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Written Testimony of Sheandinita Dyson President & CEO, McClendon Center

Before the DC Council Committee on Health
FY27 Budget Oversight Hearing
Department of Behavioral Health

April 24, 2026

Good afternoon, Chairperson and members of the Committee,

Thank you for the opportunity to submit testimony regarding the proposed FY27 budget and its impact on the behavioral health system in the District of Columbia. I am writing to share concerns in two key areas: the proposed elimination of community-based crisis beds and the potential reduction or loss of local funding for community support services.

I am writing on behalf of McClendon Center, a community-based behavioral health provider serving adults with serious mental health needs in the District. Since 2007, McClendon Center has provided community support services and maintains a deep connection to the individuals and communities we serve. We have provided direct services to the District's most vulnerable residents for more than 45 years. We also provide specialized, integrated care services to support individuals as they experience crises and emergencies. Our team regularly refers clients to community-based crisis beds as a first-line intervention to stabilize individuals and divert them from hospitalization. These services—community support, integrated care, and crisis stabilization—are critical components of how we safely support clients in the community and prevent unnecessary inpatient admissions.

Community-Based Crisis Beds

One of the most concerning proposals is the effective elimination of community-based crisis beds, with a plan to transition crisis services “in-house” to DBH and connect them to the Comprehensive Psychiatric Emergency Program (CPEP). From our experience, this shift is not a viable substitute and risks significantly undermining access to appropriate levels of care.

Community-based crisis beds have long been established as a non-institutional, voluntary option for individuals needing short-term stabilization. These programs are intentionally designed to provide a safe, supportive environment, comprehensive clinical assessment, medication stabilization, and connection to ongoing services in a therapeutic setting—while preventing unnecessary hospitalization.

Community-based crisis beds serve as a vital alternative to hospitalization, stabilizing individuals in a less restrictive, more therapeutic, and community-oriented environment with the explicit goal of preventing inpatient admission.

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CPEP, by contrast, serves a fundamentally different function. It is structured for short-term emergency stabilization and often becomes a pathway to inpatient hospitalization. The clinical approach, environment, and requirements of CPEP are not equivalent to those of community-based crisis beds, and attempting to replicate crisis bed services within CPEP is unlikely to achieve the same outcomes.

Community-based crisis bed providers demonstrate a high level of coordination and intentionality in supporting client stability. This includes warm handoffs from referring providers, active participation in care conferences, engagement in treatment planning sessions, ongoing communication with treatment teams, and coordinated discharge planning. These practices ensure continuity of care and support individuals not only during a period of crisis, but through stabilization and transition back into the community.

This coordinated approach is also reflected in outcomes. Since implementing enhanced engagement between our team and Woodley House crisis beds, we have observed measurable reductions in readmission rates, including an 8% decrease in 2020, 4% in 2021, and 12% in 2022. These outcomes demonstrate the effectiveness of community-based crisis stabilization when paired with strong care coordination and continuity of support.

It is important to note that community-based crisis bed placement and successful stabilization do not occur in isolation. The same community support services that are being reduced elsewhere in the system are the very services responsible for identifying individuals in crisis, facilitating timely referrals, coordinating placement, and maintaining engagement throughout the stabilization process. Without this foundation, access to crisis beds becomes more limited, and the effectiveness of crisis stabilization efforts is significantly diminished.

In contrast, testimony from the Department of Behavioral Health indicated that utilization at CPEP remains low. This raises important questions about how individuals in need of crisis stabilization are engaging with available services. Rather than suggesting a lack of need, low utilization may reflect barriers to access, differences in service preference, or challenges in care coordination. It highlights the importance of ensuring that crisis services are designed and delivered in ways that align with client needs and promote engagement.

As a former direct service provider, I have firsthand experience working with individuals accessing both community-based crisis beds and CPEP. In my current role as a behavioral health agency leader at McClendon Center, I continue to hear directly from clinical staff about the meaningful differences in these care environments. Community-based providers consistently offer a more collaborative, recovery-oriented experience that promotes safety, engagement, and continuity of care.

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If the Department of Behavioral Health intends to replicate these services within CPEP while expanding access to approximate a community-based crisis bed model, it would require assuming the full operational costs of those services. Given differences in staffing structures, overhead, and facility requirements, it is unclear that this approach would result in meaningful cost savings and may instead increase downstream costs through higher rates of hospitalization and strain on emergency services.

We respectfully urge the Committee to maintain funding for community-based crisis beds and preserve access to these essential services that play a critical role in stabilization, recovery, and hospitalization diversion. We support our partners at Woodley House and So Others Might Eat and the work they do.

Local Funding for Community Support Services

Another area of concern is the apparent reduction or elimination of local funding for community support services. Local dollars have historically served as a critical bridge, ensuring that individuals who are not Medicaid-eligible—often due to administrative or eligibility-related barriers—can still access essential community-based supports. These funds are specifically intended to support services for District residents who are not eligible for Medicaid but still require behavioral health care and coordination.

While the proposed budget does not explicitly identify reductions specific to community support services, it does reflect a significant decrease in funding that supports providers in delivering services to individuals who are not Medicaid-eligible. If this funding is reduced or eliminated, it would create a significant gap in care for some of the District's most vulnerable residents.

As noted in broader system testimony, reductions in coverage and reimbursement further compound these challenges and increase the likelihood that individuals will experience disruptions in access to care.

Over the past year, we have seen firsthand that there are limited alternatives for individuals who fall outside of traditional eligibility criteria but continue to have clear and ongoing needs for behavioral health care and care coordination. Without access to locally funded services, these individuals are at increased risk of deterioration, crisis, and eventual higher-cost interventions.

For many years, the District has been recognized for maintaining a system that prioritizes continuity of care and access, including options for those who do not neatly fit within eligibility categories. A reduction in local funding for community support services would represent a meaningful departure from that approach and could undermine the strength and responsiveness of the overall system.

While there may be multiple factors contributing to the proposed reduction in funding for community-based supports, it is critical that access to these services is preserved. At a minimum, the benefit should remain available through the existing authorization process, including review by Comagine, to ensure that

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services are appropriately targeted and accessible to individuals with demonstrated clinical need.

We urge the Committee to maintain local funding for community support services to ensure continuity of care and access for individuals who would otherwise be left without support.

Conclusion

As a behavioral health leader, I understand firsthand the challenges of budget constraints and system gaps. At the same time, reducing or eliminating access to effective, community-based care undermines the very purpose of our work and the individuals we are here to serve.

Taken together, these proposed changes risk weakening critical access points across the behavioral health continuum. We respectfully urge the Committee to preserve community-based crisis beds and maintain a pathway for local funding for community support services to ensure the District continues to provide a responsive, equitable, and effective system of care.

Without these supports in place, the system will face significant gaps in access, likely leading to increased emergency room utilization, higher rates of inpatient admissions, added strain on DBH resources such as CPEP, and greater long-term costs to the District.

For reference, attached are the Department of Behavioral Health FY27 proposed budget documents, including operating and capital materials, which provide additional context for the proposed changes and their potential impact.

Thank you for your time and consideration.

Sincerely,

Sheandinita Dyson
President & CEO
McClendon Center

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