Allen, Report on B23-0127, the "Omnibus Public Safety and Justice Amendment Act of 2020," pp. 15-19 (November 23, 2020), available at: https://lims.dccouncil.gov/downloads/LIMS/41814/Committee_Report/B23-0127-Committee_Report2.pdf?Id=114267

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Look Amendment Act at the end of 2020 and was rejected – twice – by the full Council.[4] The Mayor has not shown any evidence-based public safety justification for revising a process that was the subject of Council debate less than three years ago.

Having noted these concerns, we will now turn to a more detailed analysis of the aforementioned portions of the bill.

Pre-Trial Detention

The bill makes major changes to current law regarding detention of minors and detention of adults accused of crimes. These proposed changes for both youth and adults would drive up the jail population and balloon taxpayer spending on incarceration without improving public safety, while also harming children and families.

Youth Pre-Trial Detention

Current law allows for detention of juveniles before factfinding or disposition hearing only: (1) to protect the person or property of others from significant harm, or (2) to secure the child's presence at the next court hearing.[5] Title II of the bill amends these criteria so that the Court could order a child detained to protect the person or property *of the child*, in addition to the person or the property of other people.[6] This would allow the Government to argue (and the Court to order) that a child, who is presumed innocent, should be incarcerated pre-trial for their own good – even if they do not pose a danger to others. Title II also expands the range of

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[4] Title XI would include "the nature of the offense" among the factors to be considered in a reviewing a sentence. *Id*. The Council considered this change when it considered a pair of amendments, offered on December 1, 2020 and December 15, 2020, respectively, by Councilmember Mary Cheh. The first amendment failed by a vote of 11 to 2. The second failed on a voice vote. DC Council Legislative Information Management System Record for Bill 23-0127, Second Look Amendment Act of 2019 (now known as "Omnibus Public Safety and Justice Amendment Act of 2020"), available at: https://lims.dccouncil.gov/Legislation/B23-0127

[5] DC Code § 16-2310.

[6] Note 1, *supra* at Tile II.

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alleged acts that could trigger a rebuttable presumption in favor of detention. It does this by removing existing exceptions to the list of offenses relevant to the presumption, as well as removing language in current law that appears intended to focus the presumption on alleged offenses involving weapons.[7]

If the Mayor's goal with respect to young people is to reduce juvenile crime and keep young people safe, targeting more young people for pre-trial detention does not accomplish that goal. Years of research has continually shown that incarcerating young people, including detaining young people pre-trial, increases the likelihood of recidivism.[8] Incarcerating young people is also associated with interruption and/or derailment of education, poor health outcomes, and worsening mental health.[9] Further, across the country, incarceration has put youth at risk of abuse while incarcerated.[10] And incarceration exacerbates pre-existing childhood traumas and impedes the natural maturation process that is associated with young people aging out of the types of behaviors that often lead to criminal behavior.[11] The idea that the best way to address criminal behavior and public safety challenges among young people is to lock them up more often – including, purportedly, for their own protection – flies directly in the face of what we know about the damaging nature of youth incarceration, as well as the science of youth development.

Adult Pre-Trial Detention

Current law identifies a number of alleged acts that trigger a rebuttable presumption in favor of pre-trial detention.[12] Title V of the bill adds to this list of

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[7] *Id.*

[8] Richard Mendel, "Why Youth Incarceration Fails: An Updated Review of the Evidence," The Sentencing Project (Mar. 1, 2023), available at: https://www.sentencingproject.org/reports/why-youth-incarceration-fails-an-updated-review-of-the-evidence/#part-1

[9] *Id.*

[10] *Id.*

[11] *Id.*

[12] DC Code § 23-1322.

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acts that if a person has previously been convicted of a crime of violence, they will fall under the presumption in a subsequent case if the Court finds probable cause to believe another crime of violence was committed.[13]

As is the case with respect to youth detention, there is a mismatch between the goal of improving public safety and making more adults subject to pre-trial detention. Pretrial releases in the District are not driving crime: 92 percent of people released from pretrial are not rearrested and only 1 percent are rearrested for a violent offense while awaiting trial.[14] Beyond the District, data from other jurisdictions suggest that policy changes leading to increases in the rates of defendants released pretrial did not harm public safety, and further, that pre-trial detention can increase rearrest rates.[15] The Administration's proposals are not a solution to the District's public safety challenges, are not supported by evidence, and may ultimately be more damaging than helpful.

These Proposals Inappropriately Limit Judicial Discretion

District judges, in both the youth and adult contexts, already have broad discretion under current law to order detention and hold individuals accountable, especially in cases where a firearm is involved. The bill effectively narrows judicial discretion at a stage in proceedings when individuals are presumed, and may be, innocent of a crime. Especially at this stage, judges should be able to carefully consider the

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[13] Note 1, *supra*, Title V.

[14] Pretrial Services Agency for the District of Columbia, Arrest-Free Rates for Defendants Released to the Community in Washington, DC: FY 2018 – 2022 (January, 2023), available at: https://www.psa.gov/sites/default/files/FY%202018-2022%20-%20Fact%20Sheet-Arrest-Free%20Rates%20for%20DC%20Defendants%20Under%20Pretrial%20Supervision.pdf

Pretrial Services Agency for the District of Columbia, Congressional Budget Justification Fiscal Year 2024, p. 25 (March 9, 2023), available at: https://www.csosa.gov/wp-content/uploads/bsk-pdf-manager/2023/03/PSA-FY2024-Congressional-Budget-Justification-03092023.pdf

[15] Sarah Staudt, Releasing people pretrial doesn't harm public safety, Prison Policy Initiative (July 6, 2023), available at: https://www.prisonpolicy.org/blog/2023/07/06/bail-reform/

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totality of the circumstances and balance factors related to public safety against the damaging effects of incarceration.

These proposed changes should not be taken lightly. Presumptive pre-trial release should be the norm and the conditions of pre-trial release should be narrowly tailored. Pre-trial detention is a deprivation of liberty and makes an assumptive determination of guilt, based on previous actions, absent due process. As per the American Bar Association's general guidelines on Pre-Trial release, the law favors pre-trial release and the determination to hold an individual pre-trial should be made by a judge or judicial officer based on a number of conditions carefully considered by the court.[16] The court can, and does, already consider previous convictions as one of the factors in determining pre-trial release. There are fundamental values at stake any time legislation seeks to narrow judicial discretion in this area.

GPS Devices

Two different provisions of the bill touch on the use of data from GPS devices that individuals may be required to wear during their involvement in the criminal justice system.

Title V would allow information from GPS devices to be admissible on the issue of guilt in any judicial proceeding, modifying existing language that limits the purposes for which information in Pre-Trial Services' files may be used.[17] Meanwhile, Title VI would require supervisory agencies to turn over GPS data to MPD upon request if MPD determines it is necessary for a criminal investigation.[18]

As we have noted previously, the expansion of the use of surveillance technologies to capture individuals' locations and activities means that the government has ever

[16] American Bar Association, Criminal Justice Standards: Pre-Trial Release, available at: https://www.americanbar.org/groups/criminal_justice/publications/criminal_justice_section_archive/crimjust_standards_pretrialrelease_blk/#10-1.6

[17] Note 1, *supra*, Title V.

[18] *Id*. at Title VI

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growing access to information on the day-to-day activities of District residents.[19] Others have highlighted both the extensive nature of the District's known surveillance resources and troubling gaps in our knowledge of how information is being shared and used.[20] These gaps make it more difficult to put appropriate safeguards in place regarding the use of these technologies and address abuse of them. The Council needs to provide stronger oversight of the use of surveillance technologies, and until it does, it is inappropriate to entertain changes that will allow surveillance data to be used more freely.

Turning to the legislation, there are a number of concerns with its provisions regarding the use of GPS data. Preliminarily, it is important to note a potential legal concern with Title VI. Two supervisory agencies that make use of GPS devices, the Court Services and Offender Supervision Agency (CSOSA) and the Pretrial Services Agency (PSA), are both federal agencies that operate in the District. Forcing federal agencies to participate in the sharing of GPS location and identification data with the local Metropolitan Police Department raises severe preemption concerns. Further, pre-emption concerns aside, it is our understanding that CSOSA and the DC Department of Youth Rehabilitation Services already send the names of people on pretrial release who are on GPS surveillance to MPD, raising questions about the necessity of a more extensive data sharing requirement.

At the individual case level, the language of Title V lowers the bar around admissibility of GPS data in court, which in turn, may increase incentives for the Government to seek to use such technologies in individual cases. Meanwhile, Title VI would give MPD largely unfettered access to GPS data – indeed, the language does not even indicate that the person wearing the GPS device must be the actual target of the criminal investigation for which the data is requested. Taken together, these proposed changes risk adding to the growing trove of information that the

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[19] American Civil Liberties Union of the District of Columbia , Community Oversight of Surveillance DC, COS-DC: Fighting Government Surveillance, available at: https://www.acludc.org/en/campaigns/cos-dc-fighting-government-surveillance

[20] Christ Gelardi, Inside D.C. Police's Sprawling Network of Surveillance, the Intercept (June 18, 2022), available at: https://theintercept.com/2022/06/18/dc-police-surveillance-network-protests/

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government can access about people living and working in the District, all without sufficient consideration of oversight or safeguards.

Collection of DNA

Title X of the bill would require MPD to collect DNA samples from individuals who are "arrested, facing charges, or convicted" of certain sex offenses.[21] Additionally, if an individual is charged with a crime listed in this section, MPD will also take each DNA sample to perform a DNA analysis and include the results in the Combined DNA Index System (CODIS).

Mandatory DNA collection, as proposed in Title X, raises important due process and privacy concerns. As our colleagues at the ACLU of Virginia note:

> The privacy issues related to the practice of DNA collection in general cannot be overstated. A person's DNA inherently contains the most sensitive, personal information about them, including ancestry, complete health information, and predictive data about their predisposition to certain illnesses or behaviors that the individual may not even know about.[22]

Mandatory DNA collection allows the government to indefinitely retain that person's genetic makeup, even if acquitted, because there is no federal statute requiring the government to discard the full DNA sample. The ability to search for partial matches also implicates the privacy rights of family members whose DNA is a close enough match that of the person flagged in a CODIS DNA search. This expansion exacerbates the violation of individual privacy rights beyond the individual whose DNA is added to the database. As CODIS expands, so does the possibility of false hits, and as genetic researchers discover more ways to use DNA, absent adequate statutory safeguards, the potential for government misuse increases.[23] Again, quoting our colleagues in Virginia: "the practice of government

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[21] Note 1, *supra*, Title X.

[22] Bill Farrar, Proposal to Expand Mandatory DNA Collection in Virginia Raises Serious Privacy and Due Process Concerns (January 8, 2018), available at: https://www.aclu.org/news/privacy-technology/proposal-expand-mandatory-dna-collection

[23] Our colleagues in Virginia touch on this issue in their discussion of mandatory DNA collection in the Commonwealth. *Id*.

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DNA collection, storage, and analysis raises clear and obvious privacy and due process concerns that only become exacerbated as the government broadens the net it casts to gather samples."[24]

We urge the Committee to strike this title entirely. If it is not willing to do this, then it should add a requirement that all samples, profiles, and other data from arrestee DNA be automatically expunged upon the dropping of charges, acquittal, or other non-conviction outcome in the case. This essential safeguard would help protect arrestee DNA collection.

Sentencing Enhancements

Perhaps the most prominent element of this legislation is its assortment of sentencing-related provisions.

Title III would create mandatory minimum sentences for certain crimes related to firearms. Mandatory minimums effectively remove consideration of the unique circumstances of the crime or the defendant, leading to sentences that are out of proportion relative to the conduct they are attempting to punish. They also lead to the abuse of prosecutorial discretion, as prosecutors can use the threat of charging and prosecuting offenses with long minimum sentences to coerce defendants into relinquishing their constitutional rights and punish defendants when they exercise those rights.[25] When the Council unanimously passed revisions to the District's Criminal Code last year, the legislation was deliberately written to reduce the presence of mandatory minimum sentences, which, in the words of a prior iteration of this Committee, "are scattered haphazardly throughout the code."[26] Adding *more*

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[24] *Id*.

[25] See, e.g., United States v. Hungerford, 465 F.3d 1113, 1118-22 (9th Cir. 2006) (Reinhardt, J., concurring in the judgment) ("Hungerford's case is a textbook example of how [18 U.S.C.] § 924(c) permits a prosecutor, but never a judge, to determine the appropriate sentence."); United States v. Jones, No. CR 08-0887-2 MHP, 2009 WL 2912535, at *1 (N.D. Cal. Sep. 9, 2009); United States v. Redondo-Lemos, 754 F. Supp. 1401, 1406 (D. Ariz. 1990).

[26] Charles Allen, Report on B24-0416, the "Revised Criminal Code Act of 2022," at p. 7. (October 26, 2022), available at:

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mandatory minimums to a criminal code that already has an illogical assortment of them is a step backward.

Meanwhile, Title IV creates or expands sentencing enhancements to apply to: certain crimes against vulnerable adults, a wider range of for-hire vehicle operators, a wider range of Metro employees, all Metro passengers either riding Metro vehicles or waiting at a marked Metro boarding location, and people at locations administered by the Department of Parks and Recreation.[27] Extensive research, including a massive 2014 report by the National Academies of Science, has found that long sentences (which implicate sentencing enhancements) are both ineffective at protecting public safety and proven to harm children, families and communities – particular Black and Latino communities that suffer much high rates of arrest and incarceration.[28] Further, if there is one thing that the District should understand based on its own criminal justice policy history, it is that piecemeal criminal offense expansions and sentencing enhancements exacerbate some of the worst aspects of our criminal justice system. As the Judiciary Committee itself noted while re-writing the District's criminal code last Council period, our current criminal statutes (which were generated through precisely this type of piecemeal lawmaking) can lead to inconsistent and disproportionate sentences, all while making our criminal statutes harder to navigate for professionals and harder to understand for District residents.[29] Legislating based on the political pressures of the moment while failing to account for long-term trends and broader public safety needs is, over both the short and long term, a poor approach to achieving public safety.

It is truly disappointing that, instead of taking a thoughtful approach to examining whether our existing criminal statutory regime truly works to protect public safety, the Bowser Administration has chosen to layer on top of it yet another collection of

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https://lims.dccouncil.gov/downloads/LIMS/47954/Committee_Report/B24-0416-Committee_Report1.pdf?Id=148331

[27] Note 1, *supra*, Title IV.

[28] *See*, National Academies of Science, The Growth of Incarceration in the United States, Issue Brief: Sentencing Policy (September, 2014), available at: https://nap.nationalacademies.org/resource/18613/dbasse_089027.pdf

[29] *See*, note 26, *supra*, at pp. 2-3.

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punishment-oriented provisions. The Committee should reject this as more of the same approach that got us here in the first place.

Conclusion

The ACLU of DC thanks the Committee for the opportunity to testify today. We once again urge the Committee not to move forward with this legislation, as it is not the approach to protecting public safety that District residents need or deserve. We are happy to work with the Committee on a comprehensive, proactive approach to public safety that respects and values the rights of DC residents.

Testimony by

Pam Bailey, co-founder of More Than Our Crimes

Public hearing: B25-291, the Safer Stronger Amendment Act of 2023

I am testifying today on behalf of the many members of the More Than Our Crimes network who are still incarcerated 15 years or more after they were convicted of their offense. They are DC's newest voters, but they cannot be here themselves. Thus, More Than Our Crimes is committed to bringing their voices to you.

Although we support much of the other testimony you are hearing today, I will address the mayor's proposed changes to IRAA—specifically, the direction to the judge to consider the nature of individuals' criminal offenses. IRAA and its Second Look extension were passed by the DC Council because its members understood that biology and experience conclusively demonstrate that the brains of individuals below the age of 25 are still developing, rendering them highly vulnerable to peer pressure and impulsivity. What is the point, then, of essentially retrying them for the crimes they committed while still so young?

Unlike most of the other provisions in Mayor Bowser's proposed bill, her modifications to IRAA would impact District residents who have *already fulfilled* their punishment for more than a decade. To be released, they must demonstrate to a judge via a rigorous process that they are rehabilitated and ready to be productive members of their families and community.

But it's also important to understand the impact of the hope IRAA offers to District residents who were given cruel, indeterminate sentences and are thus treated as "lifers" by the federal Bureau of Prisons. Rob Barton, who is the co-founder of More Than Our Crimes, is currently incarcerated in a federal prison in Florida and is eligible for IRAA, asked me to explain it this way to you:

Try to imagine for one moment that you have been sentenced to a federal prison for 30 years to life. In light of the dismal track record of the federal parole agency, you know that you can expect to spend most of your life inside the walls. That means being confined to a cramped cell with a toilet, shared with another adult you may not even like. Because of chronic understaffing at the prison and a tendency by staff to resort to collective punishment, you're not allowed out of your cell about 50% of the time, making it difficult to participate in the scant programming available. For meals, you're served often-rotten fruit, bologna and cheese — with a serving size so insufficient you're still hungry afterward. And because violence is the way everyone around you gets their way—including the COs—you must have a weapon at the ready to protect yourself.

This is the environment DC sends us into. Our rehabilitation requires great personal effort and—sometimes—risk, since we must resist strong pressure to fight on behalf of others in the group we hang with. What gives us the strength of will to do this, however, is a powerful force called

“hope.” And that is what IRAA is for us: hope that we can someday soon leave this madhouse and return to our families.

If you approve this provision of the mayor’s bill, you will make that hope much less likely to achieve. Please preserve the hope for a second chance. If you don’t do it for people like Rob, do it for yourself. Eventually, almost all of them will return home. Do you want to welcome a hopeful, grateful individual, or someone who is bitter and broken?

THE SENTENCING PROJECT

Testimony of Nazgol Ghandnoosh

Co-Director of Research
The Sentencing Project

On Safer Stronger Amendment Act of 2023, B25-291

Before the Council of the District of Columbia, Committee on the Judiciary & Public Safety

June 27, 2023

I'm Nazgol Ghandnoosh, Co-Director of Research at The Sentencing Project and a Ward 2 resident. This year, I was appointed by the Honorable Anita Josey-Herring, Chief Judge of the Superior Court, as a member of the DC Sentencing Commission. I am eager to support the Commission in increasing fairness and effectiveness in sentencing by analyzing DC sentencing data, policies, and practices and by helping to align sentencing in DC with the best research and evidence nationwide on how to promote public safety. Insulating the Sentencing Commission from politics as much as possible is key to achieving these goals. For that reason, I strongly advise against expanding the Mayor's authority over the Commission.

One of the Mayor's proposals in the Safer Stronger Amendment Act of 2023 is to add three more voting members to the Commission. This includes empowering her office to appoint two new resident members. She makes this proposal even though for several years she has left vacant a seat for a resident member that she is already authorized to appoint.

The Mayor's proposal also includes moving the Chief of the Metropolitan Police Department from a non-voting member to a voting member. This change would elevate a law enforcement perspective which may not correspond with research and data on best practices in sentencing. We have seen, for example, current and former DC Police Chiefs rely on anecdote, rather than evidence, when weighing in on sentencing debates. Lastly, the Mayor would add the Deputy Mayor for Public Safety and Justice as a non-voting member of the Commission.

An effective sentencing commission should comprise issue experts who can bring evidence-based rationality and objectivity to criminal justice policy-making. In the words of NYU law professor and former United States Sentencing Commission member Rachel Barkow, commissioners need "an institutional architecture that rewards the use of expertise and insulates them from political pressures and from agency capture by interests in favor of harsher policies."[1]

The DC Council must build an institutional architecture for the Sentencing Commission that promotes and preserves what is working well and repairs what is not. Expanding the Mayor's authority over the Commission would weaken the existing architecture.

How can DC residents know that expanding mayoral authority over the Sentencing Commission would make the Commission more politicized and more responsive to calls for punitive, but ineffective, policies? Consider what we just experienced around the Revised

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[1] Barkow, R. E. (2019). *Prisoners of politics: Breaking the cycle of mass incarceration*, p. 178. Belknap Press.

Criminal Code Act of 2022 (RCCA): the Mayor vetoed a law modernizing the District's criminal code, which was the product of 16 years of research, an expert commission, 51 public meetings, extensive public feedback, and robust negotiation. Although the Council overturned the Mayor's veto, her actions contributed to Congress then blocking the law.[2]

The Mayor's opposition to the RCCA disregarded vast criminological research establishing that lengthening sentences is not an effective response to violence.[3] The criminological evidence is clear: certainty of punishment has a far greater deterrent effect than the severity of punishment.[4] Lengthening sentences does not reduce gun crime. Instead, it diverts scarce public tax dollars toward incarceration and away from potential interventions that actually make communities safer.[5] Extreme sentences also disproportionately impact Black Americans.[6]

Consider also the other elements of the Mayor's current proposed bill. As you'll hear from my colleagues Warren Allen and Liz Komar at The Sentencing Project, as well as from many other witnesses, many elements of this bill are at odds with evidence on how to promote community safety and seek to return us to an old playbook of passing laws that are superficially tough on crime, but actually ineffective.[7]

The Commission's composition can be improved. One valuable change would be to ensure representation of returning citizens who can share insights from their first-hand experience

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[2] Austermuhle, M. (2023, March 14). How A D.C. crime bill sparked a political firestorm and ended up blocked by Congress. *DCist*. https://dcist.com/story/23/03/14/how-congress-blocked-dc-criminal-code-bill/

[3] See Ghandnoosh, N., & Nellis, A. (2023) *How many people are spending over a decade in prison?* The Sentencing Project.

[4] National Institute of Justice. (2016). *Five things about deterrence*.

[5] John Jay College Research Advisory Group on Preventing and Reducing Community Violence. (2020). *Reducing violence without police: A review of research evidence*; Sebastian, T., Love, H., Washington, S., Barr, A., Rahman, I., Paradis, B., Perry, A. M., & Cook, S. (2023). A new community safety blueprint: How the federal government can address violence and harm through a public health approach. *Brookings*.

[6] Muhammad, K. G., Western, B., Negussie, Y., & Backes, E. (Eds.) (2022). *Reducing racial inequality in crime and justice: science, practice, and policy*. National Academies of Sciences, Engineering, and Medicine.

[7] FWD.us. (2023, June 22). More than 40 national and local organizations call on D.C. leaders to oppose safer stronger D.C. proposal that will worsen mass incarceration without improving public safety.

with incarceration, along the lines of what Minnesota has recently done. Another improvement, also following Minnesota's lead, would be to ensure that members include academic criminologists, restorative justice experts, and leaders who promote community safety through strong and supported community-based organizations.[8]

I'll conclude with a cautionary tale from another criminal justice agency: parole boards that make discretionary decisions about when certain people can be released from prison. Nationwide, parole board appointments are generally made by the executive branch. The proximity of parole commissioners to a single elected official has severely limited how often they use their discretion to release people from prison.[9] As a result, the American Law Institute has called for abolishing the discretionary parole process.[10]

Please help to insulate the DC Sentencing Commission from politics and support reliance on expertise in sentencing.

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[8] 2023 Minn. Laws ch. 52, art. 6, § 1

[9] Ruhland, E. L., Rhine, E. E., Robey, J. P., Mitchell, K. L. (2017). *The continuing leverage of releasing authorities: Findings from a national survey*. Robina Institute; Ghandnoosh, N. (2017). *Delaying a second chance: The declining prospects for parole on life sentences*. The Sentencing Project

[10] American Law Institute. (2021). *Model Penal Code: Sentencing*. Prepublication Draft.

Office of the District of Columbia Auditor

Written Testimony

of

The Office of the D.C. Auditor

Prepared for the

Council of the District of Columbia

Committee on the Judiciary and Public Safety

Public Hearing on

Bill 25-291, the "Safer Stronger Amendment Act of 2023"

June 27, 2023

12 p.m.

Virtual Platform

The John A. Wilson Building

1350 Pennsylvania Avenue N.W.

Washington, DC 20004

The Office of the D.C. Auditor (ODCA) provides this written testimony to assist the Council of the District of Columbia in considering Bill 25-291, the "Safer Stronger Amendment Act of 2023," which was introduced by Chairman Mendelson at the request of Mayor Bowser. Our written statement focuses on two sections of Bill 25-291: (1) Title VIII, Private Security Camera Incentive Program, and (2) Title IX, Criminal Justice Coordinating Council. Please include this statement in the official hearing record for Bill 25-291.

The statement draws on our June 2022 report titled NEAR Act Violence Prevention and Interruption Efforts: Opportunities to Strengthen New Program Models, which examined the private security camera program as well as the core public health programs of the NEAR Act (such as the funding of violence interrupters in target neighborhoods). Our statement also reflects insights from field work conducted for an upcoming NEAR Act report on police reform provisions. We have included questions that the Committee might wish to pose to government and public witnesses.

Title VIII: Private Security Camera Incentive Program

Title VIII of Bill 25-291 would remove provisions of current law that limit the rebates that the Office of Victim Services and Justice Grants (OVSJG) provides to residents who purchase private security cameras and register them with the Metropolitan Police Department (MPD). The current caps on the rebates, which would be removed by Bill 25-291, are as follows:

- $200 per camera installed on a building owned or leased by an individual, with a maximum rebate of $500 per camera system for each residential address.
- $200 per camera installed on a building owned or leased by a business, non-profit, religious institution, or other entity, with a maximum rebate of $750 per camera system for each address.

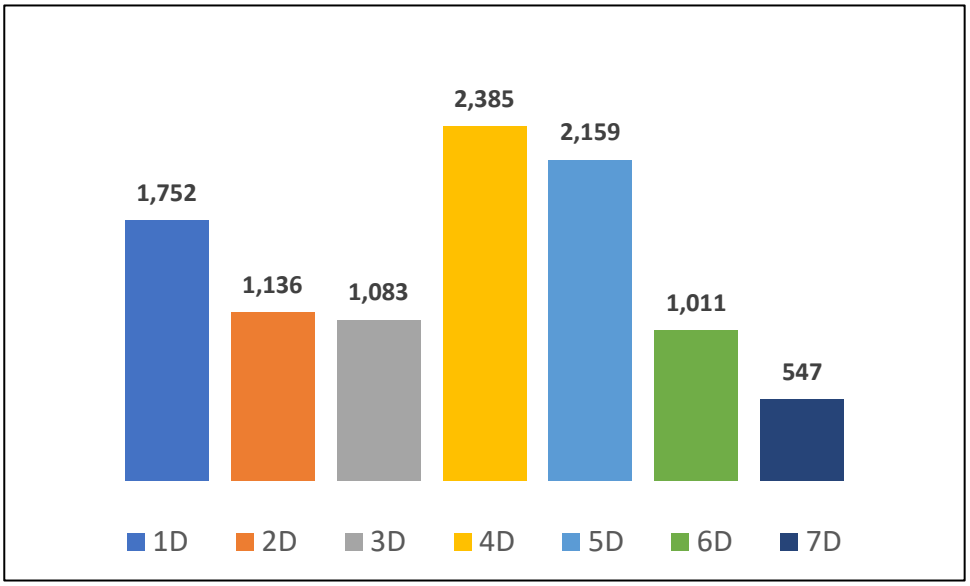
In place of the current caps, Bill 25-291 would allow the Mayor to issue rules establishing the maximum allowable rebates for individuals, entities, and addresses. A provision of current law limiting the rebate to the purchase price of the system would remain in place.

ODCA has some concerns about the proposed removal of the fixed rebate caps, which are explained below in more detail. Rather than grant the Mayor authority to set the caps through rulemaking, it might be preferable to raise the caps by specific amounts – perhaps to a maximum of $750 for residential cameras and a maximum of $1,000 for non-residential cameras – or to keep the current caps in place.

In our June 2022 NEAR Act report, we identified several strengths of the private security camera program. We found that OVSJG implemented the program in a manner consistent with the intent of the NEAR Act (which permanently authorized the private security camera program). The program had very consistent output, providing rebates and vouchers to almost 2,000 individuals and organizations each year, and subsidizing the purchase of more than 4,000 cameras per year. The program was well-publicized by OVSJG, MPD, and other agencies, as well as by Advisory Neighborhood Commissioners (ANCs) and business representatives. Finally, ANCs who had participated in the program described the application process as straightforward and stated that reimbursements were prompt.

At the same time, we noted that the issuance of program awards (rebates and vouchers) was very uneven by police district. Applicants from 4D and 5D, respectively, claimed approximately four times the number of awards as those from 7D (see figure on the next page).

Number of Security Camera Rebates and Vouchers Awarded by Police District as of July 7, 2021



Source: Office of Victim Services and Justice Grants

One reason for low participation in 6D and 7D cited by MPD officials, OVSJG management, and community leaders is that residents fear they could be targets for retaliation if they are seen as sharing information with police. Although police must receive the camera owner's consent to view recorded footage, many residents may not be aware of this protection or trust that it will be observed.

Low participation in 6D and 7D, the lowest-income and highest-poverty areas in the city—raises the possibility that the private security camera program is largely funding purchases by middle- and upper-income residents who could have bought cameras without the program. This possible displacement of private purchasing is impossible to measure, but it might be more prevalent now that security camera prices have dropped sharply.

At the same time, the voucher option offered by the private security camera program—which was intended to remove barriers to participation by low-income residents by paying for residential cameras up front—has rarely been used. As of July 2021, only 16 vouchers (less than 0.2% of total program awards) had been issued. Interviewees suggested a variety of reasons for low usage, but one factor is that the five public assistance programs which qualify a resident to receive a voucher—had very small caseloads, with the exception of Temporary Assistance to Needy Families.[1]

Because the voucher program has such a low participation rate, and lower-income neighborhoods east of the river also seem to have lower participation rates, we recommend that the Committee consider amending Bill 25-293 to include one of the recommendations from our June 2022 NEAR Act report –

[1] In addition to Temporary Assistance to Needy Families, the qualifying programs are General Assistance for Children; Emergency Shelter Family Services; Program on Work, Employment, and Responsibility; and Interim Disability Assistance.

namely, to add the Supplemental Nutrition Assistance Program (SNAP) to the list of programs that qualify residents to receive security camera program vouchers.

The number of D.C. residents benefiting from SNAP is more than six times the number of D.C. residents benefiting from TANF. Among public assistance programs, SNAP provides the best measure of economic need because the program serves low-income residents of all types, including families with or without children, senior citizens, and people with disabilities, unlike other programs that target their aid more narrowly.

Finally, the impact of the security camera program in preventing and solving crimes is difficult to assess due to data limitations, but police make extensive efforts to obtain camera footage and use it in investigations. Footage may advance investigations in multiple ways, such as identifying suspects or ruling them out, or narrowing down the time when a crime occurred.

MPD officials interviewed by ODCA consistently cited security cameras generally and the security camera program specifically as valuable tools in fighting crime. A recently retired MPD official likened security cameras to smoke detectors, stating that cameras serve an important purpose, do not cost much, and make people feel safer.

MPD officials expressed mixed views on whether security cameras help prevent crime. Those who saw a positive impact tended to focus on enhanced safety at sites where cameras were visible, leaving open the possibility that crimes were displaced to other areas. The more skeptical MPD officers also saw cameras as shifting crime rather than preventing it, whereas those who believed that cameras were not effective in deterring crime pointed to the brazen behavior of criminals, who commit crimes where they see targets even when cameras are visible.

By contrast with their views on prevention, MPD officials interviewed by ODCA were united in affirming the importance of security camera footage in investigating and solving crimes. These officials emphasized that camera footage is important in every stage of investigation while stating that footage was sometimes decisive in solving cases. For example, camera footage allows MPD to disseminate images of a crime to the public very quickly and helps detectives generate leads using stills of a person's clothing or a vehicle license plate. In addition, camera footage provides stronger evidence than witness accounts, according to MPD officials. An MPD commander stated that police can disseminate high-quality camera images "almost in real time."

As required by the NEAR Act, OVSJG has reported monthly to the Council on the number of times that MPD requested footage from a program recipient, the number of times the request was granted, and the number of times that footage from a private security camera helped lead to an arrest, including a breakdown by arrest. ODCA's analysis indicates that OVSJG and MPD had documented 124 requests by police officers to access footage from OVSJG-funded cameras as of July 2021. At least three of those requests were denied. OVSJG and MPD also cited 40 arrests in cases where footage from OVSJG-funded cameras was accessed—29 of which were for homicides—but there is no causal link between the use of camera footage and the ensuing arrests. In some cases, the footage that was accessed may not have yielded any useful information, or it may have been one factor among many that advanced the case.

Nevertheless, OVSJG and MPD officials emphasize that the data reported does not reflect actual camera usage for several reasons. First, police officers often identify private security cameras that may be useful

in an investigation by canvassing an area, rather than by requesting a list of nearby security cameras from MPD's database. Informal requests to access footage may not be recorded or connected to any arrests that may result. Second, many investigations are turned over to detectives who do not know if security cameras that provided valuable footage were funded by OVSJG. There is often a considerable lag between viewing footage and the time an arrest is made so that linking particular cameras to an arrest would involve retrospective analysis that would not be feasible for detectives or represent an effective use of their time.[2]

The most detailed examination of security cameras' impact on police work in D.C. identified by ODCA is an MPD study of the role of video footage in the investigation of 160 homicides that occurred in 2018. As shown in the table below, MPD detectives obtained video footage in 132 cases (83%) and found that video footage advanced the investigation in 59% of cases. The video footage covered in the study includes MPD's closed-circuit television cameras and private security cameras, but not cell-phone video footage.

Impact of Video Footage (VF) on MPD Investigation of Homicides Occurring in 2018

	Total	VF Available	VF Advanced Investigation	VF Contributed to Closure
Closed Cases	85	67 (79%)	57 (67%)	48 (56%)
Open Cases	75	65 (87%)	37 (49%)	-
All Cases	160	132 (83%)	94 (59%)	48 (30%)

Source: Metropolitan Police Department

When comparing the data for the 85 homicide cases that were closed from 2018 with the 75 cases that remained open, MPD analysts found that video footage advanced the investigation in 67% of the closed cases, versus 49% of the open cases. Among the 85 closed cases, MPD found that video footage contributed to case closure 56% of the time. Based on these data, MPD concluded that, "(L)ocation-based CCTV cameras and their derivative video footage play a critical support role in police investigations."

Civil liberties groups and other privacy advocates caution that private security cameras could be used to track people exercising First Amendment rights and support excessive police surveillance, particularly as Internet-connected cameras such as Ring and Google Nest become more widespread. The concern is that security cameras can reduce people's ability to enjoy normal daily activities without being monitored and can contribute to racial profiling.

Suggested questions on Title VIII

1. When the private security camera program was launched in 2015, security cameras were less prevalent than they are today. The program has helped many residents purchase cameras, but the landscape is different today because technology has advanced (Ring and other doorbell

[2] OVSJG monthly reports have stated that, "Establishing a system to track the specific utility of video and the type of camera that recorded it until an arrest is actually made is not an efficient use of law enforcement resources better directed at investigating crime. Therefore, MPD is unable to provide comprehensive data on this."

cameras serving as an example) and cameras are less of a novelty as well as less costly. Do you see a time when the D.C. government should no longer subsidize the purchase of this particular good?

2. From a public safety perspective, the key aspect of the security camera program is that program beneficiaries must register their cameras with MPD. Are there alternative ways to further this goal, such as by offering an incentive payment to residents or businesses that install security cameras on their own (without a rebate) and then register the cameras with MPD? This approach could lower costs because the D.C. government could avoid costs of $500 to $750 (or more) per beneficiary.
3. What efforts could be taken to increase program participation by residents and organizations in the 6th and 7th police districts, and by low-income residents more generally?
4. What is your view of amending the law to allow residents who receive SNAP benefits to qualify automatically for security camera program vouchers?
5. What can be done to allay concerns of civil liberties and privacy violations as private security cameras proliferate – part of what some refer to as "a surveillance state."

Title IX: Criminal Justice Coordinating Council.

Title IX requires the Criminal Justice Coordinating Council (CJCC) to report quarterly to the Mayor and Council, and to post on the CJCC website, "aggregate programmatic data on process and outcomes of programs, including diversion," and "aggregate outcomes of alternative dispositions and sentencing arrangements." This report would include relevant data from all CJCC members.

On its face, Title IX seems unobjectionable to ODCA. Nevertheless, ODCA has found in its field work on NEAR Act police reform provisions that many of the data reports required by the NEAR Act, such as a survey on police-community relations commissioned by the CJCC and annual reports on felony crime data published by the Office of the Deputy Mayor for Public Safety and Justice, have been used sparingly by policymakers and the public. Therefore, we suggest that the Committee use this hearing to probe how the administration plans to use these quarterly reports and what gaps they would fill in current data systems.

We further note that Title IX could benefit from more focus and specificity. Each CJCC member, such as the Office of the Attorney General or the Pretrial Services Agency, operates numerous programs (some of which are likely subject to other performance reporting requirements). Without more specificity, this mandate for "aggregate programmatic data on process and outcomes" may be less useful than expected.

Finally, ODCA points out that Title II, Chapter 42A (Criminal Justice Coordinating Council) of the D.C. Code has become very fragmented and unwieldly. D.C. Code § 22-4234, which sets forth the CJCC's duties, has an array of data gathering and reporting mandates; moreover, other chapters of the Code prescribe additional data requirements for the CJCC pertaining to human trafficking (D.C. Code § 22-1841) and youth rehabilitation and recidivism (D.C. Code § 24-906.02). The Committee should consider how Title IX of Bill 25-291 can best be coordinated with the CJCC's existing data collection and reporting mandates, and whether a wholesale review of the CJCC statute is needed in the future to ensure that the CJCC can administer its duties effectively and efficiently.

Suggested questions on Title IX

1. What specific gaps or deficiencies in our criminal justice data system do you hope to address through Title IX?
2. In light of prior data reports that have been little used (example: annual felony crime data reports prepared by DMPSJ, pursuant to the NEAR Act), how can we ensure that this fairly general proposal will be useful to policymakers and the public and help shape better criminal justice policy?
3. As the D.C. Code sections concerning the Criminal Justice Coordinating Council have become longer and perhaps more unwieldy, would a comprehensive review of CJCC powers and duties be beneficial?

Thank you for considering these findings, recommendations, and questions. Please let us know if we can be of further assistance as you review Bill 25-291.

PUBLIC HEARING ON B25-291, THE SAFER STRONGER AMENDMENT ACT OF 2023
BEFORE THE COMMITTEE ON THE JUDICIARY AND PUBLIC SAFETY
COUNCIL OF THE DISTRICT OF COLUMBIA

Testimony of Mark Jordan

Executive Director, Office of Independent Juvenile Justice Facilities Oversight

JUNE 27, 2023

Good afternoon, Chairperson Pinto, and members of the Committee. My name is Mark Jordan, and I am the Executive Director of the Office of Independent Juvenile Justice Facilities Oversight. The Office of Independent Oversight was created in 2021 pursuant to a settlement agreement that ended the 35-year-old Jerry M. class action lawsuit, which pertained to the conditions of confinement for youth housed in Department of Youth Rehabilitation Services ("DYRS") secure facilities.

I am here today to testify regarding B25-291, the Safer Stronger Amendment Act of 2023 as it relates to DYRS's secure facilities, particularly the Youth Services Center ("YSC"), DYRS's secure facility for detained youth. My testimony is not intended to take a position on the merits of the policies that would be effected through the legislation. Rather, my testimony is intended to address a potential consequence of the legislation that must be considered carefully, and, if the legislation is passed, managed deliberately in order to avoid detention center overcrowding and deteriorating conditions of confinement like those that existed during many years of Jerry M.

Title II, Subtitle B of the bill would amend the District of Columbia Code to allow for the detention of a child alleged to be delinquent in order to protect the child's person or property from significant harm and would add a rebuttable presumption of detention for children who a judicial officer finds a substantial

probability of having committed a dangerous crime, a crime of violence, or the crime of carrying a pistol without a license. One potential, if not likely, effect of these changes to the Code would be to increase the percentage of youth alleged to be delinquent ordered to be securely detained pending a hearing. This, in turn, would likely result in more youth being admitted to the YSC, which, all other things being equal, would cause the population of the YSC to grow.

It is this potential for increases in the YSC population and the associated consequences of facility overcrowding that I would like to focus on today. The YSC is an 88-bed facility, which opened in December 2004. For much of its history, the YSC was prone to precipitous changes in population levels and overcrowded conditions, that is, housing more than 88 youth in the facility. At its peak in 2009, the YSC housed 156 youth, 77 percent more than its designed capacity. More frequently, however, when the facility was overcrowded it housed between 90 and 120 youth.

Beginning in June 2017 there was a sustained reduction in the population of the YSC, and until very recently, which I will discuss momentarily, June 18, 2017 marked the most recent date the YSC's population exceeded its 88-bed capacity. In fact, for the period from mid-2017 through the beginning of 2023, the facility's population generally remained below 60 youth.

During a February 2023 DYRS oversight hearing, I stated the following:

> I am pleased to report that population levels at the YSC have not exceeded the facility's 88-bed capacity since June 18, 2017. Over the past six months, the average daily population at the YSC has been 50 youth….While DYRS has been able to operate its facilities below capacity for a sustained period, historical population trends, at the YSC in particular, caution against complacency. The YSC population is prone to rapid and significant changes, influenced not only by arrest rates, but as importantly by prosecutorial and judicial decision-making practices. DYRS and its partner agencies should closely monitor population trends to identify population pressures *before* they result in facility overcrowding.

In fact, shortly after that hearing the YSC population began to grow steadily. From a baseline in the mid-40s in January 2023, the population rose to over 60 by mid-March, to over 70 consistently by mid-April, and to over 80 by late-May. On May 29, the population of the YSC exceeded its 88-bed capacity for the first time since June 2017 and peaked at 91 two days later before dropping. Much of the growth of the population during this six-month period was attributable to youth with detention orders. Whereas in the beginning of 2023 there were generally 20 to 25 youth with detention orders housed at the YSC each day, by late-May that number had increased to the mid-40s.

Fortunately, since the late-May peak, YSC's population has declined to 68 youth as of yesterday, in large part due to DYRS's efforts to move committed youth to alternative placements. Notwithstanding this very recent population retrenchment, the risk of facility overcrowding remains greater now than it has been over the past several years.

There is a long and well documented history of the consequences of overcrowding at the YSC in the record of the Jerry M. lawsuit. When the facility exceeds its capacity, youth are housed in makeshift dormitories, often in areas that are otherwise used for facility programming. Critical incident and assault rates tend to rise as there are more youth interactions and fewer options to separate youth into smaller groups. More staff are required to operate the facility, as more youth require more staff to supervise additional areas of the facility, to conduct more internal escorts, and to transport youth to outside appointments. The quality of programming suffers, including education and health services as the demands of the programs exceed the designed capacity and staffing levels the services were intended to serve.

Perhaps more now than ever, the effects of an overcrowded YSC would be amplified due to current staffing shortages at the facility. The YSC staffing complement is at historically low levels and, consequently, the number of staff available to fill posts is greatly reduced compared to pre-pandemic levels. Areas of the facility that historically would be supervised by two YDRs are now frequently supervised by one YDR, creating safety risks to youth and staff alike. If the facility were to exceed it's 88-bed capacity regularly it would cause sustained and acute operational strains on facility staff.

Low staffing levels are an independent problem from facility population levels that require a different set of management solutions which I encourage be undertaken. Nonetheless, the potential for overcrowding must be considered in the context of current staffing levels.

Under any circumstances, juvenile justice stakeholders must be purposeful about the population of individuals who are subject to detention and aware of the conditions that those individuals experience. The long history of Jerry M. underscores that maintaining appropriate facility population levels and preventing overcrowding is central to ensuring the safety and health of both youth and staff. Whether to enact Title II, Subsection B of the Safer Stronger Amendment Act of 2023 is a decision for policymakers that I nor my office take a position on. However, regardless of what decision is made, juvenile justice stakeholders from all three branches must collaborate to ensure that that there are sufficient, safe resources to manage the population of securely confined youth in the District of Columbia and that conditions at the YSC do not revert back to the conditions that characterized the facility prior to the termination of Jerry M.

Thank you for the opportunity to testify today and I would be pleased to answer any questions you may have.

June 22, 2023

Dear Mayor and City Counsel,

As a native Washingtonian and resident of Washington, DC, I support "The Safer Stronger Amendment Act of 2023" to deter acts of criminal activity and protect the citizens of the city of Washington, D.C. As a citizen of the city, I like to know initiatives will be put in place to make the streets safer to enjoy it without becoming a victim of a crime. I live in the Skyline area of D.C. and have felt anxious going into some areas of the city. I invested in a Ring, this device sends alerts often alerting me to criminal activity such as, shootings, carjackings, vandalism, package theft, etc. For example, on Juneteeth, there was a shooting on Fairlawn Street, just under a mile from where I live and a block away from the entrance of Anacostia Park. Anacostia Park has and continues to be utilized by many people enjoying the park in one way or another. It is quite unnerving to think that we cannot enjoy it without fear we may become a victim to crime. Crime does impact our city negatively.

With that being said, I would like nothing better than to know that changes are being made to combat these issues. As our representatives, I am requesting that you take the steps to support these measures to toughen the penalties to hold individuals accountable for their actions. Therefore, I support, the "safer stronger amendment act of 2023".

Best Regards,

Pathenia Proctor

OPEN CITY ADVOCATES

Testimony of Penelope Spain
Co-Founder & Chief Executive Officer, Open City Advocates
Committee on the Judiciary and Public Safety
B25-291, the Safer Stronger Amendment Act of 2023
Tuesday, June 27, 2023

Good afternoon. My name is Penelope Spain. I am a resident of Ward 4 and for the past 18 years have served as CEO of Open City Advocates, which provides legal representation and mentoring to youth who have been committed to DYRS. I am staunchly opposed to the vast majority of what the Mayor has dubbed the Safer Stronger Amendment Act; a more apt name might be the Detain and Dehumanize Act. Today, I specifically call your attention to the provision expanding pretrial detention to "protect the child." Locking up our children is anything but protection. This bill would put our kids in cages instead of giving them the care and support they need to thrive. Fully 100% of the kids we lock up will be Black and brown (it's been that way for decades) and our neighborhoods and communities will be no safer for it.

Pre-trial detention of children is fundamentally traumatizing. Anyone who has walked the corridors of the Youth Services Center can feel that in their bones. Despite the flowers out front, the inside of YSC is comprised of cinder block walls, cold cells, and stainless steel toilets. YSC is the sound of sally port doors slamming and children banging their fists on their small, scratched windows….asking to be seen. And it's sometimes hard to look, because when you do, you see children's eyes pleading with you to recognize their humanity – because this place has tried to strip them of it.

And an overwhelming body of research backs up what your gut tells you – incarceration is counterproductive.[1] It is traumatic and dehumanizing, filling our children with a hurt and rage that they will carry beyond those walls, often manifesting in ways that do great harm. As DC's Criminal Justice Coordinating Council has stated repeatedly, "While the juvenile justice system is intended to rehabilitate children, involvement in the system, *particularly secure detention*, is

[1] Richard Mendel, Why Youth Incarceration Fails: An Updated Review of the Evidence (The Sentencing Project, March 2023).

well-established to have lasting negative effects on youth such as increased risk of adult incarceration, decreased likelihood of high school graduation and success in the labor market, and worsening of mental health disorders."[2]

To look at just one negative outcome of pretrial detention - research shows that incarceration greatly disrupts educational progress and can reduce the likelihood of high school graduation by 26%. This statistic doesn't surprise Open City Advocates in the slightest – as we fight ad nauseam for our clients at YSC to receive basic education, let alone the special education services to which they are entitled. And after release, it's typically our staff attorneys fighting to get our clients reenrolled in school – not the judges, probation officers, or case workers who claimed that a child needed to be locked up in order to get an education.

I understand the Mayor's desire to improve safety. My children and I live in this city, too, and like everyone who lives in or visits DC, we have a human need to feel safe. Yet we already know what we need to do to make our city safer and this bill does *none of it*. Rather than supporting this bill, I urge you to carefully review and implement the recommendations in the DC Juvenile Justice Advisory Group's report entitled, "Create New Opportunities for 'Persons in Need of Supervision' to Succeed Without Legal System Intervention." Or review the Criminal Justice Coordinating Council's "A Study of Factors that Affect the Likelihood of Juvenile Justice System Involvement." That report spells out the underlying needs of DC youth and the protective factors that can keep kids on a path towards success. Rather than putting kids in cages, let's hold the adults accountable for implementing what data and research have already told us can and will work – mentoring, tutoring, recreation, employment programs, economic supports, and robust mental health services. Nowhere in that list is pretrial detention.

Thank you for the opportunity to testify today. I am available to answer any questions.

[2] "A Study of the Root Causes of Juvenile Justice System Involvement," Criminal Justice Coordinating Council, November 2020.

bxp

By Electronic Mail
judiciary@dccouncil.gov
BPinto@dccouncil.gov

June 23, 2023

Honorable Councilmember Brooke Pinto
Committee Chair
Judiciary & Public Safety Committee
District of Columbia City Council
1350 Pennsylvania Avenue, NW
Washington, DC 20004

Re: B25-291, the Safer Stronger Amendment Act of 2023 "SSA 2023"

Dear Councilmember Pinto, Members of the Committee, and other Members of the Council:

I am writing to express support for passage of the Safer Stronger Amendment Act of 2023. Our city is currently being plagued by not only an actual increase in crime but – perhaps more impactfully – the perception of an even larger increase in crime and a corresponding reduction in perceived public safety.

While it can be argued whether SSA 2023 goes far enough and certainly argued that there is more to do on the topic of crime reduction in the District of Columbia, it would be difficult to argue whether SSA 2023 is an appropriate first step. Constituents of all stripes – residents, visitors, property owners, small business proprietors, the employees of the businesses that are so critical to the fiscal health of the city, and many others – are all seeking acknowledgement of the unacceptability of criminal behavior and the clear statement of our collective intolerance for hurtful and criminal actions. SSA is a step towards acknowledging those things in our city.

It is no secret that the District of Columbia, along with jurisdictions around the country, is facing a potentially severe decline in the valuation of its commercial properties and, therefore, a potentially significant reduction in its tax revenues. While there are many contributing causes for this decline, there can be no debate that the perception and reality of a city that is less safe is among the primary contributors. Importantly, enhanced policing, the appropriate prosecution of crimes, appropriate penalties for criminal behavior and other related topics are things that we can – and must – control. Our justice system serves to both deter the commission of a crimes as well as to punish it. SSA takes appropriate steps that can help enhance both.

To be sure, the District operates in a competitive environment. People, businesses, and visitors all get to choose how often to come into the District to visit or do business here. Likewise,

investment firms and capital have choices on where to deploy their resources. By strengthening our criminal laws and enhancing the penalties for violent crime, we make our city not only safer but undeniably more competitive at a time where that is as important as ever. We should not only pass SSA 2023, but continue to seek additional ways to enhance the safety of the city.

I ask the Committee and the Council as a whole to move swiftly and decisively to pass the SSA 2023 legislation as drafted.

Respectfully,

Peter V. Otteni

cc: Chair and Members of the City Council
PMendelson@dccouncil.gov
CAllen@dccouncil.gov
ABonds@dccouncil.gov
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Subject: Reports & Research on Pretrial Detention; Re: Council Hearing on June 27, 2023
To: Councilmember Zachary Parker and Deputy Chief of Staff Conor Shaw, Judiciary Committee
From: Tenille Patterson, Executive Partner, Pretrial Justice Institute

This memo is submitted with the intention to provide the reports and research referenced in the testimony provided by the Pretrial Justice Institute (PJI) on Tuesday, June 27, 2023. Below you will find relevant data and research on pretrial detention, its overall consequences, pretrial statistics in DC, and two case studies (New Mexico & Virginia) that demonstrate the ineffectiveness of a rebuttable presumption of pretrial detention. We invite any member of the council to follow up with Tenille Patterson at tenille@pretrial.org.

Pretrial Detention and Rearrest
Pretrial detention—for any length of time—is associated with a higher likelihood of a new arrest pending trial and increases recidivism post case disposition.

Research Study:
Hidden Cost of Pretrial Detention Revisited (pages 2, 4, 6-7)
Source:
Justice Denied: The Harmful and Lasting Effects of Pretrial Detention (pages 1, 6)

Sentencing Outcomes
Pretrial detention is associated with an increased likelihood of receiving a sentence to jail or prison, and a longer sentence compared to those who were released pretrial. This finding held even when controlling for the outcomes of pretrial release. That is, those who were rearrested or failed to appear on pretrial release were still less likely to receive a sentence to incarceration and received a shorter sentence relative to those that were detained pretrial.

Research Study:
Hidden Cost of Pretrial Detention Revisited (pages 2, 5-6)

Washington, D.C. Pretrial Statistics
93% of people released pretrial aren't rearrested and only 1% of people are rearrested for a violent offense while awaiting trial.

Source:
Pretrial Services Agency Congressional Budget Justification Fiscal Year 2024 (page 25)

New Mexico Study Proves the Ineffectiveness of Presumptions of Detention
Researchers found that 93% of people charged with felonies who would have been detained under a presumption of detention for a prior conviction for a violent felony were not rearrested and charged with a violent felony or misdemeanor awaiting trial.

Research Study:
How Accurate are Rebuttable Presumptions of Pretrial Dangerousness? (pages, 1, 10, 11-13, 17-21)

Virginia Ended Rebuttable Presumptions in 2021
Studies show the risk of new criminal offenses is not closely correlated with the initial offense with which an individual is charged.

Research Study:
Impacts of Presumptions Against Bail On Pretrial Release and Public Safety in Virginia (pages 3, 6, 8-11, 13, plus Executive Summary)

My name is Randall McNeil I work for Arnold Ventures, and I am an IRAA recipient.

When I was young my mother was very sick with Diabetes and Chronic Pancreatitis, and she was in and out of the hospitals. I had a brother with special needs due to his premature birth. From a very young age I had to step in and take care of my mother and brother. Many nights I had to comfort my mother during her suffering. I always had to take care of my brother. When I was 16 my mother went in the hospital and never came home.

After my mother died, I was the only one who was able to take care of my brother and myself. My brother and I lived alone in our mother's apartment, and we struggled to survive. My only realistic choice was to sell drugs so my brother and I could eat and keep the lights on. Along the way I made some bad decisions that changed the entire course of my life. I was arrested and sentenced to 66 years to life. I left behind my brother, my now-wife, and my 4 children.

In 2002, while incarcerated in USP Lee County, I made the decision to do everything I could to become a better person and change my ways. I worked many overtime hours to send money home to my kids, I read hundreds of legal books before they had LexisNexis in the BOP, and I stayed away from the prison culture and politics that many people succumb to. I knew that working in UNICOR and staying in the law library were the two places where I could escape the drama and the violence in prison. The more that I studied the laws in D.C., the more I lost hope that I would ever be able to come home to my family and show my community how I'd changed. In 2021, when the D.C. Council amended IRAA to include people under the age of 25, I felt hopeful for the first time in a very long time. Having hope that one day you might be free again is very helpful to an incarcerated person. Hope is what helps you walk away from trouble. Hope is what pushes you to do the right thing. Before IRAA, I never believed that lawmakers would recognize that we were children too. On August 19, 2022, I was released from the BOP after serving 24 years and 4 months of a 66 to life sentence.

Since I've been home, I married my soulmate and the mother of my children. I am the Criminal Justice Fellow at Arnold ventures, one of the largest philanthropic organizations in the country. At Arnold ventures I work with some amazing colleagues and organizations that fight everyday to make the criminal justice system better for all.

The men that have come home under IRAA are different than they were when they were children and are contributing to their communities and to their families. We are all worthy of redemption and a second chance. If I was measured under the proposed IRAA changes, I might not be here today. There are plenty of incarcerated men that have changed their lives just like I did, and they are ready to come home.

As a representative of Arnold Ventures and an IRAA recipient, I am asking the D.C. Council to protect IRAA and reject the mayor's proposed amendments.

Thank you for allowing me to speak.

REVEREND ANTHONY J. MOTLEY, MDiv
WASHINGTON, DC 20020

Tuesday, June 27, 2023

Council of the District of Columbia
Committee on the Judiciary and Public Safety
Hearing on B25-291: Safer Stronger Amendment Act of 2023
Room 500 of the John A. Wilson Building
1350 Pennsylvania Avenue, NW,
Washington, DC 20004

TESTIMONY OF
REVEREND ANTHONY J. MOTLEY

Dear Councilmember Brooke Pinto, Chair, Judiciary and Public Safety Committee, and members of the Committee. My name is Reverend Anthony Motley, a resident of Ward 8, graduate of Turner Elementary School, Frederick Douglass Jr., and Anacostia High Senior High School(s). I am a product of the streets of Southeast, an ex-offender, the subject of a Smithsonian and Anacostia Neighborhood Museum(s) Exhibit entitled "**Speak to My Heart**", and a Washington Post Magazine expose entitled "**Hustling for Souls**" highlighting my ministry work East of the River. I am also a Disabled Veteran/Paratrooper (Combat Engineer 12B2P), a graduate of the Howard University School of Divinity (Masters of Divinity (MDiv.)), and a visionary who has brought forward a number of community-based initiatives, to include; HIV & AIDS; the East of the River Clergy, Police, Community, Partnership; the Summer Academic Program "SAP" and After School Tutoring programs, under the leadership of the late Dr. Floretta McKenzie; the Poverty and Despair and Economics of Violence Symposiums; co-created the Academy of Construction and Design at Cardozo Senior High School and the JOBS Coalition

of Washington; created the first "Reentry Workforce Development and Homeownership Center" for returning citizens in the District of Columbia; served as President of the District of Columbia Coalition for the Homeless and shepherded the effort to bring the men's homeless shelter to Ward Eight in the '80s and placed six (6) homeless independent living facilities across the City; served as a Facilitator of Learning in the District of Columbia Schools aimed at creating a healthier, safer, and prosperous City, and facilitated the development of the first Conflict Resolution, Peer Mediation, and Youth Court model in the District of Columbia in the '90s. I was also one of the co-creators of the first "Midnight Basketball" program in DC with the support of MPD-7D Commander, James R. Lee., who later became an Assistant Chief for Youth. In the 90's fought to ensure that DYRS met the requirements of the "Jerry M. Consent Decree" and worked with Jenise (MaJo) Patterson of Parent Watch to be able to remain in DYRS as a valuable partner and resource for parents and children.

I am also co-visionary of the **South Capitol Street Memorial Act**, penned in 2012 with one of your former Council colleagues and parents, after the 2010 massacre of four (4) young people and the wounding of six (6) on a chilly day in March 2010, I was there! I also helped to curb a community uprising after the fatal police shooting of a young man in the Trinidad neighborhood of NE and later created next steps to keep the peace and mend the police and community rift.

I am presently assisting in the development of the East of the River Public Safety Consortium consisting of thirty-eight (38) organizations addressing a myriad of issues impacting our city.

Why do I share this aforementioned information? It is my belief that any presentation without context is nothing more than words without meaning or purpose. To address the problems of violence, and in particular gun violence, it is important I support the mayor's legislation "B25-291: Safer Stronger Amendment Act of 2023 with this in mind.

In the 90's I drove with my daughter and grandson to the District of Columbia Youth Challenge Program in Aberdeen, Maryland. The reason we had to go there was because my grandson was off the chain. After his stay at the Camp, he is now a productive contributor to society. He is an entrepreneur and now lives in Florida and has a child of his own. Today, we have many of our young people residing in fatherless, motherless, and family-less environments, surrounded by so much dysfunction. There are too many young people homeless, out-of-school, and lacking motivation and guidance. Supporting the Mayor's legislation, Safer Stronger Amendment Act of 2023, while helpful, we should also mandate the following:

1) School be a **requirement** by all young people **eighteen (18**) years of younger.

2) Any young person charged with a non-violent crime be mandated to attend the **DC Guard Youth Challenge Program**, and if a violent crime should be given the best services and environment available for their rehabilitation.

3). Ensure that **Conflict Resolution, Peer Mediation, and the Youth Court** Programs, which was created by the East of the River Clergy, Police, Community, Partnership, be reinstated throughout the District of Columbia School System, both Traditional and Charter Schools, and Recreation Centers.

4). Institutionalize the "**40 Days of Increase Peace**" Initiative throughout the District of Columbia from June to August of every year.

5). Institute a "**Gun Education and Training**" program, as designed by Inner Thoughts, Inc., CWebb and Ms. Haynie, aimed at middle and high school students.

6). Reinstitute **Driver Education** training and vehicular safety in the District.

7). Ensure that the "**Community Service Hours**" for graduation, in District of Columbia Schools, is stringently adhered too.

8). Ensure that the "**JobsNotGuns**" model, as created by the **DC Business Gun Violence Prevention Coalition**, Recruitment Fairs, Youth Workshops, and Business/Mixer's makes its way to "All Eight Wards"! on an annual basis.

9). Enact legislation as crafted and supported by the **Black Women for Justice** to create **Vocational Education Schools**, not just programs, and ensure that D**uke Ellington School of the Arts** remains an application school with auditions to attend, with oversight of its programs and staff to be maintained by the Duke Board of Trustees in collaboration with DCPS.

9). Replicate what works, like using the **Domestic Violence Wear Many Tags** model, a seamless transition of addressing domestic violence from personal hurt and pain, to healing, fulfillment, and productivity; and,

10). Embrace and support the **T.R.I.G.G.E.R. Project**, public health prevention model to addressing gun violence from a holistic and therapeutic perspective, as a university concept with different schools folded into the University model.

In Closing, while the District of Columbia has expended a ton of money in the last few years to address crime and violence, and sponsored several government programs and slogans, the lack of a coordinating strategy has caused us to fall short of those efforts. Without having a competent person of unselfish motives, and a team of devoted public servants and community-based leaders, who are not driving the anti-violence efforts in DC; we will forever have us one life short, a day behind, and pursing an illogical "good money following bad investment", outcome. Our efforts thus far, have been hampering the future of our youth and residents, all of which is making DC a public safety nightmare.

"DC-We Can Do Better Than This"!

Thank you for the opportunity to share my experiences, thoughts, and recommendations.

Sincerely yours,

Anthony J. Motley

Reverend Anthony J. Motley

MSDC
MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA

1455 Pennsylvania Ave, NW
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Washington, DC 20004

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July 10, 2023

Councilmember Brooke Pinto
Chair, Committee on the Judiciary and Public Safety
1350 Pennsylvania Ave NW
Washington, DC 20004

Dear Chair Pinto,

The Medical Society of the District of Columbia (MSDC) is the largest medical organization representing metropolitan Washington physicians in the District. We advocate on behalf of all 11,000 plus licensed physicians in the District and seek to make the District the nation's model for patient care and physician practice.

Thank you for allowing us to submit written comments on **B25-0247, the Female Genital Mutilation Prohibition Act of 2023.**

MSDC wants to echo the comments of our colleagues with the American College of Obstetricians and Gynecologists, previously submitted. MSDC supports the intent of the legislation and banning the horrendous practice of FGM. However, we do have concerns with some of the specific legislative language and again echo ACOG's suggestions:

1. Add language that specifies this law applies to banning FGM in both adult females and minors. An exception should be noted for genital 'piercings' by adults where no tissue is excised without medical indication.
2. Amend the statutory definition of "child abuse or neglect" to include prohibited acts related to female genital mutilation, as well as those who enable FGM procedures – including transporting, aiding or knowingly facilitating the procedure on a minor as defined in this bill. FGM, if defined as child abuse, becomes a reportable felony.
3. Add knowingly allowing a child or her siblings to undergo FGM to the list of circumstances constituting grounds for termination of parental rights.
4. For adults, re-define FGM as battery against the victim. Require prosecution of persons who perform or enable banned FGM procedures on adults.
5. Add these specific prohibited acts to the Mandatory Reporting requirements, including suspicion that a minor may be at risk. However, people who have arrived in the District of Columbia having already been subjected to this procedure in the past, prior to immigration to the USA should be excluded from reporting and prosecution.
6. Include data collection, documentation, and reporting requirements, in addition to the important public awareness and education initiative tasked to DC Health.

Please reach out to the MSDC office if our membership can be of assistance on this or any issue. We look forward to working with you and the Committee to improve the health of the District.

Sincerely,

Susanne Bathgate, MD
President, Medical Society of DC

OPEN CITY ADVOCATES

Testimony of Rondell Jordan
Staff Attorney, Open City Advocates
Committee on the Judiciary and Public Safety
B25-291, the Safer Stronger Amendment Act of 2023
Tuesday, June 27, 2023

Good afternoon, Chairman Pinto, et al. My name is Rondell Jordan, and I am a resident of Ward 2 and a Staff Attorney for Open City Advocates, which provides legal representation and mentoring to youth who have been committed to DYRS. Open City Advocates is also a member of the Youth Justice Project Coalition, a coalition of DC-based organizations that strives to create a DC where our children, and particularly our Black and Brown children, are free to be kids and are supported throughout their transformation into healthy, thriving adults.

I am here today to testify against the Safer Stronger Amendment Act—a poorly named bill that makes us weaker and reduces the safety of the Black community in DC. It responds to a valid concern: the increase in crime, and especially violent crime. But it's plying a failed prescription—especially for our community's children.

We are currently reaping the fruit of our city's failures. The last time we got tough on crime—so-called "Stronger, Safer"--we sent tens of thousands of Black DC residents to prison and ruined their employment prospects. Back then, we were fearful that we had raised a generation of Super Predators. Their wives lost husbands, their sisters lost brothers, their mothers and grandmothers lost their children, and their children lost their parents. DC's youth are not Super Predators—there is nothing especially bad or scary about them. What distinguishes my clients is that they are poor people of color. We are not a Chocolate City any longer, but the jails sure are Chocolate--and they are going to continue to be Chocolate unless we get honest with ourselves and avoid acting out of fear.

We should start by asking, honestly, why we're seeing more crime and especially more violent crime right now. Is it because things have gotten **better** for young people in Wards 7 and 8? Is it because of a lack of accountability?

I believe in accountability: but we adults need to hold ourselves accountable, first, for the harms that the systems we perpetuate have done before passing the baton to the next generation. 90% of my clients are Black. The other 10% are Latino. 100% of them are facing housing insecurity, poverty, and have themselves been the victim of violence. More than 90% have experienced the adverse childhood experiences that can destroy young people's lives before they touch the legal system. But 100% of my clients have now had those experiences: once they've been imprisoned, they've all had yet another of those adverse childhood experiences that can ruin someone's future.

And yet oddly, none of my clients received any support before they came into contact with the "accountability" systems of our city. I have clients who were evicted—even during the eviction moratorium—then they engaged in some petty robbery or drug dealing or carried a gun to protect themselves, and so the city decided the right response was to spend $16,000 PER MONTH to house them at YSC. Our city is, right now, saying that if you steal an $800 iPhone, we'll spend $192,000 a year to dehumanize you. Those resources could transform Wards 7 and 8. We certainly shouldn't double-down on that by passing this bill.

I don't believe a white suburb would respond to increased levels of gun crime by locking up more of their children. I just don't believe it would happen that way. And anyone who hasn't spent a night in jail, or had their children snatched away from them, or seen their kids walking in a line with their hands chained behind their back doesn't have the standing to demand that accountability means locking up more children.

We already incarcerate more young people in DC than anywhere else in the country. YSC and New Beginnings are already under-staffed and over-capacity, and we're seeing the harm that does, too. Putting youth on 23 hours of lockdown in their cells, cells flooded with fecal matter, and all the time there are DYRS staff calling my clients animals.

If DC were a State, we would have the highest unemployment rate for black men in the United States, and that's just adult men: for youth it's out of control. Well, this bill would make a lot more jobs, but they're really zookeeper jobs, and we don't need more zookeepers, and we don't need more cages, because we don't have any animals. These are our children. And one day, if

we give them the opportunity, they're going to become adults. They're going to come back home. And they're going to pay us back with the love that we show them today. They're going to pay us back for the fear that we resist today.

It's hard right now to do the right thing with gun violence ticking up, but morally, spiritually, and for people who care about the numbers, economically, the right thing to do is to vote against this bill and to support our youth.

HBI-DC provides overall health screenings and linkage to care and treatment, which include Hepatitis and HIV testing, to vulnerable communities.

Most of the clients we serve reside in wards 6,7 and 8, where substance abuse and crime rates are the highest within the District of Columbia, with a particular concern on homicides and other crimes reported.

We are testing and identifying patients who have HCV and HIV, who are motivated to seek treatment. Fear of crime around areas where opioid use and Medication **Assisted Treatment** for **Opioid** Addiction services are provided prevent some from initiating treatment. Many places such as clinics, community-based organizations, including substance abuse programs that provide MAT services, such as methadone clinics, tend to be around a *heavy* concentration of crime. The situation raises anxiety and fear for our clients.

Their fear can impact their willingness to access treatment and prevention services for overall health screening to include mental health due to the environment. We attempt to alleviate the fear of our clients by encouraging them to come for testing and care. Our clients face many barriers to overall health; safety should not be a barrier to access treatment and care . The Safer Stronger Amendment Act of 2023 must move forward as it will Enhance penalties for violent crimes that victimize or target vulnerable residents with physical or mental impairments. The amendment will also improve the safety of our Community Health Workers and the dedicated staff of clinics that serve our vulnerable population.

Thank you for the opportunity to speak on behalf of the population HBI serves.

Sandra "SS" Seegars, Convener
Concerned Residents Against Violence (CRĀV)
202-561-6616

July 27, 2023. Hearing Before Council Member Brooke Pinto on
B25-291 Safer Stronger Amendment Act of 2023,
Amendments Proposed by Mayor Muriel Bowser

I am the convener of CRAV, a Ward 8 resident, and an opponent of victims. I believe when preventative measures do not stop a person from committing a crime, they need to be prosecuted regardless of the age of the person, and there needs to be stricter consistent punishment for juveniles and young adults. I believe the City Council and Mayor should stop a handful of criminals from controlling the city. I am in full support of all amendments proposed by Mayor Bowser.

I agree that all juvenile criminals should be detained to protect the person or property of others or of the child if the judicial officer finds by a substantial probability that the child: (A) Committed a dangerous crime or a crime of violence; or (B) Committed CPWL, carrying a pistol without a license.

I proffer another recommendation. We need to include a person over the age of 12, perhaps younger, depending on the circumstances, who commits a crime such as first-degree murder, first-degree sexual abuse, aggravated assault, or conspiracy to commit such a crime should be charged as an adult. Moreover, since there has been so much discussion about a brain not developing until the age of 25; when a child is sentenced to juvenile life, instead of being released on their 21st birthday, they should be held until the day before their 26th birthday.

Pertaining to juveniles under the supervision of CFSA who are placed there because of their behavior. The law under CFSA needs to be amended to permit a parent to seek help without being charged with neglect. The parent who should be charged with neglect is the parent who does not seek help and their child committed a crime.

Pertaining to adults misleading juveniles. When an adult involves a minor in criminal activities, the adult should be charged with conspiracy.

I agree with Mayor Bowser's amendment on gun possession. My amendment proffer is that the law on gun possession should include a penalty enhancement that if the person arrested for possession of a gun does not reveal where they got the gun they should be sentenced up to one and 1/2 times the maximum fine otherwise authorized for the offense and may be imprisoned for a term of up to one and 1/2 times the maximum term of imprisonment authorized for the offense.

CRĀV Members

Sandra "SS" Seegars, Convener
Rev. Anthony Motley, Co-Convener
Robinette (Robbie) Woodland, Co-Convener
Pastor David Venable, Co-Convener
Darrell Gaston, Co-Convener
Anthony Muhammad, Co-Convener
Sandra (SV) Williams, Co-Convener
Lenwood Johnson, Co-Convener

CRAV
Concerned Residents Against Violence

I agree with all the mayor's amendments on being sentenced to one and ½ times the maximum penalties regarding the class of person she outlined.

I proffer a new section to be added that if a person randomly shoots a firearm and strikes a person who is not the intended target, upon conviction they should be punished one and ½ times the maximum penalty.

I honestly believe you should be cautious of organizations and people who always make excuses for criminals, who never try to prevent crime, and who never have empathy or sympathy for victims.

END

CRĀV Members

Sandra "SS" Seegars, Convener
Rev. Anthony Motley, Co-Convener
Robinette (Robbie) Woodland, Co-Convener
Pastor David Venable, Co-Convener
Darrell Gaston, Co-Convener
Anthony Muhammad, Co-Convener
Sandra (SV) Williams, Co-Convener
Lenwood Johnson, Co-Convener

Sara
Imershein, MD MPH

July 3, 2023

Greetings DC Councilmembers, and the Committee on the Judiciary and Public Safety.
Thank you for the opportunity to submit commentary on the pending, re-introduced bill B24-0516 "Female Genital Mutilation Prohibition Act of 2023." In 2021 I submitted testimony as Chairman of the DC Section of the American College of Obstetricians and Gynecologists. I am the currently immediate past chair and I'm submitting this testimony as a physician and resident of the District.
The ACOG 2021 testimony is attached, which included SIX suggestions from ACOG to improve the bill as written in 2021:

1) Add language that specifies this law applies to banning FGM in both adults females and minors. An exception should be noted for genital 'piercings' by adults where no tissue is excised without medical indication.
2) Amend the statutory definition of "child abuse or neglect" to include prohibited acts related to female genital mutilation, as well as those who enable FGM procedures – including transporting, aiding or knowingly facilitating the procedure on a minor as defined in this bill. FGM, if defined as child abuse, becomes a reportable felony.
3) Add knowingly allowing a child or her siblings to undergo FGM to the list of circumstances constituting grounds for termination of parental rights.
4) For adults, re-define FGM as battery against the victim. Require prosecution of persons who perform or enable banned FGM procedures on adults.
5) Add these specific prohibited acts to the Mandatory Reporting requirements, including suspicion that a minor may be at risk. However, people who have arrived in the District of Columbia having already been subjected to this procedure in the past, prior to immigration to the USA should be excluded from reporting and prosecution.
6) Include data collection, documentation and reporting requirements, in addition to the important public awareness and education initiative tasked to DCHealth.

I am not a lawyer, but as I read the bill the current iteration does not incorporate any of our opinions/suggestions submitted in 2021. Ergo, I have repeated and reiterated our stand as experts.

Take a strong stand against Female Genital Mutilation. Incorporate each suggestion delineated above to protect adults, children and other females 'under care'. These suggestions align with the policies of ACOG and have been submitted by your local experts on women's health – your DC OBGYNs.

As I read the 2023 version it addresses only FGM performed on 'individuals under care.' The legislation does not prohibit Female Genital Mutilation in adult females, or liberated minors. I believe FGM should be a banned procedure in the District – for adults as well as persons under care. As noted above, I would specifically exclude genital 'piercings' by adults. Like tattoos, genital piercings are popular and in-fashion among some consenting adults in D.C. and no tissue is removed and sensation is not altered.

Expand the legislation to protect vulnerable minors and adults from child abuse, coercion and mutilation: include FGM as a prohibited act of child abuse in minors; include performing or facilitating FGM as battery against adult females and define the procedure as child abuse; include FGM in the list of Mandatory Reportable acts of requiring prosecution, not just a civil right of action.

Sara Imershein MD PLLC 202.365.5300 SaraImersheinMD@Gmail.com www.SaraImersheinMD.com @SaraImersheinMD

Address the unique position of liberated minors – and prohibit the procedure on all females in the District, specifically excluding from legal action victims who have been subjected to the procedure prior to their arrival in DC.
Thank you for your time.
Do more. Protect females. What is the down side of taking a stronger position?

I am available for your questions,

Respectfully submitted,

Sara Imershein MD MPH FACOG
Fellow, Senior Status and
Past Chair D.C. Section American College of Obstetricians & Gynecologists

Attached: 2021 testimony and ACOG policy

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

District of Columbia Section

February 28, 2022
Testimony in Support of B24-0516 "Female Genital Mutilation Prohibition Act of 2021."
Public Hearing of the Committee on the Judiciary and Public Safety.

Greetings, Chairman Allen, members of the Committee on the Judiciary and Public Safety. Thank you for the opportunity to speak. Thank you to Council Member Cheh, and your colleagues for re-introducing this important legislation.

My name is Dr Sara Imershein. I am a board-certified obstetrician-gynecologist and Clinical Professor at George Washington University. I've been practicing medicine in the District since 1984 and I live in Ward 3.

Today, I speak as Chair of the DC Section of the American College of Obstetricians and Gynecologists (ACOG). ACOG, with over 58,000 members, maintains the highest standards of clinical practice and continuing education for our members – your DC doctors.
We endorse and support B24-0516 "Female Genital Mutilation Prohibition Act of 2021." To wit, I have referenced *ACOG's Statement of Policy* on Female Genital Mutilation[1] (approved March 2019), which is in alignment with the proposed legislation.

B24-0516 clearly outlines the scope of procedures that encompass *Female Genital Mutilation* (FGM). We support all measures to condemn and ban these procedures. The practice has no health benefits for girls or women. Lifelong painful sex and loss of genital sensation may occur. WHO summarizes major complications, both short-term and life-long including: *severe bleeding, problems urinating, and later cysts, infections, as well as complications in childbirth and increased risk of newborn deaths*[2].
B24-0516 "Female Genital Mutilation Prohibition Act of 2021 adds protections to the recently enacted Federal Public Law 18 USC 116: *STOP FGM Act of 2020*[3].

We propose the following to further strengthen the bill and benefit our patients and their families:

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[1] https://www.acog.org/advocacy/policy-priorities/female-genital-mutilation-fgm#:~:text=In%20the%20U.S.%2C%20it%20is,Ban%20the%20practice
[2] https://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation
[3] https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title18-section116&num=0&edition=prelim

1) Add language that specifies this law applies to banning FGM in both adults females and minors. An exception should be noted for genital 'piercings' by adults where no tissue is excised without medical indication.
2) Amend the statutory definition of "child abuse or neglect" to include prohibited acts related to female genital mutilation, as well as those who enable FGM procedures – including transporting, aiding or knowingly facilitating the procedure on a minor as defined in this bill. FGM, if defined as child abuse, becomes a reportable felony.
3) Add knowingly allowing a child or her siblings to undergo FGM to the list of circumstances constituting grounds for termination of parental rights.
4) For adults, re-define FGM as battery against the victim. Require prosecution of persons who perform or enable banned FGM procedures on adults.
5) Add these specific prohibited acts to the Mandatory Reporting requirements, including suspicion that a minor may be at risk. However, people who have arrived in the District of Columbia having already been subjected to this procedure in the past, prior to immigration to the USA should be excluded from reporting and prosecution.
6) Include data collection, documentation and reporting requirements, in addition to the important public awareness and education initiative tasked to DCHealth.

Thank you for recognizing the adults and children at risk for FGM in our community. Our recommendations will strengthen protections for this vulnerable population.

Respectfully submitted,

Sara Imershein, MD MPH FACOG
Fellow, Senior Status and Chair D.C. Section
American College of Obstetricians & Gynecologists

Home address:
3912 Harrison St NW
Washington, DC 20015

College Statement of Policy

As issued by the College Executive Board

FEMALE GENITAL MUTILATION

Female genital mutilation (FGM), sometimes annotated as female genital cutting or female circumcision, is described by the World Health Organization (WHO) as comprising "all procedures that involve partial or total removal of the external female genitals, or other injury to the female genital organs for non-medical reasons" [1,2]. Although these procedures are more commonly performed in Africa, the Middle East, and Asia, it is estimated that more than 513,000 girls and women in the U.S. have experienced or are at risk of FGM [3,4]. Women may arrive in the U.S. having already had the procedure performed, but there are reports of these procedures being performed in immigrant populations by traditional practitioners, or girls being sent to the family's home country to have the procedures performed.

Female genital mutilation is internationally recognized as a human rights violation and is considered an extreme form of discrimination against women [1,2]. According to U.S. federal law (18 U.S. Code § 116), it is illegal to perform FGM in the U.S. on anyone under the age of 18 years; it is also illegal to knowingly transport a girl out of the U.S. for the purpose of having FGM performed. Many state laws also prohibit FGM on minors, and some states prohibit the practice on adult women. The American College of Obstetricians and Gynecologists condemns the practice of FGM and supports all efforts to eliminate the practice of FGM in the U.S. as well as internationally *(Note: the American Medical Association (AMA) uses the term "condemns"; American Academy of Family Physicians (AAFP) uses "supports all measures to eliminate" – as written, this combines the AMA and AAFP statements)*. This position is aligned with those of the World Health Organization, the American Medical Association, and the American Academy of Family Physicians [1,2,5,6].

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1. World Health Organization. Female genital mutilation. Fact sheets. Geneva: WHO; 2018. Available at: https://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation. Retrieved March 29, 2019.
2. World Health Organization. WHO guidelines on the management of health complications from female genital mutilation. Geneva: WHO; 2016. Available at: https://www.who.int/reproductivehealth/topics/fgm/management-health-complications-fgm/en/. Retrieved March 29, 2019.
3. Goldberg H, Stupp P, Okoroh E, Besera G, Goodman D, Danel I. Female genital mutilation/cutting in the United States: updated estimates of women and girls at risk, 2012. Public Health Rep 2016;131:340-7. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4765983/pdf/phr131000340.pdf. Retrieved March 29, 2019.
4. Office on Women's Health. Female genital mutilation or cutting. Washington, DC: U.S. Department of Health and Human Services; 2018. Available at: https://www.womenshealth.gov/a-z-topics/female-genital-cutting. Retrieved March 29, 2019.
5. American Medical Association. Expansion of AMA policy on female genital mutilation H-525.980. Chicago (IL): AMA; 2017. Available at: https://policysearch.ama-assn.org/policyfinder/detail/female%20genital%20mutilation?uri=%2FAMADoc%2FHOD.xml-0-4716.xml. Retrieved March 29, 2019.
6. American Academy of Family Physicians. Female genital mutilation. Leawood (KS): AAFP; 2015. Available at: https://www.aafp.org/about/policies/all/genital-mutilation.html. Retrieved March 29,2019.

Approved by the Executive Board March 2019

The American College of Obstetricians and Gynecologists
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Testimony of Sarah Comeau
Director of Programs & Co-Founder, School Justice Project
In front of the Committee of the Judiciary and Public Safety
Public Hearing on Bill 25-291, The Safer Stronger Amendment Act of 2023
June 27, 2023, 12:00pm

Hi, My name is Sarah Comeau. I am the Director of Programs and co-founder of School Justice Project, a co-chair of Thrive Under 25, a lifelong Washingtonian, and a Ward 1 resident. Thank you for your time. My testimony sets forth **why** the Mayor's proposed changes to IRAA and the juvenile detention standard must be rejected.

The proposed changes to IRAA will keep men like my Thrive co-chairs behind bars. I consider myself lucky to know these men and proud to call them my colleagues. These are the men that are making the District safer and richer, they are healing and protecting the District.

These men literally put their physical bodies in the path of bullets to protect the District and improve public safety.

James Carpenter, for example, will be heading into areas targeted as the highest crime areas on Fourth of July to disrupt violence and keep neighborhoods safe. He spends his mornings as a Safe Passage worker before he goes into the middle school where he works as a violence prevention specialist. He dedicates the free time that he has to co-leading Thrive, meeting with Council, and advocating for District-wide reforms.

James Dunn started a nonprofit - From the Streets to Wall Street. He teaches high schoolers how to invest, provides them a stipend to make their first investment, and takes them to Wall Street where they meet with an investment firm and experience the stock market. His work does not stop there, he works for Cure the Streets, he is a mentor, he supports his family, and spends time with his niece.

You heard from Gene Downing, Gene became my Thrive co-chair a few months after he came home. Since coming home, he has joined a local theater company. I saw his play last week, it was marvelous. In addition to pursuing his passions, he is working to build a pipeline of employers to better support returning citizens so that everyone can access meaningful employment.

IRAA recipients do not jeopardize public safety. They actively make us safer. The Mayor's proposals will strip men of hope, impact children by taking away mentors, and disrupt the positive cycles of change and restoration happening in the District.

Just like we must reject the proposed changes to IRAA, we must also reject outright the modifications to the juvenile detention provision. We cannot and should not cage children as a solution to social problems. The proposals to modify the juvenile detention standard will take us

back to crime policy that we know, and science shows, does not work. This is purely performative politics.

Jailing children does not prevent crime, in fact it does that opposite - detaining young people (especially those low risk to public safety) increases recidivism. Detaining young people harms young people. Imagine the child who is detained in the name of protection. He has not been accused of any violence or action. He is pulled from school and he is jailed. This law proposes to jail children instead of providing care. Instead of investing in care, we are promoting cages.

Yes, we need accountability. Yes, we need to implement short and long-term solutions to public safety issues. But this is not how you do it. We know that these proposals do not address the root causes of violence nor do they address what is actually occurring. This is a political bill that will not address public safety. We must meaningfully invest in communities and effectively implement social programs that do work and can prevent and disrupt cycles of violence. Please reject the changes to the juvenile detention and IRAA provisions.

I have been a resident of DC since the last 17 years. My husband and I live in Columbia Heights. Never have I seen such lawlessness, terror and violence as I see in DC now. The entire city has dissolved into chaos and there is no safety, protection or justice for the residents. There are multiple shootings, car jackings, armed robberies everyday especially in NW in Columbia Heights. We have had two shootings just on our block and there have been two burglaries at our house and the summer has just arrived. In and around the area the situation is even worse. Businesses like WAWA have shut down. The local CVs and Target have armed guards and almost empty shelves because they are afraid to stock. Shooting and brawling are a daily occurrence in the Columbia Heights metro station. Residents are increasingly leaving due to the violence.

Yet the DC council keeps passing bills that help criminals and don't punish the youth, especially teenagers that are shooting, murdering, robbing and carjacking. The Attorney General, (the former and current one) do not believe in prosecuting guilty youth even those that are committing violent crimes and thus signaling to an entire generation of young people that there will be no consequences for their actions.

We the residents are paying a high amount of taxes, yet the DC government provides us no services. Every year our property taxes goes up but our quality of life declines rendering our property unsaleable. We are stuck here in this endless cycle of apathy and violence jeopardizing our lives every day. I would encourage the DC council to examine the statistics on how many innocent bystanders have been killed or injured in these shootings to reveal what this lawlessness is doing to us.

Street cleaning is almost non-existent on our streets and people from Maryland and DC come and litter the streets and there is absolutely no enforcement of the laws. The city has a huge rat problem coupled with garbage collection issues. The DC council however remains focused on policing MPD and curbing their ability to do their jobs. MPD is demotivated and police are leaving the forces. The MPD is severely under resourced in a climate of extreme violence in the city which makes it even more dangerous for us. We have personally experienced huge delay times in their response when 911 is called. Yet the council remains hyper focused on controlling MPD instead of working with the courts to enforce the laws and punish criminals.

As of June 8th, there were 103 homicides this year, a 19% increase over this time in 2022. One can only imagine what the statistics are by now! The DC council instead of tackling the law and order problem are refusing to acknowledge that this problem exists. They make excuses varying from the pandemic to gentrification. Not acknowledging the problem is at the root cause of them not being able to find solutions. We the residents demand a safer environment to live in and assurance that the council will push through policies that will force courts to prosecute, address teenage and gang violence, identify drug and other rackets like car theft and coordinate between different agencies like DEA and MPD to collectively tackle these issues.

Sunrita Sarkar

Columbia Heights

Council of the District of Columbia
Committee on the Judiciary and Public Safety
Brooke Pinto, Chair
Testimony of Shannon Battle
Public Hearing
The Safer Stronger Amendment Act of 2023
Tuesday, June 27, 2023
Room 500
Wilson Building 1350 Pennsylvania Ave NW Washington DC

Good afternoon Chairwoman Pinto and members of the Committee,

My name is Shannon Battle and I am a returning citizen who was released under the Incarceration Reduction Amendment Act (IRAA) statute in June 2019 so I am speaking on behalf of those impacted by the IRAA law, especially the men and women who are still incarcerated.

I urge the Council to keep the Incarceration Reduction Amendment Act and Second Look Amendment Act as they were originally passed and to not adopt the changes in the proposed Safer Stronger Amendment Act of 2023. I firmly believe the passing of IRAA is instrumental in creating a safer, healthier, and more inclusive DC.

I am a living example of what a second chance looks like to a IRAA recipient and living proof that the statute as is without any changes has been and will continue to be the most impactful piece of legislation the DC council has passed in the last 50 years.

I am the Advocacy & Leadership Development Specialist at Free Minds Book Club & Writing Workshop. Free Minds builds community to foster personal development and systems change for justice-involved youth and adults through the literary arts, workforce development, trauma healing, peace-building, and member-led advocacy. I am a peer supporter for my fellow Free Minds members and IRAA recipients returning from jail or prison. I also lead an extracurricular book club with middle school age children, and I co-facilitate book clubs and writing workshops with teenagers in DYRS facilities.

There are so many still incarcerated that have yet to be given the opportunity to contribute their talents and gifts to transform our neighborhoods. They are needed here, so that they can be on the frontlines of creating community-driven solutions that will build a truly safer and stronger DC. Thank you for this opportunity to speak.

Council of the District of Columbia
Committee on the Judiciary and Public Safety
Brooke Pinto, Chair
Testimony of Shawn Ruffin
Public Hearing
The Safer Stronger Amendment Act of 2023
Tuesday, June 27, 2023
Room 500
Wilson Building 1350 Pennsylvania Ave NW Washington DC

To the Honorable D.C. Council:

My name is Shawn Ruffin. After spending 31 years of my life incarcerated, I was released last year, thanks to IRAA 3.0. As a native Washingtonian, I'm aware of the recent surge in crime and violence that has taken place, and we all recognize something needs to be done. I assure you that this current crime wave is in no way related to the IRAA.

A vast majority of the people who have benefitted from this law have successfully returned and integrated back into society. I know first-hand that the beneficiaries of IRAA have returned to society with the mindset of people who are grateful and eager to make a positive change in our communities. I can speak for most of the IRAA community because I've known them for many years and watched their transformation with my very own eyes; and others I have met and formed a bond with through great re-entry programs like Free Minds Book Club, where they encourage you to network, be your best, and to hold oneself accountable.

So, I urge you to keep IRAA intact because it is changing lives for the better, reuniting families and providing a platform for young people to see examples of returning citizens making a difference in this world after being given a second chance at life.

Sincerely,

Shawn Ruffin, Proud IRAA recipient

The Committee on the Judiciary and Public Safety
Councilmember Brooke Pinto,
B25-291 Safer Stronger Amendment Act of 2023
Public Hearing
Tuesday, June 27, from 12 p.m. – 6 p.m.

Tuesday, June 27, 2023

Good afternoon, Councilwoman Brooke Pinto and Members of the committee on the Judiciary and Public Safety.

My name is _Dr. Shirley A. Hopkinson, currently living at 2803 17Th. Street, NE, Washington ,DC, 20018, in

Ward 5.

I'm submitting my written testimony in support of bill **B25-291 Safer Stronger Amendment Act of 2023**;

There is nothing more important than the safety of every DC resident, and Mayor Muriel Bowser has set clear priorities for ensuring safety through reducing crime, gun violence, and personal accountability for the respect of the law. The foregoing are intended to ensure that all residents feel safe in all of our Wards, and experience justice, through appropriate accountability, against those who harm our community.

• I believe in earned, compassionate second chances, when our youths demonstrate their responsibility, for their city, our city, and commit to the safety of all who call our city home:

• In May, Mayor Bowser introduced The Safter Stronger Amendment Act of 2023 to address gaps in the District's public safety and justice ecosystem that are necessary to build a safer, stronger DC. I support this effort strongly and suggest creative, collaborative efforts in all neighborhoods: as "stronger tides will raise many boats…if you will:

• Everyone in our community must take a critical look at the things we are doing and ask, what we can do differently for improved outcomes to reduce crime in our city. We know there is no one solution to ending violence as public safety is a community-wide effort. We must commit to visible community practice in our neighborhoods. Visibility heightens involvement:

• The Metropolitan Police Department (MPD) maintains its lowest sworn staffing numbers in more than 50 years. Mayor Bowser's Safer Stronger Amendment Act of 2023 is commonsense legislation: so support legislation that offers youths in our city well planned YOUTH CADETS TRAINING FOR POSITVE COMMUNITY LIVING..WITH COMPENSATION …AND COMMUNITY COLLEGE SUPPORT TO ENGAGE THEIR LOCAL ENVIRONMENTS WITH MEANINGFUL LIVING AND LEARNING ACTIVITIES:

• Enhance penalties for violent crimes that victimize or target vulnerable residents with physical or mental impairments, along with expanded protections for transit and for-hire vehicle employees, transit passengers, and people who try to enjoy our parks and recreation venues:

. • Increase penalties for illegal gun possession. DC Current Proposed

- Make strangulation a type of felony assault (strangulation is a key indicator that domestic violence will become deadly). According to the United States Attorney's Office, every state in the country already has provisions to support prosecuting strangulation as a felony.
- Strengthen provisions that allow individuals to petition for early release to ensure the voices of victims and community receive proper consideration.
- Provide greater discretion for the Courts to determine who should be held pre-trial, including defendants previously convicted of a violent crime while they await trial for new crimes.
- Increase the reimbursement for the District's popular Private Security Camera System Incentive Program which strengthens public safety by increasing the network of cameras available to assist MPD in solving crimes and closing cases. Videos are extremely helpful in closing or identifying leads for crimes. In one analysis of homicides, MPD found that video footage, when available, helped to advance the investigation in 71% of the cases, and helped to close 36% of the cases.

The Committee on the Judiciary and Public Safety
Councilmember Brooke Pinto,
B25-291 Safer Stronger Amendment Act of 2023
Public Hearing
Tuesday, June 27, from 12 p.m. – 6 p.m.

- Require the Criminal Justice Coordinating Council to report more data on process and outcomes.
- Collect DNA earlier in the process for First Degree sexual offenses after the probable cause hearing.
- Require supervisory agencies to provide MPD with location and identification data collected from any detection device necessary in conducting a criminal law enforcement investigation.
- Expand the District's representation on the DC Sentencing Commission.

Thank-you for your time council woman Pinto.

The Committee on the Judiciary and Public Safety
Councilmember Brooke Pinto,
B25-291 Safer Stronger Amendment Act of 2023
Public Hearing
Tuesday, June 27, from 12 p.m. – 6 p.m.

Tuesday, June 27, 2023

Good afternoon, Councilwoman Brooke Pinto and Members of the committee on the Judiciary and Public Safety.

My name is Shurland Oliver, currently living at 2636 Sheridan Rd, SE in Ward 8. Telephone number 240-389-8071.

I'm submitting my writing testimony in support of bill **B25-291 Safer Stronger Amendment Act of 2023**;

There is nothing more important than the safety of every DC resident and Mayor Muriel Bowser has set clear priorities for reducing crime, gun violence, and juvenile crime. This means ensuring all residents are safe, victims of violent crime experience justice, and those that harm our community are held accountable.

- I believe in second chances in our city, I also believe in accountability.
- In May, Mayor Bowser introduced The Safer Stronger Amendment Act of 2023 to address gaps in the District's public safety and justice ecosystem that are necessary to build a safer, stronger DC.
- Everyone in our community must take a critical look at the things we are doing and ask what we can do differently for improved outcomes in crime reduction. · We know there is no one solution to ending violence; public safety is a community-wide effort.

The Metropolitan Police Department (MPD) maintains its lowest sworn staffing numbers for more than 50 years with approximately 3,335 officers. Mayor Bowser's Safer Stronger Amendment Act of 2023 is common sense legislation that will:

- Enhance penalties for violent crimes that victimize or target vulnerable residents with physical or mental impairments as well as expanded protections for transit and for-hire vehicle employees, transit passengers, and people at rec centers.

- Increase penalties for illegal gun possession. DC Current Proposed

- Make strangulation a type of felony assault (strangulation is a key indicator that domestic violence will become deadly). o According to the United States Attorney's Office, every state in the country already has provisions to support prosecuting strangulation as a felony.

- Strengthen provisions that allow individuals to petition for early release to ensure the voices of victims and community receive proper consideration.

- Provide greater discretion for the Courts to determine who should be held pre-trial, including defendants previously convicted of a violent crime while they await trial for a new violent crime.

- Increase the reimbursement for the District's popular Private Security Camera System Incentive Program which strengthens public safety by increasing the network of cameras available to assist MPD in solving crimes and closing cases. o Videos are extremely helpful in closing or identifying leads for crimes. In one analysis of homicides, MPD found that video footage, when available, helped to advance the investigation in 71% of the cases, and helped to close it in 36% of the cases.

- Require the Criminal Justice Coordinating Council to report more data on process and outcomes.
- Collect DNA earlier in the process for First Degree sexual offenses after the probable cause hearing.
- Require supervisory agencies to provide MPD with location and identification data collected from any detection device necessary in conducting a criminal law enforcement investigation.
- Expand the District's representation on the DC Sentencing Commission.

Thank you for your time on this all important matter councilwoman Pinto.

Statement of

Robert Vinson Brannum

DC For a Safer DC

Before the

Committee on the Judiciary and Public Safety

Council of the District of Columbia

On B25-0291 - Safer Stronger Amendment Act of 2023

Tuesday, 27 June 2023

Good afternoon, Chairwoman Pinto, and members of the Committee. I am Robert Vinson Brannum, a veteran, former Advisory Neighborhood Commissioner, former President of the Bloomingdale Civic Association, President Emeritus of the DC Federation of Civic Associations, Inc., Chairman Emeritus and former Vice Chairman of the 5th District Citizens' Advisory Council, Inc., Chairman Emeritus Ward 5 Democratic Committee, former Vice-President Ward 5 Council on Education, and Chairman of the Ward 5 Leadership Council Public Safety Committee.

I do not, and I will not take a backseat to any person or individual, local, or national, in my advocacy for justice in the District of Columbia. I have marched and I have been arrested in my commitment to equality for all persons. I appear before this committee this afternoon to support *B25-0291 - Safer Stronger Amendment Act of 2023.*

This proposed amendment targets specific violent gun crimes, domestic violence, sexual assaults, assaults on vulnerable adults, and transportation providers. This legislation does not propose mass incarceration. Rather, it responds to District residents across all eight wards to the rising gun violence in the District, particularly minority communities. District residents, regardless of their race, sex, age, ethnicity, or address want to feel and to be safe to attend school or church, to walk their children and pets, to dine out at night, to attend an entertainment venue, or to relax with family and friends in the comfort of their homes.

Despite opposition from certain "40 local and national organizations," which notably excludes long standing and respected local District civic/community associations, and MPD citizens advisory councils in all eight wards, this proposed legislation does not target "Black Washingtonians" for mass incarceration, but rather persons who commit violent crimes within on our streets and in our communities.

It would be a failure of government leadership to ignore cries and prayers of concerned and innocent people who live in this city. It would be a dereliction of duty for our elected officials to turn aside this call to action for enhanced public safety. A fairer criminal justice system will not be borne from policies allowing individuals to offend without proper and swift accountability. A parent who has lost a child, a child who has lost a mother, father, brother, sister to street gun violence, a vulnerable adult victimized by crime, a transportation worker attacked on the job, a woman sexually assaulted, or someone out peacefully or sitting at home should not have their right to live peacefully shattered by violence. This proposed legislation is proper, sound, measured, and should be approved.

Thank you.

The Committee on the Judiciary and Public Safety
Councilmember Brooke Pinto,
B25-291 Safer Stronger Amendment Act of 2023
Public Hearing
Tuesday, June 27, from 12 p.m. – 6 p.m.

Tuesday, June 27, 2023

Good afternoon, Councilwoman Brooke Pinto and Members of the committee on the Judiciary and Public Safety.

My name is Sydne Smith, currently living at 120 Fort Drive NE Apt 2 Washington, DC 20011

Ward 5. telephone number 301-787-7302,

I'm submitting my writing testimony in support of bill **B25-291 Safer Stronger Amendment Act of 2023**;

There is nothing more important than the safety of every DC resident and Mayor Muriel Bowser has set clear priorities for reducing crime, gun violence, and juvenile crime. This means ensuring all residents are safe, victims of violent crime experience justice, and those that harm our community are held accountable.

· I believe in second chances in our city, I also believe in accountability.

· In May, Mayor Bowser introduced The Safter Stronger Amendment Act of 2023 to address gaps in the District's public safety and justice ecosystem that are necessary to build a safer, stronger DC.

· Everyone in our community must take a critical look at the things we are doing and ask what we can do differently for improved outcomes in crime reduction. · We know there is no one solution to ending violence; public safety is a community-wide effort.

· The Metropolitan Police Department (MPD) maintains its lowest sworn staffing numbers is more than 50 years with approximately 3,335 officers. Mayor Bowser's Safter Stronger Amendment Act of 2023 is commonsense legislation that will:

· Enhance penalties for violent crimes that victimize or target vulnerable residents with physical or mental impairments as well as expanded protections for transit and for-hire vehicle employees, transit passengers, and people at rec centers.

. · Increase penalties for illegal gun possession. DC Current Proposed

- Make strangulation a type of felony assault (strangulation is a key indicator that domestic violence will become deadly). o According to the United States Attorney's Office, every state in the country already has provisions to support prosecuting strangulation as a felony.
- Strengthen provisions that allow individuals to petition for early release to ensure the voices of victims and community receive proper consideration.
- Provide greater discretion for the Courts to determine who should be held pre-trial, including defendants previously convicted of a violent crime while they await trial for a new violent crime.
- Increase the reimbursement for the District's popular Private Security Camera System Incentive Program which strengthens public safety by increasing the network of cameras available to assist MPD in solving crimes and closing cases. o Videos are extremely helpful in closing or identifying leads for crimes. In one analysis of homicides, MPD found that video footage, when available, helped to advance the investigation in 71% of the cases, and helped to close it in 36% of the cases.
- Require the Criminal Justice Coordinating Council to report more data on process and outcomes.
- Collect DNA earlier in the process for First Degree sexual offenses after the probable cause hearing.
- Require supervisory agencies to provide MPD with location and identification data collected from any detection device necessary in conducting a criminal law enforcement investigation.
- Expand the District's representation on the DC Sentencing Commission.

Thank-you for your time council woman Pinto

The Committee on the Judiciary and Public Safety
Councilmember Brooke Pinto,
B25-291 Safer Stronger Amendment Act of 2023
Public Hearing
Tuesday, June 27, from 12 p.m. – 6 p.m.

Tuesday March 8, 2022, was just another busy day for me. Driving an hour to dental hygiene school, driving back to visit my parents and then finally coming back home to my apartment of 10 years in the district. I live over in NE right next to Catholic university and Archbishop Carroll High School. My neighborhood has always been busy due to three different schools being present. I arrived home after taking my mom grocery shopping after attending dental clinic class in the morning. Arriving home around 8PM, I parked my car and started to gather my groceries and bags to go wind down for the evening. While gathering my items, I started to notice that I couldn't find my house keys. While searching for them I heard talking and saw a group of 5 teens around high school age walking up the sidewalk on the other side of the street from the parking lot for my building near the elementary school. Looking at them, I got a feeling in my stomach that something was up. As they looked over and started to cross the street I thought "it's way too late to be cutting through the parking lot for a short cut". I quickly started closing up my car doors and before I could close my trunk, they took off running and surrounded me. The one on my right pulled out a gun and said "yeah now what birch! Give me all your shit!" I felt my heart pounding and everything started moving slower. I felt like this was a joke, and someone was going to pop out and say "Just kidding!!" but that was not the case. My response was "Are you fucking kidding me?! No!!" That is when he said, "I said give me your shit bitch!" and proceeded to punch me by my right eye and the left corner of my mouth which knocked me to the ground. They ripped the keys out of my hand, which I was holding so tightly I set my alarm off. When I fell to the ground I instantly felt excruciating pain on the right side of my head and face and I was looking at the sky. I rolled over towards my car and saw that the 5 kids had stopped the car alarm from going off, and started closing my trunk as well as getting inside. I instantly thought to myself "Get up NOW or they are going to hit you with your own car!" I walked over closer to the building and felt helpless and in so much pain. I kept thinking what to do! I looked around at all the buildings and none of my neighbors were outside, or looking through their windows. And then I thought, "Call the cop!". I took my cell phone out of my workout pants pocket and unlocked it. That's when I heard the door open and a boy got out and started walking towards me. He said "Give me that!" and I said "NO!". He walked over and we started a tug of war over my phone. He tried to wrench the phone out of my hand but I had a death grip on it so I was knocked to the ground. He bent down and tried to snatch it out of my hands while I was on my back. I held the phone tightly to my chest and put my feet out in defense pushing him away with my feet on his hips creating space. This was a defensive move we learned in Jujistu and without even thinking it just kicked in. After what felt like 5 minutes of him trying to grab my phone unsuccessfully, one of his friends sitting in the car yelled at him "Tray! Come on man just leave it and get in." He walked away and that was when my inner voice again said "Get up now or they are going to run you over with your own car!". This time I got up and walked all the way to the grass right against the building, and I watched them reverse, shift into drive and pull off with my 2021 Toyota Rav 4. I stood there for a minute and looked around and that was when I saw my neighbor stepping out on the porch to smoke a cigarette. With every movement of my head I felt a pounding headache and my face was on fire. Then I thought "This is not real! OMG Now what!" and that's when my brain started to unfreeze and work again. "Call the cops!" Now I thought and when I went

to dial my phone was completely dark and wouldn't come on. I hit the power button and my phone started to

turn back on. That is when I realized I was holding my phone with such a death grip to keep it away from those teens getting it that I accidentally turned off my phone. I walked up the stairs toward my neighbor and as I called 911 on my cell phone. The cops arrived and the first question was "Do I have any idea where my car could be?" Luckily I had a tracker from Tmobile installed in my car which allowed the cops to locate my car and even see the route they took. I was asked over and over and over the details of the incident by the police and when the ambulance showed up because I wasn't in an emergency situation as far as health went they told me unless I was going to the hospital they couldn't do much for me. I kept telling them my head was killing me and eventually they gave me an ice pack after the cop questioning me requested it for me. The first call I made was to my sister who came in a flash and was my biggest support that night. The teens had ditched my car in an alley behind the Denny's off Benning Road. They took everything out of my car, went through it, took what they wanted and dumped everything else into the trash cans in the alley. No witnesses, no one even looked out of their window. My sister and the cops helped me empty the trash cans and retrieve what I could. They stole my purse, gym bag, groceries and various other items out of my car. I had to wait hours before being able to drive my car home. Luckily I had a spare key inside my apartment because my car keys that were stolen were never recovered. That night I was photographed, fingerprinted and swabbed for DNA so that they could distinguish my prints and DNA from the teens who stole my car. For about 2 weeks I had to park my car in Maryland at my parents house as advised by the cops that if I left my car at my apartment I would be revictimized and have my car stolen all over again. The weeks after were brutal with having a headache for two weeks, anxiety, fear everytime the sun went down, and fighting with my car insurance about paying for my locks to get changed. I was told that they don't cover it because it is too expensive but eventually they agreed to cover it. I also went to the doctor and after that the ENT and the ER to be checked out for my jaw, head and face. I could barely open my mouth, I had a black eye and bruises in the left corner of my mouth as well as 3-4 bumps from contusions on my head and side of my face. I missed work for a few days and unfortunately I couldn't afford to miss school. So I had to attend clinical class with a black eye and a severe headache. All of the tests and x-rays came back stating that luckily I had not broken anything but I had sustained a concussion from the blow to the head. I spent months going to physical therapy trying to rehab from the concussion as well as work through the anxiety and fear of still living in the same building and parking in the same parking lot where I was carjacked, assaulted and robbed at gunpoint. It has been one year and three months since my carjacking and no one has been held accountable for their actions. After I followed up with the third detective assigned to my case, I was only able to find out one month shy of my one year anniversary that the DNA was processed and they have DNA from five unidentifiable males in my car and that was it. In the end I am still working through the trauma and medical bills left behind after this incident as my car insurance went back on their promise to cover my medical bills related to this claim. The damage done and the scars left behind are slow to heal and will never go away. Something **HAS** to be done, and these youth need to be held accountable for their actions!

Council of the District of Columbia
Committee on the Judiciary and Public Safety
Brooke Pinto, Chair
Testimony of Tara Libert, Free Minds Book Club
Public Hearing
The Safer Stronger Amendment Act of 2023
Tuesday, June 27, 2023
Room 500
Wilson Building 1350 Pennsylvania Ave NW Washington DC

Good afternoon Chairwoman Pinto and members of the Committee,

My name is Tara Libert and I am the Executive Director and Co-founder of Free Minds Book Club & Writing Workshop, a nonprofit here in Washington DC that builds community to foster personal development and systems change for justice-involved youth and adults through the literary arts, workforce development, trauma healing, peace-building, and member-led advocacy. We have been providing services specifically for youth ages 16 to 24 in the adult criminal legal system for the past 20 years. Free Minds is the vision of a young man named Glen McGinnis, who was sentenced to die in Texas for a crime committed when he was just 17 years old. If he were here today, Glen would have been eligible for the Incarceration Reduction Amendment Act, and there is no telling what incredible good he might have done. Instead, the world lost a talented, giving young man--but he left behind a legacy in Free Minds, charging us with a commitment to share the transformative and liberatory power of reading and writing with other young people like him who were caught in the punitive adult prison system rather than given the care and compassion a young person needs to heal and thrive.

I see Glen's legacy and drive for change every day in the talented, caring, and thoughtful people I have the privilege of working with through Free Minds.

Free Minds works with IRAA petitioners and recipients pre- and post-release, and currently we have 196 IRAA members in our prison program and 145 home and actively participating in our robust reentry program. I am here today to state unequivocally that IRAA must not be changed. The key to public safety in this city is more IRAA petitioners returning home to our city. They are the sons, daughters, parents, uncles, aunts, siblings, friends, neighbors, and co-workers. They have become a stabilizing force in their neighborhoods Currently 39 Free Minds IRAA recipients work on the frontlines of violence prevention and community peacebuilding, whether acting as Credible Messengers, Violence Interrupters, or mentors to young people. IRAA recipients have formed a powerful network of peer support, exchanging job leads and resources, and looking out for each other through the challenging reentry journey. 99% of Free Minds IRAA recipients are currently employed or in training programs. They are also hard working, civic-minded, tax-paying coworkers, family members and active community members.

I am here today to urge the Council to keep the Incarceration Reduction Amendment Act and Second Look Amendment Act as they were originally passed and to not adopt the proposed Safer Stronger Amendment Act of 2023. IRAA is instrumental in creating a safer, healthier, and more inclusive DC. I have witnessed the personal and community progress made by Free Minds IRAA recipients. They are home in our community mentoring youth through peacebuilding initiatives,

working on policies that promote educational opportunities for system-impacted individuals, using art as a source of hope and healing, and giving daily proof that positive change in our community is possible.

Every day we witness acts of service and devotion to family and community. Here are just a few examples of our members' many accomplishments and ways of giving back:

- Using poetry and art as tools for healing and education in our community peacebuilding initiative
- Leading after school book clubs and writing workshops with children
- Co-facilitating book clubs and mentoring youth incarcerated as adults at the Youth Services Center and New Beginnings Youth Development Center
- Starting their own nonprofits
- Working in the Safe Passages program to ensure children can get to and from school safely
- Leading our Community Healing program using Restorative Justice practices and certified as Restorative Justice practitioners
- Volunteering with
- Engaging with victims and building pathways to healing for all
- Studying Black History and working together to successfully advocate for posthumous pardons for the Martinsville 7 (7 Black men who were unjustly executed in Virginia in 1951)
- And working together on coalitions and movements such as Hands Off DC for the benefit of all DC residents.

The process of petitioning for resentencing under IRAA is already an extremely thorough and rigorous process. Those that have come home are transformative leaders in DC. Their work has even been recognized by the NFL Foundation's Inspire Change initiative, highlighting IRAA recipients going back into the DC jail to lead programming and working as peer supporters for fellow Free Minds members. There are many more people ready and waiting for a chance to give back to the DC community--to truly make this city safer and stronger together.

We are a leader in the country now. It is imperative we don't roll back this progress. Protect Second Look! Thank you for your time.

Testimony of Ifetayo Belle
Managing Attorney, School Justice Project
In front of the Committee of the Judiciary and Public Safety
Public Hearing on Bill 25-291, The Safer Stronger Amendment Act of 2023
June 27, 2023, 12:00pm

Hi. My name is Tayo Belle, I am a managing attorney at School Justice Project and a Ward 1 resident. I am here to talk about why you **must** reject the Mayor's proposals to modify the juvenile detention standard.

As a starting issue, setting aside policy arguments for **why** these proposals will do the opposite of addressing public safety, Youth Services Center is a mess. YSC is understaffed. It is unsafe. Out of the 8 units, we have heard reports that 5 keep children inside their cells, only letting them out individually, one at a time for an hour. The facility has been at capacity recently. If it is at capacity, where are the kids going to be held? Increasing the number of children subjected to detention leads to quite a logistical problem and directly will impact the safety of the children already inside the full facility.

DC's detention rate is higher than any other state and already four times the national average. With this change, we will only see our rate of jailing young people increase. The majority of court-involved young people have experienced trauma and have histories of adverse childhood experiences and special education needs. Detention causes significant disruption to access to services, education continuity, and family supports.

In fact, we believe that these proposed changes will only further strengthen the school to prison pipeline. Our organization was founded to dismantle the school to prison pipeline by enforcing access to education and thereby disrupting cycles of incarceration. Education continuity results in decreased future court-involvement. This bill will do quite the opposite. The proposed changes to the detention standard will disrupt education continuity.

When a child is detained, they are immediately removed from their community school. When a child is detained for their "own protection," we imagine or could hope that lengths of detention would be short but just long enough to have the child miss school and likely fall the grade. School failure leads to court-involvement. We know that low academic performance leads to school failure. We also know that prevalence of disability leads to increased rates of suspension and expulsion. School failure + discipline both lead to court involvement. As many as two thirds of young people who leave the juvenile system drop out of high school. School dropout is a major indicator of future court involvement. Youth who drop out of school are three to four times more likely to be imprisoned. The result of this? Recidivism, future court contacts, unemployment, poverty.

These changes to the juvenile detention statute only widen the net to catch more kids in jail. This is not how you combat crime. This is not how you protect a child. We ask that you reject these changes. Thank you.

Bill 25-0291, the "Safer Stronger Amendment Act of 2023"

STATEMENT OF PEGGY KELLER

4607 Connecticut Avenue NW, #816

Washington, D.C. 20008

Chairwoman Pinto and Members of the Council:

My name is Peggy Keller and I am a District- based business owner and resident, and previously worked for DC Health for many years. Currently, I conduct emergency preparedness planning and training for District government agencies and stress the importance of personal and community preparedness, readiness and reduction of risks. I conduct training on CPR/AED and Stop the Bleed to teach District employees how to respond and to save lives in an emergency. These emergencies happen more frequently and cause death and injury.

I strongly support Bill 25-0291, the "Safer Stronger Amendment Act of 2023" and I thank you for the opportunity to submit this testimony on the proposed legislation. I applaud Mayor Bowser for advancing this Bill to confront continuing violence, many times committed by young teenagers.

The American Public Health Association (APHA), located here in the District considers gun violence a public health crisis and expresses that exposure to violence and abuse has been associated with death and severe physical and mental health outcomes. Violence disproportionately affects vulnerable populations such as women, children, lesbian, gay, bisexual, transgender, questioning, and intersex individuals, and those living in poverty, among others.

Every day I get alerts on my phone for robberies, carjackings, assaults and even murder. People in my community are concerned and many are afraid. It is critical to make the communities and this great city (we hope soon to be state) safe. When I worked for DC Health, I frequently worked in the field and felt safe going into communities across the District. I would be very fearful now to do that.

I support the "Safer Stronger Amendment Act" because it should make the community safer by increasing penalties for firearms and violent crimes; supporting violent crime investigations; enhancing pretrial detention for violent crimes; and expanding information considered in second look sentence reductions for the most serious violent crimes. This legislation offers targeted, common-sense measures to address shortcomings in our criminal justice system. Fixing these deficiencies should make our judicial system work better and, consequently, increase community health and safety.

I support this Bill in the hope that the elements of the Bill can reduce violence, death and injury in the District. The elements are:

- Increased penalties for firearms and violent crimes, especially related for ghost guns and high powered firearms.
- Increasing penalties to felonies, for, unlawfully discharging a firearm, possession of a ghost sun or machine gun, strangulation, and loss of consciousness.
- Sentencing enhancements to reflect the additional severity of committing crimes against certain protected classes of people.
- Earlier collection of DNA that could solve crimes and future crimes.
- Use of GPS records and data as a condition for pretrial release.
- Increasing courts' authority to detail adults with felony crimes when they pose a danger to the community.

I appreciate the Committee's consideration of this legislation as part of a wholistic approach to improving the criminal justice system. This legislation will (we hope and pray) improve community safety and address issues related to violent crime. Thank you for your strong leadership in supporting the community to protect public health and safety and reduce violence, death and injury. And thank you to Mayor Bowser for her commitment in solving the problems of violence. It was always an honor to be part of the District workforce under Mayor Bowser.

RAMW
RESTAURANT ASSOCIATION
METROPOLITAN WASHINGTON

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June 27, 2023

Councilmember Brooke Pinto
Chair, Committee on the Judiciary and Public Safety
John A. Wilson Building
1350 Pennsylvania Avenue NW, Suite 106
Washington, DC 20004

Re: B25-0291, Safer Stronger Amendment Act of 2023

Dear Honorable Committee Chair Pinto,

The Restaurant Association Metropolitan Washington (RAMW) thanks you and the Committee on the Judiciary and Public Safety for holding today's public hearing for the Safer Stronger Amendment Act of 2023.

For more than 100 years, RAMW has advocated and provided community for more than 1,400 entrepreneurs and small businesses in the greater Washington area. We count among our members favorite neighborhood spots, family-owned businesses, homegrown restaurant groups, and national and regional favorites. Together we are one of the largest job creators in the District and leading contributors to revenues.

RAMW is proud to add our support for the Safer Stronger Act. Ongoing gun violence results in the tragic irreplaceable loss of life almost every week in our community; but something less discussed is the cost violent crime has on the District's economic performance, which is vital to supporting services to address the root causes of crime.

Small businesses, especially our local restaurant operators, feel like they are on the front lines of regular violence with little support from authorities or a resolution in sight. Public safety consistently tops our operators' concerns.

Among our membership are operators who have been repeatedly robbed, both in smash and grab burglaries and at gunpoint. I know operators who pay hundreds of thousands of dollars a year to hire off-duty police officers or private security to keep their businesses safe. With the shortage of police officers on the force, the guarantee that an officer will show up for an assignment has decreased, as they are being pulled for more pressing challenges. Violence is so regular in one neighborhood that one of our members paid tens of thousands of dollars to break her restaurant lease and move to a safer area. In some cases, this move has been to Maryland and/or Virginia. Operators regularly share with me their struggles to console workers after shootings occur outside of their restaurants, as well as the ensuing challenge to keep those workers motivated to return to work.

The damages are more than just the immediate financial costs. Crime deters economic investment in communities, furthering an environment where violence persists.

The Safer Stronger Amendment Act takes an important step to closing some gaps in the criminal justice system. Among other measures, it increases penalties for illegal gun possession and gives courts greater discretion over who should be held pretrial, including defendants previously convicted of a violent crime. It also increases rebates for the District's popular security camera program, which can deter crime and assist with prosecutions.

Some advocates are calling for reforms beyond the Safer Stronger Act along with investment in violence prevention and community-driven solutions. We support those initiatives, but they are long-term approaches. Our community's small businesses need help today.

It's for that reason RAMW supports the Safer Stronger Act. We ask you and the committee to advance it to the full DC Council for passage. I am happy to answer any questions that the Committee may have. Thank you.

Shawn Townsend

President and CEO

Testimony of Travis Ballie
Public Witness, Ward 7 Resident
Council of the District of Columbia
Committee On The Judiciary & Public Safety
Public Hearing on B25-291

June 27, 2023

My name is Travis Ballie and I am a Ward 7 resident.

I would normally say thank you Chair for hosting this public hearing today, but I do not believe that one of the bills we are hearing today, B25-291, deserves even indirect civility. Bill B25-291, whose misleading name I refuse to parrot, is without a doubt the most racist bill I have seen in my decades as a resident of the District. It is soaked in white supremacy and would not shock me if the GOP insurrection caucus ghost wrote this bill that we are discussing here today. A better title for this bill would be the Criminalize Black Youth Act of 2023, which is exactly what would happen if this bill were to pass. Let's all keep in mind that 9 in 10 of all youth under 18 stopped by the Metropolitan police department are Black, nearly double their percent of the District's population. They will bear the brunt of the imposition of these failed policies from the 80s.

Three provisions have been echoed today that deserve broad and loud condemnation for even being considered, as they are tailor made to put our District in a time machine back to the 1980s, where we had a de facto policy of jailing Black people and throwing away the key.

First of the white supremacist provisions of this bill is to reimpose mandatory minimums, which are, to quote the Leadership Conference on Civil and Human Rights "engines of racial injustice". Judge Stephanos Bibas describes mandatory minimums as acting as "sledgehammers rather than scalpels," meaning that it equates all offenders as equal to the worst and most heinous offenders, a dehumanizing policy that also restricts judges from using their discretion to mete out punishment to match the unique case and circumstances in front of them. For such failed policies to actually be considered here in 2023 is proof of either hollow and craven political messaging, reactionary anti-black impulses or a combination of both.

Secondly, is the provision of this bill around expanding the number of adults and youth incarcerated pre-trial even though they are presumed innocent. Over the past 50 years the number of individuals nationally held in pre-trial detention has increased by more than 400%. This flies in the face of U.S. Supreme Court case law declaring that detaining people in jail before trial should be the "carefully limited exception" and liberty "the norm." The only party that stands to gain from this proposal is the prison industry, as nationally approximately 2/3 of the more than 740,000 people held in locally run jails across the United States have not been convicted of a crime. This proposal is also coming forth as the Mayor has not adopted any of the alternate recommendations made by the District Task Force Jails & Justice, the D.C. Police Reform Commission, or the Criminal Code Reform Commission.

Regarding attempts to repeal “second look provisions” that give judges the ability to review unduly harsh sentences of young adults, I simply want to echo the words of the Campaign for Fair Sentencing of Youth: “The overwhelming majority of the nearly 200 people who have been released under IRAA are serving their communities and living peacefully with their loved ones.” I was never more proud then when the DC Council adopted the first in the nation DC Second Look Amendment into law in 2020, and I have never been more ashamed of the DC Council than today’s disgracing of the progress we have previously made by even considering Bill B25-291.

TESTIMONY BY TROY BURNER

Associate, Justice Policy Institute

Bill 25-247, the "Safer Stronger Amendment Act of 2023"

Councilmember Brooke Pinto, Chairperson
Committee on the Judiciary & Public Safety

Tuesday, June 27, 2023, 12:00p.m.
John A. Wilson Building
1350 Pennsylvania Avenue, N.W.
Washington, D.C. 20004

Thank you, Chairperson Pinto, and the rest of the Committee members, for the opportunity to provide testimony to this Committee on the Judiciary and Public Safety for the public hearing on B25-247, Safer Stronger Amendment Act of 2023. Hereinafter, I am providing testimony in opposition to all five (5) of Mayor Bowser's proposed changes to The Incarceration Reduction Amendment Act.

I humbly stand before you today, honored to provide testimony as a representative of the Justice Policy Institute, but also as a profoundly grateful beneficiary of the Incarceration Reduction Amendment Act (IRAA) of 2016. After serving 24 years, 8 months, and 22 days, I had a hearing pursuant to IRAA, was resentenced and granted immediate release. The release decision included a series of rigorous, intense, and thorough examinations of my character, my past, as well as my incarceration record. Others may say that they welcomed being placed under a microscope, I frankly resented it. That resentment was born out of the fact that I was innocent, yet I was still vigorously scrutinized, examined, and made to carry the burden of proving that I was not a threat to public safety.

While IRAA opened the door for my second chance, I was fully exonerated nearly two years after being home, which provides a unique perspective to my testimony. My testimony in opposition to the proposed changes cover four areas, language subjectivity, nature of offense, remorse, and community impact statements.

Subjectivity

The 11 factors guiding a judge during a re-sentencing hearing provide the necessary information to make an objective determination. However, the legislation under debate takes away the objectivity of the factors by changing the language from *shall* to *may* when determining a reduction of a term of imprisonment. The intent and design provide an individual serving a lengthy prison sentence with the opportunity to demonstrate their growth, maturity, and fitness to reenter the community. The use of the word "may" expand the possibility that a subjective decision is made. Furthermore, it renders meeting the requisite requirements fruitless. The use of "shall" is a directive that clearly indicates that an individual satisfies the precise factors and meets the requirements to be resentenced.

"Nature of offense"

The language in IRAA is meticulously and thoughtfully written. The IRAA hearing process is thorough, intense, and a deep dive analysis of an individual's growth, maturity, and the demonstration that one is not a threat to public safety fitness. The "nature of offense" is relitigating static factor. The "nature of offense cannot be changed or mitigated. Its insertion opens the door to reconsideration and relitigating the facts of the case. During my IRAA hearing, it was clear that the Honorable Judge Rigsby has no interest in hearing the factors of my alleged offense. Multiple times Judge Rigsby stopped the prosecution from attempting to present facts from the trial, *" the trial is over, this is a resentencing hearing, not a retrial and anymore attempts to do so is an indication that you are unable to follow the rules of the court."* My re-sentencing hearing was only evaluating the 11 factors, my time while incarcerated, and my potential future in society.

The insertion of "nature of offense" is reminiscent of the Federal Parole Commission and D.C. Parole board before them, going outside of the guidelines and imposing individuals' new sentences. The use of "nature of the offense" should not be permitted. It should be recognized for what it is, double jeopardy.

"Remorse"

Remorse cannot be quantified. Inserting remorse implies that an individual can satisfy all the factors required yet be denied because some ghost remorse radar overrides what

the record reflects. No one should be given the discretion to determine whether someone is remorseful. How does remorse look? What are the signs? In my case, the prosecution argued that I was not showing remorse. The Honorable Judge Rigsby asked, "what does remorse look like? ?" He then stated, "the record reflects the fact that Mr. Burner has stated from the very beginning that he was innocent, how would he be remorseful now, just because going home is now a possibility?" Well in the end, I was proven innocent, and a judgement on remorse would have stripped me away from my second chance through IRAA; and ultimately completing my innocence claim.

The implementation of IRAA is not a get out of jail free card. It is not a mandate or guarantee of release. Just because you are eligible, does not mean that your release is a given. The hearing process is an in-depth examination, of mitigating factors, disciplinary record, programming, one's fitness to reenter society and the record reflecting that one poses no danger to public safety. The proposed language changes are vague and ambiguous. As an innocent man, I was made to jump through figurative hoops to earn my release. If not for the implementation of IRAA, I may still be in prison.

"Community Impact"
The proposal to allow community impact statements is unprecedented, unreasonable, and serves no purpose in the resentencing process. Safer Stronger? There is no proposal submitted that goes to expanded programs and giving youth options. Expand on and support the multitude of men and women IRAA who has returned home against all odds and have dedicated themselves, boots on the ground and otherwise presenting as a positive point of reference to the youth, in the streets and their own homes. Decarceration is one of the stronger tools to address public safety.

The proposed language changes to IRAA have no correlation to the current crime. Those proposed changes are not consistent with the interest of justice or safety of the public. Thank you!

To date, **125 people** have been killed in the District this year, a 17% increase over last year. Especially notable, as the vast majority of U.S. cities are seeing decreases (about 11% nation wide).

As it currently stands, the average homicide suspect in the District has 11 prior arrests and approximately 86 percent of all homicide victims and suspects were known to the criminal justice system prior to incidents. Of those identified with illegal guns, less than 40% are convicted. Violent crime in the District, like most cities in the U.S., is highly concentrated, both in people and location.

When you look at the level of reckless driving, car jackings, fare evasion, rampant shoplifting, reckless ATV driving, and open air drug dealing**,** it feels as though the city, through inaction and policy, has signaled that all of this behavior is okay. It certainly feels like a "Give them an inch, they take a mile" scenario. Offenders take advantage of opportunity and the District has been more than accommodating in providing these opportunities. You get the behavior you tolerate and the city is seeing this.

Enforcement is the missing ingredient in the District's current criminal justice strategy. Data shows that enforcement has in fact waned since 2020. Certainty of punishment, more so than severity**,** has been found to be the most effective crime fighting tool. Speeding doesn't matter if people aren't pulled over or ticketed, fare evasion will continue if not enforced and carrying illegal firearms doesn't matter if charges aren't brought.

The sections of B25-0291 increasing penalties for illegal gun possession, expansion of pre-trial detention for violent offenders, use of ankle monitoring data, and increased judicial discretion are all great starts.

The city knows the blocks and the offenders. Arrest, charge, and prosecute offenders. Provide resources to those looking to turn their lives around. It is incumbent on the Council to draft and pass legislation that will accomplish this.

Thank you.

END
FGM/C
U.S. NETWORK

June 28, 2023

Council of the District of Columbia
Committee on the Judiciary and Public Safety
1350 Pennsylvania Avenue, N.W.
Washington, DC 20004

Re: Support for the "Female Genital Mutilation Prohibition Act of 2023" (B25-247)

Dear Committee on the Judiciary and Public Safety,

We are writing to express the U.S. End FGM/C Network's strong support for B25-247 - "Female Genital Mutilation Prohibition Act of 2023" that would prohibit the practice of female genital mutilation and cutting (FGM/C) in the District of Columbia. This robust bill properly defines FGM/C, which is extremely important in protecting all girls from this practice, provides an essential education and outreach campaign through the Department of Health, and provides survivors the option of civil action. As members of the Committee on the Judiciary and Public Safety, The U.S. End FGM/C Network requests that you vote the bill favorably out of committee and urge House and Senate Leadership to bring the bills to their respective chambers for a vote.

Although there is a federal law against FGM/C in the United States, it is important to have laws at the municipal and state levels, where health, child protection, education, law enforcement, social and other services are provided and to train first responders and service providers on the issue and on their responsibilities in implementing the law. Additionally, state and municipal laws fill gaps left by federal laws, and can provide a holistic and comprehensive approach to ending FGM/C including providing education and outreach, bans on taking a girl outside of the state to undergo FGM/C, and gives survivors the opportunity to stand up for themselves in a court of law, should they choose to do so. The "Female Genital Mutilation Prohibition Act of 2023" addresses all of these gaps.

The D.C. Metropolitan area ranks second in the United States for the number of women and girls at risk for FGM/C, with estimates over 51,000. Nationally, there are over half a million women and girls who are at-risk or have undergone FGM/C and 200 million women and girls worldwide. There are no health benefits to FGM/C, but rather FGM/C has both short and long-term mental and physical health implications.

The U.S. End FGM/C Network is a collaborative group of over 200 members including FGM/C survivors, civil society organizations, foundations, activists, policy makers, researchers, healthcare providers, and others committed to promoting the abandonment of FGM/C in the U.S. and globally.

END
FGM/C
U.S. NETWORK

The U.S. End FGM/C Network fully supports this bill and respectfully urges you to immediately take the necessary steps to pass the “Female Genital Mutilation Prohibition Act of 2023” (B25-247). Girls in the District of Columbia and the United States need to be protected from female genital mutilation/cutting and they deserve your urgent attention.

You can contact me directly at caitlin@endfgmnetwork.org if you have any questions or would like any additional information on FGM/C.

Sincerely,

Caitlin LeMay
Executive Director
The U.S. End FGM/C Network

BEFORE THE
COUNCIL OF THE DISTRICT OF COLUMBIA
COMMITTEE ON THE JUDICIARY AND PUBLIC SAFETY
COUNCILMEMBER BROOKE PINTO, CHAIRWOMAN

PUBLIC HEARING

on

Bill 25-0291, the "Safer Stronger Amendment Act of 2023"
Bill 25-0247, the "Female Genital Mutilation Prohibition Act of 2023"

STATEMENT OF ELANA SUTTENBERG
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Tuesday, June 27, 2023, 12:00 p.m.

Room 500, John A. Wilson Building
1350 Pennsylvania Avenue, N.W., Washington, D.C. 20004

Chairwoman Pinto and Members of the Council:

My name is Elana Suttenberg, and I am the Special Counsel for Policy and Legislative Affairs at the United States Attorney's Office for the District of Columbia (USAO-DC). I thank you for the opportunity to appear at today's public hearing to share the Office's views on the proposed legislation. USAO-DC strongly supports both Bill 25-0291, the "Safer Stronger Amendment Act of 2023," and Bill 25-0247, the "Female Genital Mutilation Prohibition Act of 2023."

USAO-DC supports the "Safer Stronger Amendment Act" because it will make the community safer by increasing penalties for firearms and violent crimes; supporting violent crime investigations; enhancing pretrial detention for violent crimes; and expanding information considered in second look sentence reductions for the most serious violent crimes. This legislation offers targeted, common-sense measures to address shortcomings in our criminal justice system. Fixing these deficiencies will make our judicial system work better and, consequently, increase community safety.

Increasing Penalties for Firearms and Violent Crimes

We support this bill making several crimes felonies with higher penalties, including: unlawfully discharging a firearm; possessing a machine gun or a "ghost gun" (a privately manufactured firearm); and strangulation. Felony liability for unlawfully discharging a firearm fills a gap in current law, as any discharge of a firearm creates significant risk to the surrounding community, and the shots fired may hit any person nearby, causing death or serious injury. Felony liability for possession of a machine gun or a "ghost gun" reflects the potential increased danger to the community caused by possession of a machine gun—which includes possession of a "Glock switch" that can convert a semi-automatic firearm into an automatic firearm—or a "ghost gun" that is not traceable. Felony liability for strangulation recognizes that strangulation is one of the most dangerous forms of domestic violence, and a significant predictor for future lethal violence.

This bill also allows a judge to give a higher sentence when certain sentencing enhancements apply, including where the crime was committed against a Metro operator or passenger, a public or private for-hire driver (such as Lyft, Uber, or DoorDash), or a vulnerable adult.

Further, this bill strengthens accountability in several other ways. First, it fills a gap in liability by ensuring that an assault causing "any loss of consciousness" is punishable as felony assault. Second, it clarifies that a contractor or consultant of a church, school, synagogue, or similar institution may be charged with sexual abuse of a child, minor or student.

Felony Liability for Unlawful Discharge of a Firearm

We support creation of a felony offense of unlawful discharge of a firearm and believe that it fills a gap in current law. Unlawfully shooting a gun—even where it is not aimed at a person—can result in serious injury or death to others, including bystanders. We recommend that this offense carry a maximum penalty of at least 5 years' incarceration to account for the

significant danger created by discharging a firearm. Even where a person does not intend to hit someone, unlawfully discharging a firearm merits a higher maximum penalty.

Felony Liability for Possession of a Machine Gun or Ghost Gun

Under current law, possession of a machine gun[1] is generally punishable as misdemeanor possession of a prohibited weapon ("PPW"), with a statutory maximum of 1 year incarceration.[2] If a person "carries" a machine gun without a license outside their home or business, that conduct can be prosecuted as carrying a pistol without a license ("CPWL"), as the machine gun is a type of "pistol" or "deadly or dangerous weapon," with a statutory maximum of 5 years' incarceration. *See* D.C. Code § 22-4504(a)(1). Possession of a machine gun can often be prosecuted as CPWL, except where the person possesses the machine gun in their home, in the truck of their car, or in a similar location where they would not be "carrying" the machine gun. In those situations, possession of a machine gun would be subject to the 1-year maximum for PPW(a). Felony liability for this conduct, however, is proportionate to the severity of the conduct.

Felony Liability for Strangulation

Strangulation is widely recognized as one of the most dangerous forms of domestic violence, and a significant predictor for future lethal violence. However, virtually all non-fatal strangulation cases can be prosecuted in the District only as misdemeanor simple assault. By contrast, based on the documented physical and emotion harm associated with strangulation, particularly in the domestic violence context, and the fact that strangulation is a strong predictor of future domestic violence fatality, 49 states have a law allowing strangulation to be prosecuted as a felony.[3] There is overwhelming support from experts for the creation of felony liability for

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[1] The definitions section in D.C. Code § 22-4501(4) cites to the "machine gun" definition in D.C. Code § 7-2501.01(10), which provides:

> "Machine gun" means any firearm which shoots, is designed to shoot, or can be readily restored to shoot, automatically more than one shot, without manual reloading, by a single function of the trigger. The term "machine gun" shall also include the frame or receiver of any such firearm, any part designed and intended solely and exclusively, or combination of parts designed and intended, for use in converting a firearm into a machine gun, and any combination of parts from which a machine gun can be assembled if such parts are in the possession or under the control of a person.

[2] *See* D.C. Code §§ 22-4514; 22-4515. If a person has been previously convicted in the District of Columbia of violating D.C. Code § 22-4514, or of a felony, either in the District of Columbia or in another jurisdiction, possession of a machine gun is punishable as a felony, with a statutory maximum of 10 years' incarceration. *See* D.C. Code § 22-4514(c).

[3] Since the public hearing on this bill in May 2021, one additional state—Ohio—now allows strangulation to be prosecuted as a felony. *See* https://www.news5cleveland.com/news/local-news/investigations/ohio-finally-recognizes-strangulation-as-a-felony-was-the-last-state-in-the-country-to-do-so. There is advocacy for South Carolina to create a stand-alone felony of strangulation as well. *See* https://www.live5news.com/2021/07/22/strangulation-not-standalone-felony-sc-advocates-call-change/.

strangulation. We presented detailed testimony in support of this proposal in May 2021,[4] alongside other witnesses who supported this proposal.[5]

Sentencing Enhancements

This bill proposes several sentencing enhancements to reflect the additional severity of committing crimes against certain protected classes of people. For example, the bill proposes a sentencing enhancement where a crime of violence or dangerous crime is committed against an adult who suffers from physical or mental impairment, or where certain crimes are committed against a Metro operator or passenger. This bill also proposes filling a gap in liability by extending the current sentencing enhancement that applies to a "taxicab driver"[6] to include people who operate both public vehicles-for-hire or private vehicles-for-hire. Limiting this enhancement to apply only to a "taxicab driver" is outdated, and does not reflect that private vehicles-for-hire—such as Lyft and Uber—have replaced many taxis.

These sentencing enhancements provide a judge discretion to impose an appropriate sentence, but do not require the imposition of an enhanced sentence. A statutory maximum does not represent the community's and legislature's sense of what the minimum amount, or even average amount, of punishment for a crime should entail. Rather, a statutory maximum—by definition—reflects the community's and legislature's belief as to what the sentence should be for committing the *worst* possible version of the offense, including when the person has a substantial criminal history. Crimes that are not the worst possible version of the offense or that are committed by individuals who lack a significant criminal history may be sentenced below the statutory maximum. To be sure, the certainty of being caught for a crime is a more powerful deterrent than the maximum punishment for a crime. But the maximum penalty for a crime does have some deterrent value and, even more importantly, the maximum penalty must be sufficiently high to hold a person who has already committed a serious, violent crime proportionately accountable for that crime and to ensure that a person who is a danger to the community is incarcerated for an appropriate length of time.[7]

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[4] *See* https://www.justice.gov/usao-dc/pr/statement-us-attorneys-office-district-columbia-dc-council-regarding-measures-strengthen.

[5] *See* https://lims.dccouncil.gov/downloads/LIMS/46637/Hearing_Record/B24-0116-Hearing_Record1.pdf.

[6] *See* D.C. Code § 22-3751.

[7] Social science literature indicates that the length of punishment may have some deterrent effect, though the *certainty* of being caught is a vastly more powerful deterrent than the punishment. Crucially, however, there are important reasons for lengthy sentences other than general deterrence—including punishment and incapacitation. The National Institute of Justice published a summary of research on deterrence, titled "Five Things About Deterrence." As to the length of sentences, the National Institute of Justice summary stated the following:

> It is important to note that while the assertion in the original "Five Things" focused only on the impact of sentencing on deterring the commission of future crimes, a prison sentence serves two primary purposes: punishment and incapacitation. Those two purposes combined are a linchpin of United States sentencing policy, and those who oversee sentencing or are involved in the development of sentencing policy should always keep that in mind."

National Institute of Justice, *Five Things About Deterrence*, https://nij.ojp.gov/topics/articles/five-things-about-deterrence (June 5, 2016). Further, the literature does not provide that the length of sentence has *no* deterrent effect; rather, the literature provides that the certainty of being caught is a vastly more powerful deterrent than the

Additional Accountability Mechanisms

Felony Liability for Any Loss of Consciousness

This bill provides that "any loss of consciousness" would constitute a "significant bodily injury" for the felony offense of assault with significant bodily injury under D.C. Code § 22-404(a)(2). Any loss of consciousness caused by an assault—regardless of the length of the loss of consciousness—is a serious injury that should result in felony liability.

Current District law implies that there is no felony liability for an assault resulting in a brief loss of consciousness. Aggravated assault is a felony with a 10-year statutory maximum, which requires a finding of "serious bodily injury."[8] Assault with significant bodily injury is a felony with a 3-year statutory maximum, which requires a finding of "significant bodily injury"—a lesser injury threshold.[9]

For purposes of the aggravated assault statute, "serious bodily injury" means an injury that involves a substantial risk of death, *unconsciousness*, extreme physical pain, protracted and obvious disfigurement, or protracted loss or impairment of the function of a bodily member, organ, or mental faculty.[10] However, although the aggravated assault statute includes "unconsciousness" as a basis for "serious bodily injury," the D.C. Court of Appeals has held that a brief loss of consciousness of approximately a minute or less does not qualify as a "significant bodily injury."[11] In a separate case, the D.C. Court of Appeals has questioned, but not decided, whether any loss of consciousness, however brief, could amount to the requisite serious bodily injury to sustain an aggravated assault conviction.[12]

Moreover, if the victim is the only witness to the loss of consciousness, the victim may not be able to ascertain how long they were unconscious or be able to establish that the loss of consciousness lasted more than a brief time. Under this bill, no medical testimony or eyewitness testimony would be needed to establish the loss of consciousness required to establish that the victim had a loss of consciousness, and this level of "significant bodily injury" could be established by the victim's testimony that the assault resulted in a loss of consciousness.

Clarifying the Definition of "Significant Relationship" in Sexual Abuse Cases

This bill clarifies the definition of "significant relationship" in sexual abuse cases. This would fill a gap in liability by clarifying that a "contractor" or "consultant" of a school, church, synagogue, or similar institution has the same liability for sexual abuse as an "employee" or "volunteer" of the same.

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punishment. *Id.*

[8] *See* D.C. Code § 22-404.01.

[9] *See* D.C. Code § 22-4040(a)(2).

[10] *See Nixon v. United States*, 730 A.2d 145, 150 (D.C. 1999) (adopting definition of "serious bodily injury," now codified at D.C. Code § 22-3001(7), for purposes of the aggravated assault statute).

[11] *In re D.P.*, 122 A.3d 903, 913 (D.C. 2015).

[12] *Vaughn v. United States*, 93 A.3d 1237, 1269 n.39 (D.C. 2014) (cited in *D.P.*, 122 A.3d at 913 n.10)).

Under current law, there is liability for certain sexual offenses and enhancements where the defendant and victim are in a "significant relationship," as defined in D.C. Code § 22-3001(10). This includes circumstances where the defendant is an "employee" or "volunteer" of a school, church, synagogue, or similar institution. Adding the term "contractor" provides a more comprehensive definition of those responsible for the care and supervision of children at schools and other institutions. Many organizations do not hire all of their employees directly; rather, they enlist contractors as part of that staffing. The contractors have the same interactions with children and responsibilities as many of the direct employees do, and it makes no sense to distinguish them for purposes of liability. This bill would ensure that a "contractor" of such an organization would have the same liability as an "employee" or "volunteer," filling a gap in liability.

Supporting Violent Crime Investigations

Solving Crime Through Earlier Collection of DNA

Earlier collection of DNA would help to solve some of the District's most serious and violent crimes, and thereby help to prevent future crimes. 31 states and the federal government rely on earlier collection of DNA to help them solve violent crimes, and this bill would bring the District in line with the majority of states by providing the District with this additional tool to investigate violent crimes.

As the Supreme Court held in *Maryland v. King*, when upholding the constitutionality of collection and analysis of DNA at the time of arrest: "When officers make an arrest supported by probable cause to hold for a serious offense and they bring the suspect to the station to be detained in custody, taking and analyzing a check swab of the arrestee's DNA is, like fingerprinting and photographing, a legitimate police booking procedure that is reasonable under the Fourth Amendment."[13] The Supreme Court further held in *Maryland v. King*: "DNA identification is an advanced technique superior to fingerprinting in many ways, so much so that to insist on fingerprints as the norm would make little sense to either the forensic expert or a layperson."[14]

Accordingly, we support this bill, which would require law enforcement to collect DNA earlier in serious sexual abuse cases. We also support building on this bill by both: (1) requiring law enforcement to collect DNA from people arrested for all of the offenses for which DNA collection is mandated upon conviction; and (2) closing a loophole in the law by allowing District agencies to collect "lawfully owed" DNA from people previously convicted of offenses that already require a DNA sample to be provided.

After DNA collection, the DNA profiles would be analyzed and uploaded to the Combined DNA Index System ("CODIS"). CODIS is a national database operated by the Federal Bureau of Investigation ("FBI") that contains DNA profiles developed from crime scene evidence (such as, for example, semen collected during a sexual assault forensic examination or blood collected from a homicide crime scene) and known DNA profiles of certain convicted offenders and arrestees (from states with arrestee laws). When a convicted offender or arrestee

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[13] *Maryland v. King*, 569 U.S. 435, 465-66 (2013).

[14] *Id.* at 459.

DNA profile is uploaded to CODIS, it allows the possibility of linking that known DNA profile to an unknown DNA crime scene profile, providing a crucial investigative link for law enforcement to solve serious and violent crimes.

Importantly, academic research has found that "DNA databases deter crime by profiled offenders, reduce crime rates, and are more cost-effective than traditional law enforcement tools."[15] Moreover, academic research has found that "DNA databases provide the cleanest test of the effect of increasing the probability of punishment, and there is strong evidence that this reduces recidivism across a wide range of offenders."[16] An academic study of a 2005 change to Denmark's DNA database collection law that "allowed police to add anyone charged with what is roughly equivalent to a felony in the United States"—which "increase[ed] offenders' average probability of being included in the DNA database dramatically"—found that "DNA registration reduces recidivism within the following year by up to 42 percent" and "increases the probability that offenders are identified if they recidivate."[17] As summarized by an author of that study: "The bottom line: Expanding government DNA databases to add more criminal offenders has a big deterrent effect, reducing the number of crimes committed."[18]

Aligning with Other Jurisdictions' Laws that Allow DNA Collection from Arrestees to Solve and Prevent Crime

Currently, at least 31 states and the federal government have laws permitting the taking of DNA upon arrest for certain crimes. The following states permit the taking of DNA upon arrest: Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Florida, Illinois, Indiana, Kansas, Louisiana, Maryland, Michigan, Mississippi, Missouri, Nevada, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, and Wisconsin. Of those 31 states, approximately 20 states allow the sample to be analyzed after it is collected at booking, and approximately 11 states allow it to be analyzed after a probable cause finding. Of those 31 states, approximately 19 states allow collection of DNA for all felonies, of which approximately 9 states also allow collection for certain misdemeanors; and approximately 12 states allow for collection of DNA for certain felonies and, for some of the states, certain misdemeanors as well.

In *Maryland v. King*, the Supreme Court cited to studies demonstrating the effects of state DNA collection laws on the state's ability to solve crime:

> In considering laws to require collecting DNA from arrestees, government agencies around the Nation found evidence of numerous cases in which felony arrestees would have been identified as violent through DNA identification matching them to previous

[15] Jennifer L. Doleac, *The Effects of DNA Databases on Crime*, American Economic Journal: Applied Economics 2017, 9(1), at 165 (2017).

[16] Jennifer L. Doleac, *Encouraging Desistance from Crime*, Journal of Economic Literature 2023, 61(2), at 386 (2023).

[17] Anne Sofie Tegner Anker, Jennifer L. Doleac, and Rasmus Landersø, *The Effects of DNA Databases on the Deterrence and Detection of Offenders*, American Economic Journal: Applied Economics 2021, 13(4), at 194-95 (2021).

[18] Jennifer L. Doleac, *How DNA Databases Deter Crime*, Bloomberg Opinion (Feb. 1, 2021).

> crimes but who later committed additional crimes because such identification was not used to detain them. *See* Denver's Study on Preventable Crimes (2009) (three examples), Chicago's Study on Preventable Crimes (2005) (five examples); Maryland Study on Preventable Crimes (2008) (three examples).[19]

Further, a recent article highlighting Louisiana's use of Rapid DNA to test arrestee DNA samples stated that, "[i]n the last eight months, the Louisiana State Police report five people have been connected to previous crimes via Rapid DNA, including a 2013 homicide, a 2020 carjacking case that is being investigated by the Georgia Bureau of Investigation, two burglaries, and the police officer shooting in the Baton Rouge area."[20]

In the District, there are several notable examples of how—if the District had a law allowing DNA collection and analysis from arrestees—this practice could have solved an open violent crime case, and even prevented the assailant from committing additional violent crimes. First, in 2012, an unidentified assailant raped a 26-year-old stranger at gunpoint. DNA from the evidence was entered into CODIS with no hits. In 2014, the later-identified assailant was arrested and charged with assault with a dangerous weapon and assault with significant bodily injury. In 2015, while that case was still pending, the same assailant sexually assaulted an 11-year-old girl. Detectives were later able to solve both sexual assault cases with leads from the second case. If this assailant's DNA had been collected at the time of his 2014 arrest, law enforcement would have *solved* the 2012 rape and *prevented* the rape of an 11-year-old child. Second, in 2001 and 2002, an unidentified assailant raped two different strangers while armed. In 2010, the later-identified assailant was arrested for assault with a dangerous weapon. In 2015, this case was ultimately solved by cold case detectives, who reinvestigated leads, but if this assailant's DNA had been collected at the time of his 2010 arrest, both cases could have been solved earlier.

Closing a Loophole for DNA Collection Post-Conviction for Qualifying District Offenses

This proposal would also close a loophole in the law as to who is permitted to collect DNA from individuals who already "lawfully owe" a DNA sample due to a qualifying conviction.

Federal law requires the Bureau of Prisons ("BOP") to "collect a DNA sample from each individual *in the custody of* the Bureau of Prisons who is, or has been, convicted of a qualifying District of Columbia offense."[21] Federal law also requires the Court Services and Offender Supervision Agency ("CSOSA") to "collect a DNA sample from each individual *under the supervision of the Agency who is on supervised release, parole, or probation* who is, or has been, convicted of a qualifying District of Columbia offense."[22] As to qualifying offenses, federal law provides: "The government of the District of Columbia may determine those offenders under the District of Columbia Code that shall be treated for purposes of this section as qualifying District

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[19] *Maryland v. King*, 569 U.S. at 454 (internal citations to websites omitted).

[20] Roby Chavez, *How Louisiana police are using a DNA 'lab in a box' to solve crimes*, PBS News Hour (May 8, 2023).

[21] 34 U.S.C. § 40703(a)(1) (emphasis added).

[22] 34 U.S.C. § 40703(a)(2) (emphasis added).

of Columbia offenses."[23] District law defines "qualifying offenses for the purposes of DNA collection."[24]

There are two loopholes that this proposal remedies by providing District agencies authority to collect these "lawfully owed" DNA samples from convicted offenders. Under the first loophole, there are some people who are convicted of qualifying offenses who are never "in the custody" of BOP or "under the supervision" of CSOSA. For example, if a person receives a sentence of incarceration-only that is less than one year, without any period of supervision to follow, that person would serve their entire sentence in the D.C. Department of Corrections. Therefore, there would be no lawful opportunity for either BOP or CSOSA to collect the lawfully owed DNA sample. Under the second loophole, despite the requirement that BOP and CSOSA collect the samples from people in their custody or under their supervision who have been convicted of qualifying offenses, there are situations where BOP or CSOSA do not collect the sample. This proposal provides District agencies—including the Metropolitan Police Department and the D.C. Department of Corrections—authority to collect such samples from people who have been convicted of qualifying offenses.

Clarification of the Admissibility of GPS Data

This bill clarifies that GPS records from the Pretrial Services Agency ("PSA") are admissible in court as evidence of guilt in a criminal case or other judicial proceeding. This is a common-sense clarification that GPS records from PSA that, for example, indicate that a defendant was on the scene of a domestic violence incident or a murder can be admissible in that defendant's trial for domestic violence or murder. This clarification would not affect law regarding the admissibility of any statements that the defendant may make to PSA.

Global Positioning Systems (GPS) and other tracking devices are used by the court and the PSA as a condition of pretrial release designed to "reasonably assure the appearance of the person as required and the safety of any other person and the community."[25] As the Committee on Public Safety and the Judiciary noted in enacting D.C. Code § 22-1211 (Tampering with a detection device), GPS devices and "other electronic monitoring equipment serve as a deterrent for monitored persons to commit new crimes, thereby protecting public safety without the necessity of incarceration. Further, GPS devices can be utilized to identify probable suspects by matching their whereabouts to the scene of the crime."[26]

D.C. Code § 23-1303(d) currently reads:

> (d) Any information contained in the agency's files, presented in its report, or divulged during the course of any hearing shall not be admissible on the issue of guilt in any judicial proceeding, but such information may be used in proceedings under sections 23-

[23] 34 U.S.C. § 40703(d).

[24] D.C. Code § 22-4151.

[25] D.C. Code § 23-1321(c)(1)(B).

[26] Committee on Public Safety and the Judiciary, *Report on Bill 18-0151, the "Public Safety and Justice Amendments Act of 2009"* at 5 (Council of the District of Columbia June 26, 2009).

1327, 23-1328, and 23-1329, in perjury proceedings, and for the purposes of impeachment in any subsequent proceeding.

In interpreting this statute, however, some defendants have attempted to construe D.C. Code § 23-1303(d), standing alone, to prohibit the use of GPS data collected by PSA not only in prosecuting a violation of D.C. Code § 22-1211, but also in prosecuting much more serious crimes, up to and including murder. It is important for the Council, therefore, to clarify that the limitations in D.C. Code § 23-1303 do not apply to GPS records that are in the possession of PSA. This clarification is consistent with the legislative intent of the statute.

In litigation, we consistently maintain that this statute allows for GPS records from PSA to be admissible as guilt in a court proceeding. Several trial court judges have addressed this issue and have agreed with our reading of the statute. Until the Council clarifies the plain language of the statute, however, there will likely be additional litigation on this point.

To remove any possible ambiguity about its scope, D.C. Code § 23-1303(d) should be amended so that its language is consistent with its original intent—that is, protecting communications between a defendant and a pretrial services officer, and not protecting a defendant on pretrial release from the use of probative evidence of the defendant's commission of another crime or from information from other sources. GPS monitoring would not serve as a deterrent to committing new crimes if GPS monitoring evidence could not be used in the prosecution of those crimes. The Council can resolve the question now and completely by amending the statute as proposed above. It would be tragic if we could prove that a person on pretrial release was on the site of a murder, rape, armed robbery, or aggravated assault, but were precluded from doing so because a court interpreted the language more broadly than intended by the statute.

Enhancing Pretrial Detention for Violent Crimes

Courts should have additional authority to detain adults charged with certain felony crimes pretrial when they pose a danger to the safety of another person or the community. In the District, there is a general statutory presumption that a person charged with a criminal offense will be released pending trial, except under limited circumstances. Thus, prosecutors can only request that a person be detained in jail pending trial when authorized by statute. We support this bill, which enhancing pretrial detention for violent crime. We also support building on this bill by creating a rebuttable presumption of detention where a judge has found probable cause to believe that the person committed any "crime of violence," by creating greater transparency to the community where a judge decides to release a person and a rebuttable presumption of pretrial detention exists, and by providing judges additional discretion to extend the 100-day trial clock when there is good cause to do so. Further, we support expanding the court's ability to detain people pretrial who are charged with the most serious sexual crimes—first degree sexual abuse and first degree child sexual abuse—and aligning the standard of proof for a presumption of detention for the most serious crimes with the standard of proof for most serious felonies.

Rebuttable Presumption of Pretrial Detention for a Crime of Violence

Under current law, when a person is charged with a crime and makes their first appearance in court, there are certain statutes that authorize prosecutors to request pretrial

detention, including: (1) where the person is charged with first or second degree murder, or assault with intent to kill while armed; (2) where the person is charged with a crime of violence or a dangerous crime; (3) where the person poses a risk of flight; or (4) where the person is on release in a pending case or is under post-conviction supervision.

When the court authorizes pretrial detention at that first appearance, the court holds a detention hearing, typically several days later. At the detention hearing, the court determines if there is probable cause to move forward with the case and whether the person should be detained pending trial. At this point, unless a statutory rebuttable presumption of pretrial detention applies, there is a presumption that a person will be released. The government must show by clear and convincing evidence that no condition or combination of conditions will reasonably assure the appearance of the person as required or the safety of any other person in the community.

There are certain situations, however, where there is a statutory rebuttable presumption that a person should be detained pending trial, and to release a person, the court must find evidence to rebut that presumption. The statute contains a rebuttable presumption of pretrial detention where, for example, the court finds probable cause that the person committed a crime of violence while armed with a firearm, threatened a witness or juror, or committed a crime of violence while on release pending trial.

By contrast, *there is no general presumption of detention when the court finds probable cause to believe that a person has committed a crime of violence*. This proposal would create a rebuttable presumption of detention where the person is charged with committing a "crime of violence," as defined in D.C. Code § 23-1331(4).

This proposal would also create more transparency and accountability to the community by requiring a judge to issue written findings of fact and a written statement of the reasons for the release when a rebuttable presumption applies, setting forth the evidence that it found had rebutted the statutory presumption. These written orders are akin to the orders that judges are required to issue pursuant to § 23-1322(g) when finding that a person should be detained pretrial. This proposal would also clarify the standard that a judge must find to release a person to the community where a rebuttable presumption applies.

This change would retain the general presumption of pretrial release for crimes that are not considered "crimes of violence" (including many felonies and all misdemeanors), but would provide a judge more discretion to protect the community where they have found probable cause to believe that the person committed any crime of violence, and where that person has been found to be a danger to the community. Notably, § 23-1322(c) only creates a *presumption* of detention, and does not require detention. Therefore, the court retains discretion to find that the presumption of detention has been rebutted, and to decide not to detain a person.

Enhanced Pretrial Detention for Serious Sexual Offenses

This proposal would align pretrial detention for the most serious sexual offenses—first degree sexual abuse (rape) and first degree child sexual abuse (non-forced sexual abuse of a child)—with the pretrial detention provisions for murder and assault with intent to kill while armed. Under current law, if a defendant is charged with first degree sexual abuse or first degree child sexual abuse and is pretrial, the case must be indicted within 90 days, and a trial must

commence within 100 days.[27] By contrast, if a defendant is charged with first degree murder, second degree murder, or assault with intent to kill while armed, and is preventatively detained pretrial, the case must be indicted within 9 months.[28]

Given that the government must indict these serious sex offenses within 90 days and go to trial within 100 days of arrest, the government is limited and often rushed in its investigations and trial preparation. The government has just over three months to investigate the offense, build trust with the victim(s) and witness(es), conduct DNA testing, and collect and review evidence. Although a 100-day case may be continued for good cause, continuances are typically limited.

Sexual assault cases are unique in that they often require more time to build trust with the victims, who are often very vulnerable. This is particularly true when the victim is a child. Moreover, many serious sexual offenses involve serial offenders, so the government must work with multiple victims as it investigates and prepares for indictment and trial. It is difficult to build so many meaningful relationships and fully investigate the allegations in the short span of 100 days, even if there are limited extensions of time granted. Further, as with homicide cases, multiple rounds of DNA testing are often needed. Allowing nine months to indict the most serious sexual offense cases allows the government time to ensure that it completes a comprehensive investigation of these serious allegations that disproportionately affect women and children.

Further, these offenses are recognized as some of the most serious offenses in other parts of the criminal justice system. The D.C. Sentencing Commission, for example, has recognized the seriousness of certain sexual offenses, aligning them with other serious offenses delineated in § 23-1325(a) in the voluntary sentencing guidelines. Second degree murder and first degree sexual abuse are both categorized as Group 2 offenses in the sentencing guidelines, which means that they are subject to the same sentencing guideline ranges. Likewise, assault with intent to kill while armed and first degree child sexual abuse are both categorized as Group 3 offenses, so they are also subject to the same sentencing guideline ranges. (First degree murder is categorized as a Group 1 offense.) Because first degree sexual abuse and first degree child sexual abuse are subject to the same guideline ranges as second degree murder and assault with intent to kill while armed, respectively, they should be treated comparably for purposes of pretrial detention.

Rebuttable Presumption Standard Under § 23-1325(a)

This proposal would create, in § 23-1325(a), a rebuttable presumption of detention for murder, assault with intent to kill where armed, and serious sexual offenses where a judge finds "probable cause" that the person committed the offense "while armed with or having readily available a pistol, firearm, or imitation firearm," rather than, as current law provides, "substantial probability" to believe that the person committed the offense while armed. This proposal would align the standard of proof that leads to a presumption of detention under § 23-1325(a) (which applies to the most serious crimes, including murder while armed, and allows up to 9 months to indict) with the standard of proof that leads to a presumption of detention under § 23-1322(c) (which applies to all other rebuttable presumptions, and allows 100 days for a trial). That is, if a

[27] *See* D.C. Code § 23-1322(h).

[28] *See* D.C. Code § 23-1325(a); D.C. Code § 23-102; D.C. Sup. Ct. Rule of Crim. Pro. 48(c).

judge finds "probable cause" to believe that the defendant committed the charged crime under § 23-1325(a) while armed, there would be a presumption of detention pretrial. Judges would still retain the ultimate decision as to whether the presumption has been rebutted, which could include consideration of the strength of the government's evidence.

Under current law, for example, there would be a presumption of pretrial detention under § 23-1322(c)(1) if a judge found probable cause that a person committed a carjacking while armed with a firearm. However, if a judge found probable cause that a person *murdered someone* while committing a carjacking while armed with a firearm, there would be *no* presumption of pretrial detention under § 23-1325(a), because this statute requires a substantial probability finding, not probable cause. This change would create parity between the standards in these provisions. (Likewise, if a judge found probable cause that a person committed an unarmed carjacking, there would be no rebuttable presumption of detention under § 23-1322(c), because there is no general presumption of detention for commission of a crime of violence.)

100-Day Trial Clock

When a person is detained pretrial for any offense other than an offense listed in § 23-1325(a), the trial must begin within 100 days of the initial detention. When the government is requesting more time to prepare for trial, the 100-day clock may be extended only in 20-day increments, for good cause shown.

This proposal would eliminate the requirement that extensions to the 100-day clock be granted only in 20-day increments. Rather, it would provide a judge discretion to approve an extension for the time that the judge believes is appropriate. If the judge believes that a 20-day continuance is appropriate, the judge may continue to impose a 20-day continuance, but this proposal would also provide a judge discretion to continue the trial beyond 20 days. The 20-day limitation means that, in practice, even if there is no expectation that either the government or the defense will be ready for trial in 20 days, the judge is limited to continuing the case in 20-day increments. This is inefficient for court and government resources, but also a burden on witnesses, who must be prepared for a new trial every 20 days and prepare to travel and take off work to testify at trial. For example, even if an essential witness were out of the country for 40 days on military duty, the trial could only be continued in 20-day increments. Notably, before any continuance at the government's request, the government would still need to show "good cause" to the judge as to the need for an extension of the 100-day clock.

Further, this proposal would create a presumption of good cause where the government requests additional time for trial due to forensic analysis of evidence that was requested within a reasonable time after the preliminary hearing or delayed due to defense motions. Forensic testing has expanded significantly since this statute was written, and this statute should be amended to recognize the modern realities of forensic testing, which include the significant time required to conduct testing in light of the expectation and desire for such testing in almost all serious cases.

Expanding Information Considered in Second Look Sentence Reductions for the Most Serious Violent Crimes

We support the bill's proposed changes to the Incarceration Reduction Amendment Act ("IRAA"), which would make the following changes.

First, this bill reinstates the requirement that the court consider the "nature of the offense" for which defendant was convicted when considering a sentence reduction. Although courts interpreting this statute have considered the nature of the offense under other factors under this statute, it is crucial that the statute expressly require the court to consider the nature of the offense. The only reason that a defendant is incarcerated at all is because of the "nature of the offense" that the defendant committed. It is only the most serious violent crimes in the District that would have received sentences of more than 15 years—murder, violent sexual assaults, or other violent crimes such as assault with intent to kill while armed and kidnapping while armed, and may involve either single victims or multiple victims.

Second, this bill removes language that counsels against sentencing people under 25 to lengthy terms in prison "despite the brutality or cold-blooded nature of any particular crime." Although a court will consider certain features of juveniles that may include immaturity, impetuosity, and failure to appreciate risks and consequences, it also is relevant to a sentencing assessment whether a person under 25 committed a particularly brutal or cold-blooded crime. Indeed, the existence of brutality or cold-bloodedness may indicate that the crime was *not* merely the result of juvenile immaturity, impetuosity, or a failure to appreciate risks and consequences.

Third, this bill requires the court to consider the defendant's "remorse" alongside other factors that would support rehabilitation. Remorse is a crucial part of accountability, growth, rehabilitation, and maturity. The court should be directed to consider whether a defendant has accepted responsibility for their actions that harmed another person—murdering them, seriously sexually assaulting them, or committing another violent crime against them—because such remorse is an essential component of whether the defendant has been rehabilitated and is fit to reenter society.

Fourth, this bill clarifies that the court may consider a "community impact statement," and that the court must consider "the position of the United States Attorney."

We also propose that the Council make additional changes to this statute.

First, we propose clarifying that, to be eligible for IRAA, a defendant must have served 15 years "resulting from the sentence imposed in this case." If, for example, a defendant has served 20 years' incarceration for a homicide that was committed in Maryland, but has not yet begun serving his sentence in the District for a different homicide that was committed in the District, the statute would appear to allow the defendant to be eligible for IRAA in the District because the defendant has been *imprisoned* for more than 15 years.

Second, we propose clarifying that a person is only eligible for IRAA when that person "is currently in prison or jail." At least one judge has ruled that a person who is on parole *is* eligible to file for a sentence reduction under IRAA; the effect of relief under IRAA would be resentencing to a shorter period of community supervision, or even to no supervision at all. This interpretation would both contravene the original intent of the statute—that is, allowing people who are currently in prison or jail an opportunity to move for release from incarceration—and would greatly increase the number of people eligible to apply for IRAA relief and exacerbate the burden on the courts.

Third, we propose clarifying that, when resentencing a defendant under IRAA, the court "shall not reduce the term of imprisonment to a term that is less than the term of imprisonment the defendant has already served." If a defendant's sentence is reduced below the amount of time that

the defendant has served, it would result in an overserved sentence. This would allow the defendant to be released from a wholly unrelated sentence imposed by a different judge or even in a different jurisdiction.

Factors that a Court Must Consider

Second look sentencing should provide an opportunity for a defendant to receive a second look at their sentence to ascertain if it remains an appropriate sentence, and should contain a balanced review of multiple factors, including: the offense that led to the defendant's term of incarceration, and its impact on the victim(s) and the community; the defendant's rehabilitation and growth while incarcerated; whether the defendant is a danger to the public safety of any person or the community; and whether a reduction is in the interests of justice. To ensure that a court is conducting a balanced and neutral look at the sentence and whether a reduction is justified, it is appropriate to make several changes to the factors that a court is required to consider under subsection (c) of D.C. Code § 24-403.03.

Mandatory Consideration of "the Nature of the Offense" under Subsection (c)(2)

This bill reinstates, in subsection (c)(2), the requirement that the court consider "the nature of the offense and the history and characteristics of the defendant." Although courts interpreting this statute have considered the nature of the offense as part of their consideration of the other factors under this statute—including the victim impact statement under subsection (c)(6) and the extent of the defendant's role in the offense under subsection (c)(9)—it is crucial that the statute expressly require the court to consider the nature of the offense as part of its "second look" at a defendant's sentence. The only reason that a defendant is incarcerated at all is because of the nature of the offense that the defendant committed. Indeed, it is only the most serious violent crimes in the District that would have received sentences of more than 15 or 20 years. The defendants who would be eligible for consideration under this section have primarily been convicted of murder, but also have been convicted of violent sexual assaults or other violent crimes, such as assault with intent to kill while armed and kidnapping while armed. Some of these offenses involve single victims, and some involve multiple victims who the defendant violently assaulted or murdered. In assessing whether a particular sentence remains appropriate, the nature of the offense must be considered. The D.C. Council's Committee on the Judiciary and Public Safety (Judiciary Committee) has stated: "As part of its 'second look' at a person's sentence, the Court also considers the underlying offense through its review of the various factors and evidence, including the pleadings, case files, the defendant's testimony, the government's position, and the testimony of the survivor of the crime, if they wish to participate either in support or opposition."[29] The Judiciary Committee has further stated: "The Committee is clear that the facts and circumstances of the underlying offense are interwoven through the statute, but to be explicit on this point, the Committee has included language in the Print that the 'court may consider any records related to

[29] Committee on the Judiciary and Public Safety, *Report on Bill 23-0127, the "Omnibus Public Safety and Justice Amendment Act of 2020"* at 18 (November 23, 2020).

the underlying offense,' as has been the practice in IRAA cases considered thus far, both before and after amendments to the statute."[30]

It is not sufficient, however, if the nature and circumstances of the offense are only included as part of a consideration of another factor. The Council's original language requiring the court consider "the nature and circumstances of the offense, and the history and characteristics of the defendant" is appropriate. Moreover, the change made by IRAA 3.0[31] to clarify that the court may consider "any records related to the underlying offense" is primarily an evidentiary modification, and does not modify the factors that a court is required to consider under subsection (c). Soon after the initial enactment of the IRAA, some expressed concerns that USAO was focusing too heavily on the nature of the offense to justify continued incarceration. The Judiciary Committee stated: "Prior standalone language in the list of factors—the 'nature and circumstances of the offense'—was unanimously removed by the Council in earlier legislation in response to the over-reliance on the underlying offense by the USAO as an argument for denying the petitions of potentially rehabilitated defendants."[32] It is wholly appropriate, however, to require the court to consider the nature and circumstances of the offense—along with the other factors set forth in the statute—in assessing whether the movant has established that they are not a danger and that a reduction is in the interests of justice. Although the Council's intent is clear that other factors must be considered as part of a court's analysis, removing the nature of the offense from the list of mandatory factors is not consistent with a holistic assessment of an appropriate outcome in an individual case.

IRAA 1.0 recognized the importance of mandatory consideration of this factor, as it required the court to consider, among other factors, "the nature of the offense and the history and characteristics of the defendant." IRAA 2.0 made certain modifications to that statute. Among other changes, IRAA 2.0 modified subsection (c)(2) to remove the words "the nature of the offense," so that subsection (c)(2) now requires the court to consider only "the history and characteristics of the defendant."

The Committee Report to IRAA 2.0 stated the following in making these changes:

> [T]he Committee Print amends a relatively new provision in Section 301 of the Comprehensive Youth Justice Amendment Act of 2016—the Incarceration Reduction Amendment Act of 2016—to account for lessons learned since its effective date. This act allows for sentence reviews for individuals who have served a certain number of years in prison for crimes committed as juveniles. The sentence reviews conducted by the Superior Court thus far have provided several opportunities for clarification and enhancement, but as of the date of this report, the Committee is quite pleased with Superior Court judges' interpretations of the new law. This section important[ly] now includes a wider number of individuals within the law's sentence review petition process, revisits the factors used by

[30] *Id.* at 19.

[31] The Comprehensive Youth Justice Amendment Act of 2016 (Law 21-0238), which contained the original version of the Incarceration Reduction Amendment Act (IRAA), is colloquially known as "IRAA 1.0." The Omnibus Public Safety and Justice Amendment Act of 2018 (Law 22-0313), which contained amendments to the IRAA, is colloquially known as "IRAA 2.0." The Omnibus Public Safety and Justice Amendment Act of 2020 (Law 23-0274) is colloquially known as "IRAA 3.0."

[32] *Report on Bill 23-0127,* at 19.

> the court, and lowers the number of years an individual must have served prior to applying.[33]

The Council's removal of the words "nature of the offense" in IRAA 2.0 from the list of factors that a court must consider implied that the nature of the offense may be a less relevant factor for a court to consider. Although other factors such as a defendant's rehabilitation, remorse, and maturity are important factors that a court should consider, a second look takes place in a vacuum if the nature of the offense is not considered. We see firsthand the devastation that violent crime inflicts on victims and communities. These voices must be fully heard in any resentencing, which can only happen if a judge is permitted to fully consider the nature of the defendant's conduct to determine if the defendant remains a danger to the community and if a reduction is in the interests of justice. This is also consistent with 18 U.S.C. § 3553(a), which sets forth the factors that a court shall consider as part of a sentencing. 18 U.S.C. § 3553(a)(1) provides that, in determining the particular sentence to be imposed, the court shall consider "the nature and circumstances of the offense and the history and characteristics of the defendant."

Removal of the Words "Despite the Brutality or Cold-Blooded Nature of any Particular Crime" from Subsection (c)(10)

As part of IRAA 2.0, the Council made the following changes to what the court is required to consider under subsection (c)(10):

> The diminished culpability of juveniles as compared to that of adults, and the hallmark features of youth, including immaturity, impetuosity, and failure to appreciate risks and consequences, which counsel against sentencing them to ~~a lifetime~~ lengthy terms in prison, despite the brutality or cold-blooded nature of any particular crime.

For similar reasons as stated above with respect to express inclusion of "nature and circumstances of the offense," this bill removes the words "despite the brutality or cold-blooded nature of any particular crime" from subsection (c)(10). Although a court will consider certain features of juveniles that may include immaturity, impetuosity, and failure to appreciate risks and consequences, it also is relevant to a sentencing assessment whether a juvenile committed a particularly brutal or cold-blooded crime. Indeed, the existence of brutality or cold-bloodedness may indicate that the crime was *not* merely the result of juvenile immaturity, impetuosity, or a failure to appreciate risks and consequences.

In addition to removing this language, we propose reinstating language from IRAA 1.0, which provides that this diminished culpability counsels against sentencing juveniles to "a lifetime in prison," rather than the language changed by IRAA 2.0 to "lengthy terms in prison."

Addition of "Remorse" to Subsection (c)(5)

This bill amends subsection (c)(5) to read: "Whether the defendant has demonstrated maturity, rehabilitation, remorse, and a fitness to reenter society sufficient to justify a sentence reduction."

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[33] Committee on the Judiciary and Public Safety, *Report on Bill 22-0255, the "Omnibus Public Safety and Justice Amendment Act of 2018"* at 8 (November 28, 2018).

Remorse is a crucial part of accountability, growth, rehabilitation, and maturity. The court should be directed to consider whether a defendant has accepted responsibility for their actions that harmed another person—murdering them, seriously sexually assaulting them, or committing another violent crime against them—because such remorse is an essential component of whether the defendant is fit to reenter society. If a defendant does not express genuine remorse and accept responsibility, the defendant necessarily cannot show that they have been rehabilitated.

Some—though not all—other jurisdictions include "remorse" or similar language as a factor that a court or a parole board must consider when evaluating whether a young person is eligible for release from incarceration.[34] Consistent with these jurisdictions, this bill requires that a court consider the defendant's remorse as part of its analysis.

It is important to note here that the addition of "remorse" to subsection (c)(5) would not be outcome-determinative. To the extent that a defendant contends that they are actually innocent of the charge of which they have been convicted, the court may give the "remorse" factor as much weight as the court deems appropriate, balanced alongside the other factors, and balanced with the fact that there are other statutory avenues in the D.C. Code for a defendant to allow a court to consider whether the defendant is actually innocent.

Clarification that a Court Must Consider a Community Impact Statement under Subsection (c)(6)

This bill clarifies that subsection (c)(6) includes consideration of any "community impact statement" submitted. Subsection (c)(6) provides that a court shall consider a victim impact statement from a victim or a victim's family member provided pursuant to D.C. Code § 23-1904. We note here that D.C. Code § 23-1904(f)(1) also allows a "representative of a community affected by the crime of which the defendant has been convicted" to submit a statement prior to imposition of sentence.

Clarification to the Position of USAO-DC in Subsection (c)(4)

Subsection (c)(4) provides that the court shall consider "any report or recommendation received from the United States Attorney." This bill modifies this provision to require consideration of "the position of the United States Attorney." One judge found the language of this subsection to be unclear, stating that this may either refer to recommendations from the government when a defendant cooperates, or may refer to the government's position with respect

[34] Florida requires consideration of, among other factors, "Whether the juvenile offender has shown sincere and sustained remorse for the criminal offense." § 921-1402(6)(e), Fla. Stat. Connecticut requires that the defendant demonstrate "substantial rehabilitation," as demonstrated by factors including "whether such person has demonstrated remorse and increased maturity since the date of the commission of the crime or crimes." Conn. Gen. Stat. Sec. 54-125a(f)(4)(C). California has implemented regulations that set forth additional parole considerations in hearings for youth offenders. One of those factors is "Subsequent Growth and Increased Maturity of the Inmate While Incarcerated, which includes, but is not limited to, consideration of the following factors: (1) Considered reflection; (2) Maturity of judgment including, but not limited to, improved impulse control, the development of pro-social relationships, or independence from negative influences; (3) Self-recognition of human worth and potential; (4) Remorse; (5) Positive institutional conduct; and (6) Other evidence of rehabilitation." 15 C.C.R. § 2446(c). Oregon requires consideration of factors including "Whether the person demonstrates accountability and responsibility for past and future conduct." Or. Rev. Stat. § 420A.203.

to relief under the IRAA statute. To remove any potential confusion, this bill clarifies this provision.

Clarifications Regarding Eligibility Under IRAA

Clarification Regarding Length of Incarceration

We propose clarifying that, to be eligible to move for relief under IRAA, a defendant must have served the requisite number of years "resulting from the sentence imposed in this case." If, for example, a defendant has served 20 years' incarceration for a homicide that was committed in Maryland, and has not yet begun serving the period of incarceration in the District for a homicide that was committed in the District, the plain language of the statute would appear to allow the defendant to move for relief in the District because the defendant has been *imprisoned* for more than 15 years.

Clarification Regarding Parole

We propose clarifying that a person is only eligible to move for relief under IRAA when that person is currently incarcerated. This clarification would provide that this statute applies to someone "who is currently in prison or jail." There has been some litigation over the issue of whether a person who previously served more than 15 years and was released on parole is eligible for relief under IRAA; the effect of relief under IRAA would be resentencing to a shorter period of community supervision or, in some circumstances, no supervision at all. At least one judge has ruled that a person who is on parole *is* eligible to file for a sentence reduction under IRAA. In addition to contravening what we understand to be the intent of the statute—that is, allowing people who are currently in prison or jail an opportunity to move for release from incarceration—interpreting the statute in this manner will greatly increase the number of people eligible to apply for IRAA relief and exacerbate the burden on the courts. We understand the Council's intent to allow a person who is incarcerated and awaiting review by the U.S. Parole Commission to be eligible for second look, and we recommend that the Council clarify this in the plain language of the statute.

Permitted Scope of Resentencing

We propose stating that, when resentencing a defendant pursuant to this provision, the court "shall not reduce the term of imprisonment to a term that is less than the term of imprisonment the defendant has already served." This language is taken from U.S. Sentencing Guidelines, Policy Statement § 1B1.10(b)(2)(C), which prohibits a reduction in the term of imprisonment as a result of an amended guideline range from being less than the term of imprisonment that the defendant has already served.

A defendant's reduced sentence under IRAA should only be permitted to be reduced to the amount of time that the defendant has already served on that sentence. If a defendant's sentence is reduced below the amount of time that the defendant has served on that sentence, it would result in an overserved sentence. This would allow the defendant to be released from a wholly unrelated sentence imposed by a different judge or even in a different jurisdiction.

For example, in one IRAA case, a defendant was originally sentenced to an aggregate sentence of approximately 26 years to life for murder and assault with intent to kill while armed. While incarcerated, he was convicted of assault with a dangerous weapon in another jurisdiction, for which he was sentenced to an additional sentence of 20 months of imprisonment—ordered to run consecutively to any other sentence. His IRAA petition was granted after he had been incarcerated for almost 26 years. When granting the defendant's IRAA petition, the court resentenced the defendant to 24 years' incarceration—that is, below the 26 years that he had already served—so that he could be immediately released and would not have to serve any additional time on the unrelated, consecutive 20-month sentence.

In a different IRAA case, the court granted the defendant's IRAA motion, sentencing the defendant to time served in that case. The defendant had not yet, however, served a separate 41-month sentence for assault with a dangerous weapon in another jurisdiction, which that court had ordered to run consecutively to the D.C. Superior Court sentence. When the Superior Court judge resentenced the defendant under the IRAA, the defendant requested that the court reduce his sentence to time served, back-dated to 2017. The government argued that this would effectively eliminate the defendant's sentence in an unrelated federal case imposed by a different court for a different crime. The Superior Court judge agreed with the government, and specifically declined to fashion a sentence reduction that would have eliminated the defendant's sentence in an unrelated case.

Additionally, permitting a less-than-time-served sentence under the IRAA would also allow the defendant to "bank time" against potential future incarceration related to his or her conviction in the Superior Court case. For example, an overserved sentence might affect the resolution of violations committed while on probation or supervised release, because BOP would credit the overserved time toward the possible later term of imprisonment.

For these reasons, this proposal codifies the principle that a sentence reduction under IRAA can serve only to reduce the defendant's sentence in that case, rather than, for example, having the effect of also reducing an unrelated sentence for a different crime imposed by a different judge, even in a different jurisdiction.

Bill 25-0247, the Female Genital Mutilation Prohibition Act of 2023

USAO-DC also supports Bill 25-0247, the "Female Genital Mutilation Prohibition Act of 2023." This bill will help to protect girls in our community who have been or are at risk of being subject to female genital mutilation or cutting (FGM/C). The Department of Justice has declared that there will be no tolerance for the harmful and traumatic practice of FGM, and the Department is dedicated to enforcing laws barring female genital mutilation to protect girls from this traumatic experience.[35] The U.S. Government opposes FGM/C, no matter the type, degree or severity, no matter what the motivation for performing it. The U.S. Government considers

[35] U.S. Department of Justice, *Justice Department, ICE and the FBI Recognize International Day of Zero Tolerance for Female Genital Mutilation* (Feb. 4, 2022), https://www.justice.gov/opa/pr/justice-department-ice-and-fbi-recognize-international-day-zero-tolerance-female-genital.

FGM/C to be a serious human rights abuse and a form of gender-based violence and child abuse.[36]

According to UNICEF, more than 200 million girls and women alive today have undergone FGM, which refers to procedures that injure the female genital organs for non-medical reasons.[37] While primarily concentrated in north, west, and central Africa, as well as parts of the Middle East and Asia, FGM also occurs in the United States. The Centers for Disease Control estimates that approximately 500,000 women and girls in the United States are either victims of FGM or are at risk of being subjected to it.[38] The practice is global in scope and found in multiple geographies, religions, and socioeconomic classes.

* * *

We appreciate the Committee's consideration of this legislation as part of a wholistic approach to improving the criminal justice system. We believe that this legislation takes meaningful steps to improve community safety and address issues related to violent crime. We look forward to continuing to work with the Council, our criminal justice partners, and the community on our common goals to improve public safety in the District.

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[36] U.S. Department of State, *U.S. Government Fact Sheet on Female Genital Mutilation or Cutting (FGM/C)*, https://travel.state.gov/content/travel/en/us-visas/visa-information-resources/fact-sheet-on-female-genital-mutilation-or-cutting.html.

[37] U.S. Centers for Disease Control and Prevention, *Female Genital Mutilation/Cutting (FGM/C)*, https://www.cdc.gov/reproductivehealth/womensrh/female-genital-mutilation.html.

[38] U.S. Government Accountability Office, *Female Genital Mutilation/Cutting: Existing Federal Effort to Increase Awareness Should Be Improved* (June 30, 2016), https://www.gao.gov/products/gao-16-645.

Appendix: Proposed Redline

Supporting Violent Crime Investigations: Solving Crime Through Earlier Collection of DNA

Proposed Redline to D.C. Code Title 22, Chapter 41B

§ 22–4151. Qualifying offenses.

(a) The following criminal offenses shall be qualifying offenses for the purposes of DNA collection under the DNA Analysis Backlog Elimination Act of 2000, approved December 19, 2000 (Pub. L. No. 106-546; 114 Stat. 2726) [42 U.S.C. §§ 14135-14135e]:

(1) Any felony;

(2) Any offense for which the penalty is greater than one year imprisonment;

(3) § 22-1312(b) (lewd, indecent, or obscene acts (knowingly in the presence of a child under the age of 16 years));

(4) § 22-2201 (certain obscene activities involving minors);

(5) § 22-3102 (sexual performances using minors);

(6) § 22-3006 (misdemeanor sexual abuse);

(7) § 22-3010.01 (misdemeanor sexual abuse of a child or minor); and

(8) Attempt or conspiracy to commit any of the offenses listed in paragraphs (1) through (7) of this subsection.

(b) DNA collected by an agency of the District of Columbia shall not be searched for the purpose of identifying a family member related to the individual from whom the DNA sample was acquired.

§ 22-4152. Collection and use of DNA identification information from arrestees and defendants.

(a) *Collection of DNA samples.*

(1) The Metropolitan Police Department shall collect a DNA sample from each individual arrested for an offense set forth in D.C. Code § 22-4151.

(2) If an individual appears in court having been charged with an offense set forth in D.C. Code § 22-4151 without previously having a DNA sample collected, the court shall direct the collection of a DNA sample from that individual.

(3) DNA sample collection under this section may be limited to individuals who are fingerprinted.

(4) The Metropolitan Police Department or the court (as applicable) may authorize, or enter into agreements with, other local, state, or federal governmental agencies or private entities to collect DNA samples under this section.

(5) An agency or entity may, but need not, collect a DNA sample from an individual if:

(A) Another agency or entity has collected, or will collect, a DNA sample from that individual and has provided, or will provide, the sample for analysis and inclusion of the results in CODIS as provided in subsection (b); or

(B) CODIS already contains a DNA analysis with respect to that individual.

(6) DNA sample collection may be repeated if the agency or entity responsible for collection is informed that a sample collected from the individual does not satisfy the requirements for analysis or for entry of the results of the analysis into CODIS.

(b) *Analysis and use of DNA information collected under this section.* The Metropolitan Police Department or other authorized agency or entity (as applicable) shall furnish each DNA sample collected under this section to the Federal Bureau of Investigation Laboratory, or to another laboratory approved by the FBI, for the purpose of carrying out a DNA analysis on each such DNA sample and including the results in CODIS. The requirements of this subsection may be waived, with the permission of the Federal Bureau of Investigation, if DNA samples are analyzed by means of Rapid DNA instruments and the results are included in CODIS.

(c) *Collection procedures.* Each individual described in subsection (a) shall cooperate in the collection of a DNA sample from that individual. If an individual from whom the collection of a DNA sample is authorized under this section refuses to cooperate in the collection of the sample:

(1) The Metropolitan Police Department or the court (as applicable) may use or authorize the use of such means as are reasonably necessary to detain, restrain, and collect a DNA sample from the individual; and

(2) The individual shall be guilty of a misdemeanor and may be imprisoned for not more than one year.

(d) *Expungement.* DNA information secured pursuant to this section shall be expunged, in conformity with 34 U.S.C. § 12592(d), if all relevant charges have been dismissed or have resulted in acquittal, or no charges are brought within the applicable period.

(e) *Non-preemption of other authorities.* The authorization of DNA sample collection by this section does not limit DNA sample collection by any agency pursuant to any other authority.

(f) *Definitions.* In this section, the terms "DNA sample," "DNA analysis," and "Rapid DNA instruments," have the meanings set forth in 34 U.S.C. § 40703(c).

§ 22-4153. Collection of DNA identification information from convicted offenders.

(a) *Collection of DNA samples.*

(1) Agencies of the District of Columbia may collect a DNA sample from an individual who is, or has been, convicted of an offense set forth in D.C. Code § 22-4151.

(2) Agencies of the District of Columbia or the court (as applicable) may authorize, or enter into agreements with, other local, state, or federal governmental agencies or private entities to collect DNA samples under this section.

(3) An agency or entity may, but need not, collect a DNA sample from an individual if:

(A) Another agency or entity has collected, or will collect, a DNA sample from that individual and has provided, or will provide, the sample for analysis and inclusion of the results in CODIS as provided in subsection (b); or

(B) CODIS already contains a DNA analysis with respect to that individual.

(4) DNA sample collection may be repeated if the agency or entity responsible for collection is informed that a sample collected from the individual does not satisfy the requirements for analysis or for entry of the results of the analysis into CODIS.

(b) *Analysis and use of DNA information collected under this section.* The agency or entity (as applicable) shall furnish each DNA sample collected under this section to the Federal Bureau of Investigation Laboratory, or to another laboratory approved by the FBI, for the purpose of carrying out a DNA analysis on each such DNA sample and including the results in CODIS. The requirements of this subsection may be waived, with the permission of the Federal Bureau of Investigation, if DNA samples are analyzed by means of Rapid DNA instruments and the results are included in CODIS.

(c) *Collection procedures.* Each individual described in subsection (a) shall cooperate in the collection of a DNA sample from that individual. If an individual from whom the collection of a DNA sample is authorized under this section refuses to cooperate in the collection of the sample:

(1) The collecting agency or entity or the court (as applicable) may use or authorize the use of such means as are reasonably necessary to detain, restrain, and collect a DNA sample from the individual; and

(2) The individual shall be guilty of a misdemeanor and may be imprisoned for not more than one year.

(d) *Non-preemption of other authorities.* The authorization of DNA sample collection by this section does not limit DNA sample collection by any agency pursuant to any other authority.

(e) *Definitions.* In this section, the terms "DNA sample," "DNA analysis," and "Rapid DNA instruments," have the meanings set forth in 34 U.S.C. § 40703(c).

Conforming amendment to § 23-1321:

D.C. Code § 23-1321 is amended as follows:

(a) In subsection (b), by inserting "and subject to the condition that the person cooperate in the collection of a DNA sample from the person if the collection of such a sample is authorized pursuant to § 22-4152" after "period of release"; and

(b) In subsection (c)(1)(A), by inserting "and that the person cooperate in the collection of a DNA sample from the person if the collection of such a sample is authorized pursuant to § 22-4152" after "period of release".

§ 23-1321. Release prior to trial.

(a) Upon the appearance before a judicial officer of a person charged with an offense, other than murder in the first degree, murder in the second degree, first degree sexual abuse, first degree child sexual abuse, or assault with intent to kill while armed, which shall be treated in accordance with the provisions of § 23-1325, the judicial officer shall issue an order that, pending trial, the person be:

(1) Released on personal recognizance or upon execution of an unsecured appearance bond under subsection (b) of this section;

(2) Released on a condition or combination of conditions under subsection (c) of this section;

(3) Temporarily detained to permit revocation of conditional release under § 23-1322; or

(4) Detained under § 23-1322(b).

(b) The judicial officer shall order the pretrial release of the person on personal recognizance, or upon execution of an unsecured appearance bond in an amount specified by the court, subject to the condition that the person not commit a local, state, or federal crime during the period of release, unless the judicial officer determines that the release will not reasonably assure the appearance of the person as required or will endanger the safety of any other person or the community.

(c)(1) If the judicial officer determines that the release described in subsection (b) of this section will not reasonably assure the appearance of the person as required or will endanger the safety of any other person or the community, the judicial officer shall order the pretrial release of the person subject to the:

(A) Condition that the person not commit a local, state, or federal crime during the period of release; and

(B) Least restrictive further condition, or combination of conditions, that the judicial officer determines will reasonably assure the appearance of the person as required and the safety of any other person and the community, which may include the condition or combination of conditions that the person during the period of release shall:

(i) Remain in the custody of a designated person or organization that agrees to assume supervision and to report any violation of a condition of release to the court, if the designated person or organization is able to reasonably assure the judicial officer that the person will appear as required and will not pose a danger to the safety of any other person or the community;

(ii) Maintain employment, or, if unemployed, actively seek employment;

(iii) Maintain or commence an educational program;

(iv) Abide by specified restrictions on personal associations, place of abode, or travel;

(v) Avoid all contact with an alleged victim of the crime and with a potential witness who may testify concerning the offense;

(vi) Report on a regular basis to a designated law enforcement agency, pretrial services agency, or other agency;

(vii) Comply with a specified curfew;

(viii) Refrain from possessing a firearm, destructive device, or other dangerous weapon;

(ix) Refrain from excessive use of alcohol or marijuana, or any use of a narcotic drug or other controlled substance without a prescription by a licensed medical practitioner; provided, that a positive test for use of marijuana or a violation of § 48-1201 shall not be considered a violation of the conditions of pretrial release, unless the judicial officer expressly prohibits the use or possession of marijuana, as opposed to controlled substances generally, as a condition of pretrial release; the terms "narcotic drug" and "controlled substance" shall have the same meaning as in § 48-901.02;

(x) Undergo medical, psychological, or psychiatric treatment, including treatment for drug or alcohol dependency, if available, and remain in a specified institution if required for that purpose;

(xi) Return to custody for specified hours following release for employment, schooling, or other limited purposes;

(xii) Execute an agreement to forfeit upon failing to appear as required, the designated property, including money, as is reasonably necessary to assure the appearance of the person as required, and post with the court the indicia of ownership of the property, or a percentage of the money as the judicial officer may specify;

(xiii) Execute a bail bond with solvent sureties in whatever amount is reasonably necessary to assure the appearance of the person as required; or

(xiv) Satisfy any other condition that is reasonably necessary to assure the appearance of the person as required and to assure the safety of any other person and the community.

(2) In considering the conditions of release described in paragraph (1)(B)(xii) or (xiii) of this subsection, the judicial officer may upon his own motion, or shall upon the motion of the government, conduct an inquiry into the source of the property to be designated for potential forfeiture or offered as collateral to secure a bond, and shall decline to accept the designation or the use as collateral of property that, because of its source, will not reasonably assure the appearance of the person as required.

(3) A judicial officer may not impose a financial condition under paragraph (1)(B)(xii) or (xiii) of this subsection to assure the safety of any other person or the community, but may impose such a financial condition to reasonably assure the defendant's presence at all court proceedings that does not result in the preventive detention of the person, except as provided in § 23-1322(b).

(4) A person for whom conditions of release are imposed and who, after 24 hours from the time of the release hearing, continues to be detained as a result of inability to meet the conditions of release, shall upon application be entitled to have the conditions reviewed by the judicial officer who imposed them. Unless the conditions of release are amended and the person is thereupon released, on another condition or conditions, the judicial officer shall set forth in writing the reasons for requiring the conditions imposed. A person who is ordered released on a condition that requires that the person return to custody after specified hours shall, upon application, be entitled to a review by the judicial officer who imposed the condition. Unless the requirement is removed and the person is released on another condition or conditions, the judicial officer shall set forth in writing the reasons for continuing the requirement. In the event that the judicial officer who imposed the conditions of release is not available, any other judicial officer may review the conditions.

(5) The judicial officer may at any time amend the order to impose additional or different conditions of release.

(d) Notwithstanding any other provision of law, when issuing an order of release pursuant to this section, the court shall, upon request of defense counsel and with the knowing, intelligent, and voluntary consent of the defendant, order that the defendant be transferred to the custody of the Department of Corrections for release from the Central Detention Facility or Correctional Treatment Facility within 5 hours after the issuance of the order.

§ 23-1322. Detention prior to trial.

(a) The judicial officer shall order the detention of a person charged with an offense for a period of not more than 5 days, excluding Saturdays, Sundays, and holidays, and direct the attorney for the government to notify the appropriate court, probation or parole official, or local or state law enforcement official, if the judicial officer determines that the person charged with an offense:

(1) Was at the time the offense was committed, on:

(A) Release pending trial for a felony or misdemeanor under local, state, or federal law;

(B) Release pending imposition or execution of sentence, appeal of sentence or conviction, or completion of sentence, for any offense under local, state, or federal law; or

(C) Probation, parole or supervised release for an offense under local, state, or federal law; and

(2) May flee or pose a danger to any other person or the community or, when a hearing under § 23-1329(b) is requested, is likely to violate a condition of release. If the official fails or declines to take the person into custody during the 5-day period described in this subsection, the person shall be treated in accordance with other provisions of law governing release pending trial.

(b)(1) The judicial officer shall hold a hearing to determine whether any condition or combination of conditions set forth in § 23-1321(c) will reasonably assure the appearance of the

person as required and the safety of any other person and the community, upon oral motion of the attorney for the government, in a case that involves:

(A) A crime of violence, or a dangerous crime, as these terms are defined in § 23-1331;

(B) An offense under section 502 of the District of Columbia Theft and White Collar Crimes Act of 1982, effective December 1, 1982 (D.C. Law 4-164; D.C. Official Code § 22-722);

(C) A serious risk that the person will obstruct or attempt to obstruct justice, or threaten, injure, or intimidate, or attempt to threaten, injure, or intimidate a prospective witness or juror; or

(D) A serious risk that the person will flee.

(2) If, after a hearing pursuant to the provision of subsection (d) of this section, the judicial officer finds by clear and convincing evidence that no condition or combination of conditions will reasonably assure the appearance of the person as required, and the safety of any other person and the community, the judicial officer shall order that the person be detained before trial.

(c) Rebuttable Presumptions: There shall be a rebuttable presumption that no condition or combination of conditions of release will reasonably assure the safety of any other person and the community under certain circumstances. ~~if the judicial officer finds by probable cause that the person:~~If the judicial officer finds that a rebuttable presumption applies, the person shall be detained unless the judicial officer finds by clear and convincing evidence that the person is not likely to flee or pose a danger to any other person or to the community. To determine if the presumption has been rebutted, the judicial officer shall examine the factors articulated in subsection (e). Generally, one single factor standing alone, such as a lack of criminal history, will not be sufficient to rebut the presumption by clear and convincing evidence. A rebuttable presumption applies if the judicial officer finds by probable cause that the person:

(1) Committed a dangerous crime or a crime of violence, as these crimes are defined in § 23-1331, while armed with or having readily available a pistol, firearm, imitation firearm, or other deadly or dangerous weapon;

(2) Has threatened, injured, intimidated, or attempted to threaten, injure, or intimidate a law enforcement officer, an officer of the court, or a prospective witness or juror in any criminal investigation or judicial proceeding;

(3) Committed a dangerous crime or a crime of violence, as these terms are defined in § 23-1331, and has previously been convicted of a dangerous crime or a crime of violence which was committed while on release pending trial for a local, state, or federal offense;

(4) Committed a dangerous crime or a crime of violence while on release pending trial for a local, state, or federal offense;

(5) Committed 2 or more dangerous crimes or crimes of violence in separate incidents that are joined in the case before the judicial officer;

(6) Committed a robbery in which the victim sustained a physical injury;

(7) Violated § 22-4504(a) (carrying a pistol without a license), § 22-4504(a-1) (carrying a rifle or shotgun), § 22-4504(b) (possession of a firearm during the commission of a crime of violence or dangerous crime), or § 22-4503 (unlawful possession of a firearm); ~~or~~

(8) Violated [subchapter VIII of Chapter 25 of Title 7, § 7-2508.01 et seq.], while on probation, parole, or supervised release for committing a dangerous crime or a crime of violence, as these crimes are defined in § 23-1331, and while armed with or having readily available a firearm, imitation firearm, or other deadly or dangerous weapon as described in § 22-4502(a); or~~.~~

(9) Committed a crime of violence, as that term is defined in D.C. Code § 23-1331(4).

(d)(1) The hearing shall be held immediately upon the person's first appearance before the judicial officer unless that person, or the attorney for the government, seeks a continuance. Except for good cause, a continuance on motion of the person shall not exceed 5 days, and a continuance on motion of the attorney for the government shall not exceed 3 days. During a continuance, the person shall be detained, and the judicial officer, on motion of the attorney for the government or sua sponte, may order that, while in custody, a person who appears to be an addict receive a medical examination to determine whether the person is an addict, as defined in § 23-1331.

(2) At the hearing, the person has the right to be represented by counsel and, if financially unable to obtain adequate representation, to have counsel appointed.

(3) The person shall be afforded an opportunity to testify. Testimony of the person given during the hearing shall not be admissible on the issue of guilt in any other judicial proceeding, but the testimony shall be admissible in proceedings under §§ 23-1327, 23-1328, and 23-1329, in perjury proceedings, and for the purpose of impeachment in any subsequent proceedings.

(4) The person shall be afforded an opportunity to present witnesses, to cross-examine witnesses who appear at the hearing, and to present information by proffer or otherwise. The rules concerning admissibility of evidence in criminal trials do not apply to the presentation and consideration of information at the hearing.

(5) The person shall be detained pending completion of the hearing.

(6) The hearing may be reopened at any time before trial if the judicial officer finds that information exists that was not known to the movant at the time of the hearing and that has a material bearing on the issue of whether there are conditions of release that will reasonably assure the appearance of the person as required or the safety of any other person or the community.

(7) When a person has been released pursuant to this section and it subsequently appears that the person may be subject to pretrial detention, the attorney for the government may initiate a pretrial detention hearing by ex parte written motion. Upon such motion, the judicial officer may issue a warrant for the arrest of the person and if the person is outside the District of Columbia, the person shall be brought before a judicial officer in the district where the person is arrested and shall then be transferred to the District of Columbia for proceedings in accordance with this section.

(e) The judicial officer shall, in determining whether there are conditions of release that will reasonably assure the appearance of the person as required and the safety of any other person and the community, take into account information available concerning:

(1) The nature and circumstances of the offense charged, including whether the offense is a crime of violence or dangerous crime as these terms are defined in § 23-1331, or involves obstruction of justice as defined in § 22-722;

(2) The weight of the evidence against the person;

(3) The history and characteristics of the person, including:

(A) The person's character, physical and mental condition, family ties, employment, financial resources, length of residence in the community, community ties, past conduct, history relating to drug or alcohol abuse, criminal history, and record concerning appearance at court proceedings; and

(B) Whether, at the time of the current offense or arrest, the person was on probation, on parole, on supervised release, or on other release pending trial, sentencing, appeal, or completion of sentence for an offense under local, state, or federal law; and

(4) The nature and seriousness of the danger to any person or the community that would be posed by the person's release.

(f) In a release order issued under § 23-1321(b) or (c), the judicial officer shall:

(1) Include a written statement that sets forth all the conditions to which the release is subject, in a manner sufficiently clear and specific to serve as a guide for the person's conduct; and

(2) Advise the person of:

(A) The penalties for violating a condition of release, including the penalties for committing an offense while on pretrial release;

(B) The consequences of violating a condition of release, including immediate arrest or issuance of a warrant for the person's arrest; and

(C) The provisions of § 22-722, relating to threats, force, or intimidation of witnesses, jurors, and officers of the court, obstruction of criminal investigations and retaliating against a witness, victim, or an informant.

(3) Where there is a rebuttable presumption of detention pursuant to either § 23-1322(c) or § 23-1325(a), the judicial officer shall include written findings of fact and a written statement of the reasons for the release, setting forth the clear and convincing evidence that supported the rebuttal of the presumption.

(g) In a detention order issued under subsection (b) of this section, the judicial officer shall:

(1) Include written findings of fact and a written statement of the reasons for the detention;

(2) Direct that the person be committed to the custody of the Attorney General of the United States for confinement in a corrections facility separate, to the extent practicable, from persons awaiting or serving sentences or being held in custody pending appeal; provided,

that after October 1, 2018, if the person is younger than 18 years of age, direct that the person be transferred to the custody of the Department of Youth Rehabilitation Services, subject to the federal standards under 28 C.F.R. § 115.14;

(3) Direct that the person be afforded reasonable opportunity for private consultation with counsel; and

(4) Direct that, on order of a judicial officer or on request of an attorney for the government, the person in charge of the corrections facility in which the person is confined deliver the person to the United States Marshal or other appropriate person for the purpose of an appearance in connection with a court proceeding.

(h)(1) The case of the person detained pursuant to subsection (b) of this section shall be placed on an expedited calendar and, consistent with the sound administration of justice, the person shall be indicted before the expiration of 90 days, and shall have trial of the case commence before the expiration of 100 days. However, the time within which the person shall be indicted or shall have the trial of the case commence may be extended. ~~for one or more additional periods not to exceed 20 days each~~ Extensions may be requested on the basis of a petition submitted by the attorney for the government and approved by the judicial officer. The additional period or periods of detention may be granted only on the basis of good cause shown, including due diligence and materiality, and shall be granted only for the additional time required to prepare for the expedited indictment and trial of the person. Good cause may include, but is not limited to, the unavailability of an essential witness, the necessity for forensic analysis of evidence, the ability to conduct a joint trial with a co-defendant or co-defendants, severance of co-defendants which permits only one trial to commence within the time period, complex or major investigations, complex or difficult legal issues, scheduling conflicts which arise shortly before the scheduled trial date, the inability to proceed to trial because of action taken by or at the behest of the defendant, an agreement between the government and the defense to dispose of the case by a guilty plea on or after the scheduled trial date, or the breakdown of a plea on or immediately before the trial date, and allowing reasonable time to prepare for an expedited trial after the circumstance giving rise to a tolling or extension of the 100-day period no longer exists. If the government petition requesting additional time is based on forensic analysis of evidence that was requested within a reasonable time after the preliminary hearing, or delayed due to defense motions, good cause will be presumed, and the burden will be on the defense to rebut the presumption. If the time within which the person must be indicted or the trial must commence is tolled or extended, an indictment must be returned at least 10 days before the new trial date.

(2) For the purposes of determining the maximum period of detention under this section, the period shall begin on the latest of:

(A) The date the defendant is first detained under subsection (b) of this section by order of a judicial officer of the District of Columbia after arrest;

(B) The date the defendant is first detained under subsection (b) of this section by order of a judicial officer of the District of Columbia following a re-arrest or order of detention after having been conditionally released under § 23-1321 or after having escaped;

(C) The date on which the trial of a defendant detained under subsection (b) of this section ends in a mistrial;

(D) The date on which an order permitting the withdrawal of a guilty plea becomes final;

(E) The date on which the defendant reasserts his right to an expedited trial following a waiver of that right;

(F) The date on which the defendant, having previously been found incompetent to stand trial, is found competent to stand trial;

(G) The date on which an order granting a motion for a new trial becomes final; or

(H) The date on which the mandate is filed in the Superior Court after a case is reversed on appeal.

(3) After 100 days, as computed under paragraphs (2) and (4) of this section, or such period or periods of detention as extended under paragraph (1) of this section, the defendant shall be treated in accordance with § 23-1321(a) unless the trial is in progress, has been delayed by the timely filing of motions, excluding motions for continuance, or has been delayed at the request of the defendant.

(4) In computing the 100 days, the following periods shall be excluded:

(A) Any period from the filing of the notice of appeal to the issuance of the mandate in an interlocutory appeal;

(B) Any period attributable to any examination to determine the defendant's sanity or lack thereof or his or her mental competency or physical capacity to stand trial;

(C) Any period attributable to the inability of the defendant to participate in his or her defense because of mental incompetency or physical incapacity; and

(D) Any period in which the defendant is otherwise unavailable for trial.

(i) Nothing in this section shall be construed as modifying or limiting the presumption of innocence.

§ 23–1325. Release in first degree murder, second degree murder, first degree sexual abuse, first degree child sexual abuse, and assault with intent to kill while armed cases or after conviction.

(a) A person who is charged with murder in the first degree, murder in the second degree, first degree sexual abuse, first degree child sexual abuse, or assault with intent to kill while armed shall be treated in accordance with the provisions of § 23-1321 unless the judicial officer has reason to believe that no one or more conditions of release will reasonably assure that the person will not flee or pose a danger to any other person or to the community. If such a risk of flight or danger is believed to exist, the person may be ordered detained. In any pretrial detention hearing under the provisions of this section, if the judicial officer finds that there is ~~a substantial probability~~probable cause that the person has committed any of the foregoing offenses while armed with or having readily available a pistol, firearm, or imitation firearm, there shall be a

rebuttable presumption that no condition or combination of conditions of release will reasonably assure the safety of any other person or the community.

(b) A person who has been convicted of an offense and is awaiting sentence shall be detained unless the judicial officer finds by clear and convincing evidence that he is not likely to flee or pose a danger to any other person or to the property of others. Upon such finding, the judicial officer shall treat the person in accordance with the provisions of section 23-1321.

(c) A person who has been convicted of an offense and sentenced to a term of confinement or imprisonment and has filed an appeal or a petition for a writ of certiorari shall be detained unless the judicial officer finds by clear and convincing evidence that (1) the person is not likely to flee or pose a danger to any other person or to the property of others, and (2) the appeal or petition for a writ of certiorari raises a substantial question of law or fact likely to result in a reversal or an order for new trial. Upon such findings, the judicial officer shall treat the person in accordance with the provisions of section 23-1321.

(d) The provisions of section 23-1324 shall apply to persons detained in accordance with this section, except that the finding of the judicial officer that the appeal or petition for writ of certiorari does not raise by clear and convincing evidence a substantial question of law or fact likely to result in a reversal or order for new trial shall receive de novo consideration in the court in which review is sought.

Expanding Information Considered in Second Look Sentence Reductions for the Most Serious Violent Crimes

Proposed Redline to D.C. Code § 24-403.03

§ 24–403.03. Modification of an imposed term of imprisonment for violations of law committed before 25 years of age.

(a) Notwithstanding any other provision of law, the court may ~~shall~~ reduce a term of imprisonment imposed upon a defendant who is currently in prison or jail for an offense committed before the defendant's 25th birthday if:

(1) The defendant was sentenced pursuant to § 24-403 or § 24-403.01, or was committed pursuant to § 24-903, and has served at least 15 years in prison resulting from the sentence imposed in this case; and

(2) The court finds, after considering the factors set forth in subsection (c) of this section, that the defendant is not a danger to the safety of any person or the community and that the interests of justice warrant a sentence modification.

(b)(1) A defendant convicted as an adult of an offense committed before the defendant's 25th birthday may file an application for a sentence modification under this section. The application shall be in the form of a motion to reduce the sentence. The application may include affidavits or other written material. The application shall be filed with the sentencing court and a copy shall be served on the United States Attorney.

(2) The court may direct the parties to expand the record by submitting additional testimony, examinations, or written materials related to the motion. The court shall hold a hearing on the motion at which the defendant and the defendant's counsel shall be given an opportunity to speak on the defendant's behalf. The court may permit the parties to introduce evidence. The court may consider any records related to the underlying offense.

(3)(A) Except as provided in subparagraph (B) of this paragraph, the defendant shall be present at any hearing conducted under this section unless the defendant waives the right to be present. Any proceeding under this section may occur by video teleconferencing, and the requirement of a defendant's presence is satisfied by participation in the video teleconference.

(B) During a period of time for which the Mayor has declared a public health emergency pursuant to § 7-2304.01, a defendant in the custody of the Bureau of Prisons who committed the offense for which the defendant has filed the application for sentence modification after the defendant's 18th birthday but before the defendant's 25th birthday may not petition the court to return to the Department of Corrections for a proceeding under this section.

(4) The court shall issue an opinion in writing stating the reasons for granting or denying the application under this section, but the court may proceed to sentencing immediately after granting the application.

(c) The court, in determining whether to reduce a term of imprisonment pursuant to subsection (a) of this section, shall consider:

(1) The defendant's age at the time of the offense;

(2) The nature of the offense and the history and characteristics of the defendant;

(3) Whether the defendant has substantially complied with the rules of the institution to which the defendant has been confined, and whether the defendant has completed any educational, vocational, or other program, where available;

(4) ~~Any report or recommendation received from~~The position of the United States Attorney;

(5) Whether the defendant has demonstrated maturity, rehabilitation, remorse, and a fitness to reenter society sufficient to justify a sentence reduction;

(6) Any statement, provided orally or in writing, provided pursuant to § 23-1904 or 18 U.S.C. § 3771 by a victim of the offense for which the defendant is imprisoned, or by a family member of the victim if the victim is deceased, or a community impact statement provided pursuant to § 23-1904(f)(1);

(7) Any reports of physical, mental, or psychiatric examinations of the defendant conducted by licensed health care professionals;

(8) The defendant's family and community circumstances at the time of the offense, including any history of abuse, trauma, or involvement in the child welfare system;

(9) The extent of the defendant's role in the offense and whether and to what extent another person was involved in the offense;

(10) The diminished culpability of juveniles and persons under age 25, as compared to that of older adults, and the hallmark features of youth, including immaturity, impetuosity, and failure to appreciate risks and consequences, which counsel against sentencing them to ~~lengthy terms~~ a lifetime in prison, ~~despite the brutality or cold-blooded nature of any particular crime,~~ and the defendant's personal circumstances that support an aging out of crime; and

(11) Any other information the court deems relevant to its decision.

(d) If the court denies or grants only in part the defendant's 1st application under this section, a court shall entertain a 2nd application under this section no sooner than 3 years after the date that the order on the initial application becomes final. If the court denies or grants only in part the defendant's 2nd application under this section, a court shall entertain a 3rd and final application under this section no sooner than 3 years following the date that the order on the 2nd application becomes final. No court shall entertain a 4th or successive application under this section.

(e)(1) Any defendant whose sentence is reduced under this section shall be resentenced pursuant to § 24-403, § 24-403.01, or § 24-903, as applicable.

(2) Notwithstanding any other provision of law, when resentencing a defendant under this section, the court:

(A) May issue a sentence less than the minimum term otherwise required by law; ~~and~~

(B) Shall not impose a sentence of life imprisonment without the possibility of parole or release; and~~.~~

(C) Shall not reduce the term of imprisonment to a term that is less than the term of imprisonment the defendant has already served.

(f) The version of this section that was effective from May 10, 2019, to April 27, 2021 shall apply to all proceedings initiated under this section in any District of Columbia court, including any appeals thereof, by defendants who were eligible under this section prior to April 27, 2021 and shall apply to all proceedings under this section in any District of Columbia court, including any appeals thereof, that were pending prior to the April 27, 2021.

(g) In considering applications filed by defendants for offenses committed after the defendant's 18th birthday, the court shall endeavor to prioritize consideration of the applications of defendants who have been incarcerated the longest; except, that the inability to identify those defendants shall not delay the court acting on other applications under this section.

(h) Notwithstanding any other law, if a District government workforce development program requires District residency as a condition of program eligibility, the residency requirement shall be waived for defendants resentenced pursuant to this section.

(i) Beginning in Fiscal Year 2022, the Office of Victim Services and Justice Grants shall, on an annual basis, issue a grant of $200,000 to an organization that provides advocacy, case, management, and legal services, for the purpose of developing and offering restorative justice practices for survivors of violent crimes who seek such practices, such as for survivors impacted by post-conviction litigation.

Saint Mary Mother of God Catholic Church

CM Brooke Pinto
DC Council Member, Ward 2
The Wilson Building
Washington, DC
Transmitted Electronically

27 June 2023

Dear Ms. Pinto,

I was slated to give personal testimony to the Judiciary and Public Safety Committee today, but due to the exceptional number of witnesses and my position on the list, I am unable to attend as I'd hoped. Nevertheless, I submit the following comments for your consideration and that of the Council.

I write in support of The Safer Stronger Amendment Act of 2023 (B25-291), and I do so as a Pastor and community leader in Chinatown and Mt. Vernon Triangle. In this capacity I have witnessed the breakdown of public safety over the last three years. Those most negatively impacted by this breakdown are the neediest of our city. Those already *on the edge* are pushed into permanent poverty by the ready supply of drugs on our streets, all too often laced with poisonous chemicals. Households already overburdened by material and educational poverty fall into complete chaos through domestic violence. Young people living in such an environment are convinced that life in legitimate enterprise is pointless; resorting to criminal behavior themselves. And this is only a consideration of the neediest among us. Business owners regularly find their properties and patrons abused, and housed citizens are regularly molested, even attacked in broad daylight.

How will B25-291 contribute to solving these issues? Within the bounds of safety, that is to say within the bounds of legal behavior, our city's social and health services have a wonderful opportunity to make longterm improvements

to people's lies. Presently the problem is that the safe zone within which those agencies work has been so narrowed by the violent behavior of some adults and (too often) adolescents. This narrowing came about because since 2020, intentionally or otherwise, the DC Council has transmitted, by its legislation and other communications that anything goes. Failure to prosecute misdemeanors; to enforce the city's own existing drug laws; gaps in the prosecution of gun possession charges; and most of all the release of those awaiting trial onto our streets under their own recognizance... all of these present dangers to the citizens, especially to the neediest among us.

Running down just a few items from Chinatown/MVT that will be directly effected by B25-291:

> Increasing penalties for crimes against transit workers, passengers and for-hire vehicle operators - a huge number of our recent auto thefts have been against food delivery drivers from our neighborhood's local eateries, endangering the drivers themselves and the businesses they aide.
>
> Making strangulation a felony offense - the MPD's victim services division reports that when strangulation is part of a relationship, that relationship is 700 times more likely to result in a murder. Strangulation is tantamount to murder.
>
> Firearm penally increases - obviously given what our city is going through in terms of gun violence we need to telegraph that the boundaries set on bad behavior in this area are absolute.
>
> Holding those charged with violent crimes prior to adjudication - Comments by Chief Contee and my own experience on ride alongs with MPD officers confirm how frequently we are re-arresting those already awaiting trial. The practice of release on recognizance is NOT working for our city.

Finally we must face up to the fact that however good our longterm services may become, we need an effective MPD to hold the firm boundaries of acceptable behavior and secure short-term safety in which social services can work. The Mayor's public safety summit showed everyone just how efficient our MPD is; and this during severe decrease in the number of officers. In my conversation with police I've fond that we are bleeding officers for three reasons: (a) The Council has made policing more difficult by so severely circumscribing what officers can do that they feel they cannot do their job. (b) the liability now placed on officers by Council legislation makes law

enforcement not only physically risky (as it always has been), it places officers in legal jeopardy. If one bad decision or mistake can cost an officer his/her job, pension, and even freedom, that's not a risk he/she wants to take for his/her family. (C) Our officers are stressed to the max: bad enough that those engaging in criminal behavior neither respect nor fear them, what has been telegraphed to the department is that the Council doesn't respect them either.

Passing B25-291 would contribute positively to all of the points above. I hope and pray that you and the Council Member's cc'd will strongly consider my insights as a community leader and citizen.

Grateful for your good work and praying for you I remain

Yours sincerely,

Rev. Vincent J De Rosa
Pastor

June 27, 2023

Testimony of Warren Allen
End Life Imprisonment Campaign Fellow
The Sentencing Project

Hearing on B25-291, the Safer Stronger Amendment Act of 2023

Before the Committee on the Judiciary and Public Safety of the Council of the District of Columbia

My name is Warren Allen and I'm the End Life Imprisonment Campaign Fellow at The Sentencing Project. Thank you for your time.

I'm also a recipient of a second look under the Incarceration Reduction Amendment Act, which allowed me to come home after serving two decades of a 35 year to life sentence.

Today, I am a father, a mentor, and I work with the Safe Passage project to protect youth. The streets of DC are safer because I am on them making a difference. That's what we stand to lose by rolling back IRAA. People like me will remain in prison.

Last fall, this Council voted twice to expand IRAA and create a universal opportunity for a second look.

So why today are you considering making it harder for people to benefit from IRAA?

Why are we rolling back when we should be rolling forward?

IRAA is working.

Recidivism is low and the benefits to the community are extraordinary.

Out of 195 releases, only 7 have been rearrested. Less than 4% recidivism is a success story.

IRAA is based on clear evidence.

Humans are repairable and the research is real. Criminality decreases as a person ages. And emerging adults share many of the characteristics of youth and deserve similar second chances.

The changes the mayor proposes would gut IRAA.

First, Mayor Bowser suggests making relief discretionary by changing "Notwithstanding any other provision of law, the court shall reduce a term of imprisonment…" to "the court *may* reduce a term of imprisonment…."

Imagine being in prison, doing everything to prove that you've been rehabilitated, fitting all the factors for release under IRAA, and knowing that a judge may still deny your petition because of politics or prejudice.

That's the difference between "shall" and "may" – it's everything.

Second, the mayor suggests placing more emphasis on the original offense.

Someone's worst act should not define them forever. Placing more emphasis on the original offense will mean that many of the people serving the longest sentences – who most need a second chance – won't get one.

Third, she suggests creating the opportunity for people not personally impacted by the crime to offer a Community Impact Statement. Someone who wasn't a victim of the offense, who has no concept of the way that someone has grown and evolved over the prior decades should not play a role in determining their release.

Fourth, she wants to require remorse, meaning that people who maintain their innocence will be denied a second chance.

And as law professor Susan Bandes has explained, there is no evidence that remorse can be accurately evaluated in a courtroom but "there is evidence that race and other impermissible factors create hurdles to evaluating remorse."[1]

And last she wants to give more weight to the position of the prosecutors, who we know will likely oppose release.

The sum of those parts is a dramatically weakened second look.

DC is a national model for second chances. Keep it that way.

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[1] Bandes, S. (2015). Remorse and Criminal Justice. *Emotion Review*. https://doi.org/10.1177/1754073915601.