616 H Street, NW · Suite 300
Washington, DC 20001
T 202.467.4900 · F 202.467.4949
www.childrenslawcenter.org

Testimony before the District of Columbia Council
Committee on Health
March 8, 2012

Performance Oversight Hearing
Department of Mental Health

Judith Sandalow
Executive Director
Children's Law Center

Good morning Chairman Catania and members of the Committee on Health. My name is Judith Sandalow. I am the Executive Director of Children's Law Center[1] (CLC) and a resident of the District. I am testifying today on behalf of CLC, the largest non-profit legal services organization in the District and the only such organization devoted to a full spectrum of children's legal services. Every year, we represent more than 1,200 low-income children and families, focusing on children who have been abused and neglected and children with special health and educational needs. The children we serve have some of the most significant and complex mental health needs in the District, and my colleagues routinely cite the lack of appropriate mental health services as the greatest barrier to success our children face. I appreciate this opportunity to testify regarding the performance of the Department of Mental Health (DMH) over this past year.

I want to join others in recognizing the important step forward for the District that is marked by the end of the Dixon class action law suit and congratulate Mr. Baron and the staff of DMH for their dedication and hard work. With the end of federal court oversight, the importance of the DC Council's oversight and community involvement cannot be overstated. Mr. Catania, the thoroughness with which you conduct agency oversight hearings is a model for the DC Council and brings forward information necessary to allow both the Council and the community to meaningfully participate.

Despite many improvements this past year, the bottom line, unfortunately, is that DC children still have a paucity of quality mental health services to assist them as they struggle to address a myriad of problems in their families, schools and community. Approximately 90,000 children are enrolled in the District's Medicaid program.[2] Although there is not a comprehensive assessment of their mental health needs, a comparison to national data suggests that we are not close

to meeting the needs of our children. Nationally, 12.4% of children aged six to 17 years old who receive Medicaid have mental health conditions.[3] Yet, DMH is serving at most seven percent of children in the District through its Mental Health Rehabilitative Services (MHRS) and Medicaid Managed Care Organization (MCO) system.[4] That means that almost 5,000 children who need mental health services are currently not getting them. And many of the approximately 6,000 children who are reported to get services are not receiving the right services. Instead, they are simply receiving at least one mental health service, not necessarily the correct treatment or all the services to which they are entitled or need to truly improve their health and quality of life.

The Department of Mental Health has piloted several good evidence-based programs, but they are small, serving only dozens of children. Thousands of children are never seen at all. We need to move beyond piecemeal progress to create a mental health system that provides a seamless array of comprehensive services, which are individualized and easily accessible. The system should focus on early identification so that children receive screening and assessments at the earliest stages. But screening is of little use unless children are quickly linked to appropriate services.

Although the District's failure to provide adequate mental health services to our children has a long history, we have seen many positive improvements during Steve Baron's tenure as director. Much credit is also due to Director of Child and Youth Services, Ms. Marie Morilus-Black, who clearly articulates an understanding of the problems to be overcome and some of the key steps to success. We greatly appreciate Ms. Morilus-Black's energy, willingness to collaborate with the community and engage with other agencies to work on interagency solutions.

This past year, DMH trained and recruited providers to offer several much needed evidenced-based practices. Five DMH providers now offer Trauma Focused Cognitive Behavioral Therapy, two providers offer Family Functional Therapy, two providers offer Parent Child Interaction Therapy and one providers offer Multi-Systemic Therapy for Problem Sexual Behaviors.[5]

DMH is continuing to train additional clinicians in these evidence-based practices and also plans to begin training for Child Parent Psychotherapy for Family Violence this month.[6]

We also commend DMH for its school-based mental health program (now in 59 schools)[7] which provides clinical services to hundreds of children each year. DMH has also responded to the community need for more psychiatric services by creating a Children's Psychiatric Practice Group with three psychiatrists who are available to see children on an emergency basis for medication management and other services.[8] This has been a valuable resource.

In response to the lack of services for young children (under 6), DMH launched the Parent Infant Childhood Enhancement Program in June 2010 at its Howard Road clinic. This program provides treatment to infants, toddlers, young children and their parents who are experiencing social, emotional and behavioral difficulties.[9] This clinic is now offering an evidence-based practice, Parent Child Interaction Therapy, in addition to its other treatment options.[10] DMH is also running the Early Childhood Mental Health Consultation project which has placed mental health specialists in 24 child care centers across the District. These clinicians are able to offer training to staff, services to children and parents and provide necessary referrals.[11] This type of community-based, preventive, collaborative work is an essential component of a robust children's mental health system.

Finally, DMH has taken steps this year to improve its psychiatric residential treatment facility (PRTF) placement process. As many agencies are involved in placing children in residential facilities, we also applaud DMH for its leadership in convening an interagency committee on residential placements and creating a uniform PRTF placement criteria form in April 2011.[12] All child serving agencies seeking PRTF placements most now complete this referral form and submit it to the PRFT Review Committee (the Committee is comprised of representatives from the various youth-serving agencies in the District). This Committee is responsible for making placement decision for all youth who are eligible for Medicaid-funding PRTFs.[13] The number of youth in PRTFs has decreased in

recent months: from 153 in May 2011 to 92 in September 2011 to 89 in December 2011.[14] The number of CFSA youth in PRTFs has also greatly declined from 112 in FY09 to only 24 in at the end of the first quarter of FYT12.[15] Unfortunately, there is no corresponding information in how the children diverted from PRTFs, or those discharged and returned to their homes and communities, are now faring. The well-being of those children, not just lowered utilization numbers, is, of course, how we can truly measure success.

Despite the progress DMH has made, there is still much work to be done to improve our children's mental health system. These new pilots will not expand, and will ultimately fail, unless the District addresses the underlying structural problems that make DC an untenable environment for high quality service providers. Despite the progress mentioned earlier, the District is still lacking many important mental health services for children, such as: treatment foster care, intensive day treatment programs; therapeutic after-school and summer school programs; and integrated mental health and substance abuse services for youth with co-occurring disorders. DMH must come up with a clear plan on how to recruit and retain providers in these areas.

DMH and the Child and Family Service Agency (CFSA) are working more closely together on ensuring children involved with CFSA get proper mental health care, but much work remains to be done in this area as well. In FY11, DMH clinicians found that 66% of children that CFSA removed from their homes had mental health needs.[16] DMH has mental health clinicians on site at CFSA to conduct mental health screens, but they still only screened 56% of children they deemed eligible for screening during FY11. This is an increase from the 35% screened in FY10.[17] Being removed from one's family is a traumatic event and DMH and CFSA must redouble their efforts to ensure that all children are screened.

For many years, a major gap in our service array has been specialty mental health services. It is a promising sign that DMH is focusing on training providers in several evidence-based therapies.

However, training providers is just the first step. To ensure that trained providers translates into improved outcomes for children, DMH must address the system's current difficulty in timely identifying and timely referring children to the right service providers. We often hear that specialty providers have open spots despite the high need for these services. This is indicative of a lack of coordination and proper case management. DMH must also ensure that these services are not only available to the small percentage of children who have fee-for-service Medicaid, but also to the vast majority of children enrolled in the MCOs. While DMH has made notable progress working with the Department of Health Care Finance (DHCF) to receive Medicaid reimbursement for several new services (such as Functional Family Therapy, which became Medicaid reimbursable as of October 1, 2011),[18] many other specialty services and programs are funded through local dollars. Funding services that may be Medicaid-eligible with local dollars prevents limited local dollars from being used for important, non-Medicaid reimbursable services. We understand DMH and DHCF are exploring which services may be billable to Medicaid and we urge them to make this a high priority.

DMH must continue its work to ensure children are receiving services in a timely manner. Unfortunately, only 47% of children discharged from an inpatient hospital had an outpatient appointment within a week.[19] Follow-up care is critically important to ensure that children are receiving required treatment and medication and aren't unnecessarily readmitted to the hospital. Timeliness of services is also a problem for non-hospitalized children seeking services from DMH; Only 26% of children were seen by a Core Service Agency within seven days of their enrollment in MHRS and only 50% were seen within a month.[20] MHRS regulations require that CSAs provides consumers with an appointment within seven business days of referral.[21] It is important to remember children are eligible for MHRS services in the first place because of their *severe* mental

health needs. A child's condition deteriorates when he or she goes without services and such long waits are damaging.

DMH must also ensure services are high-quality. In DMH's last Consumer Service Review (CSR) process (required by the *Dixon* lawsuit), in only 59% of cases did reviewers find that the system performed "in the acceptable range."[22] While this is a slight improvement over last year, we can hardly celebrate that the quality was "acceptable" in only slightly over half the cases. This poor performance did not surprise me, since my colleagues frequently complain of the poor quality services provided to our child clients. Performance problems include assessments that do not happen in a timely or complete manner and major mental health conditions left undiagnosed for months or years. Children leave hospitals without proper discharge plans or supports in place and end up back in the hospital soon thereafter. Clinicians who are pressed for time do not talk to each other or to the child's caregivers. They, therefore, often review complex situations superficially and fail to identify core issues. Effective teamwork is critically important in developing a robust community-based mental health system; we know DMH is committed to improving teaming and we hope to see the tangible effects of this commitment demonstrated through improved outcomes for children. We understand DMH is working extensively with several CSAs that received low CSR scores last year to improve their practice and hope this leads to concrete improvements for children.

Successfully increasing the array and quality of community-based mental health services is critically important to achieving another major goal: reducing the number of children in residential placements. In FY10 the Wraparound Pilot had 144 slots and served a total of 217 youth;[23] in FY11 it had 154 slots and served a total of 211 youth.[24] While an increase of ten slots is positive, it did not lead to more children being able to benefit from the Wraparound Pilot because a child's length of stay in the program is unpredictable. With hundreds of youth remaining in out-of-home placements (in both PRTFs and other types of residential treatment centers),[25] this program must be further

expanded. DMH added 17 more slots in FY12,[26] but there is a much greater need than this. Not investing more in this program is extremely shortsighted as huge savings were achieved for every child who was diverted from a PRTF last year and a percentage of these savings should have been re-invested in the Wraparound Pilot. In FY11, of the 162 youth served by the school wrap pilot, 98% were diverted from a PRTF. Of the 49 youth in the community wrap pilot, 69% were diverted from PRTFs.[27] The cost of a PRTF ranges from $150,000-$250,000 per year whereas the cost of wraparound support provided in the community ranges from $20,000-$27,000 per youth.[28]

While the number of children who have been diverted from PRTFs is promising, and we believe it would be wise to re-invest more money in this program, careful DMH oversight is also necessary to ensure that the program's contractor, DC Choices, is running a high-quality program. A careful examination of the results of the Wraparound Pilot reveals mixed outcomes. An annual report assesses the participants across five functions (functioning at home; functioning at school; safety and functioning in the community; overall functioning; caregiver functioning) for a year after their entry into the program. The youth functioning improves in some areas, decreases in others and waivers over the months.[29] My colleagues with clients in the wrap program have reported similarly mixed results. Some of the children have received robust services and are doing extremely well. Other children have not received any new or additional services and, while they may have avoided a PRTF, they are not thriving. Also a diversion program can only be as good as our community-based services; if services continue to be difficult to access and mediocre in quality, no amount of teaming and flexible funds will help children succeed.

None of the problems I've discussed will be fully addressed until DMH and the District address the fragmentation and complexity that makes our Medicaid-funded mental health system unattractive to high-quality mental health providers. There are three MCOs, fee-for-service Medicaid and a separate MHRS system. MCOs are responsible for providing office-based mental

health services, such as counseling or family therapy. However, for children diagnosed with severe mental illness who need more intensive in-home therapies, the responsibility for providing these services shifts to DMH and the payments often shift to Medicaid. To complicate matters, children who are enrolled in an MCO switch to fee-for-service Medicaid if they enter the foster care system, which makes maintaining continuity of services all the more difficult. In order to see all children – and often just keep one's business afloat -- providers must credential separately with each MCO and contract separately with each Core Service Agency which is a time-consuming process and is often mentioned by providers as the reason they will not accept DC Medicaid. This leads to a shortage of providers, resulting in many children failing to get important mental health treatment or facing long delays that impair their health. Too often children go without services or treatment until a crisis arises. Crisis care is extremely disruptive to children and families and also costs the system significantly more than less-intrusive mental health care.

The District acknowledges the current system is too complex and fragmented and this is impeding access to services. There have been several projects undertaken to find solutions to this problem. In the spring of 2009, DHCF contracted with Department of Health Policy at the George Washington University to conduct an assessment of the children's behavioral health services in the DC Medicaid system and examine whether a mental health carve-out would be a good way to improve service delivery.[30] In March 2011, that report was finally released, and while the report did good job describing the bifurcated mental health system and the problems it leads to, it did not offer any concrete solutions.[31]

In December 2011, DMH received a System of Care Expansion Grant from the U.S. Department of Health & Human Services' Substance Abuse and Mental Health Services Administration. In January, DMH began a strategic planning process focused on improving the mental health system for children and families in the District.[32] We hope this will not be another

exercise in merely identifying the problems and barriers. These are well documented. What we need now are solutions. The children of DC cannot wait another year -- or two or three -- for actions. They have waited and waited while other problems have taken priority.

No one agency is responsible for fixing this problem and for too long this shared responsibility has prevented the District from tackling and solving this problem. The Mayor and the Deputy Mayor for Health and Human Services need to make this a priority and the agencies must coordinate to find a solution.

If the solution to fix our children's mental health system includes the continued use of MCOs to provide mental health services, DMH must be involved in oversight and accountability. A recent study by RAND Corporation found that many MCOs authorize only a limited number of mental health visits which often doesn't adequately meet a child's mental health needs;[33] this is particularly troubling given the expansive right to services children have under federal Medicaid law.[34] In addition to the general charge DMH has to oversee the mental health services of *all* children in the District, DMH should pay special attention to the services received by children in MCOs: If these children are not receiving appropriate office-based care and their mental health conditions worsen, DMH will then become responsible for providing for and paying for their care.

In conclusion, we applaud DMH for the positive steps they have taken this year to improve the children's mental health system. In the coming year, we hope to see the array and quantity of services continue to expand and the quality and coordination of services continue to improve. Most importantly, however, we hope that DMH, the Mayor and the Council will treat the situation facing children using mental health services as the crisis that it is – and make solving the problem a priority. This will require working together to address and dismantle the underlying systemic barriers presented by our fragmented, complex mental health system. We look forward to working with all of you to achieve these goals.

Thank you again for the opportunity to testify. I am happy to answer any questions.

---

[1] Children's Law Center works to give every child in the District of Columbia a safe home, meaningful education and healthy life. As the largest nonprofit legal services provider in the District, our over 80-person staff partners with hundreds of pro bono attorneys to serve 1,200 at-risk children each year. Applying the knowledge gained from this direct representation, we advocate for changes in the city's laws, policies and programs. For more information, visit www.childrenslawcenter.org.

[2] The number of total individuals eligible for EPSDT (Early, Periodic Screening, Diagnosis and Treatment) is 91,340. Department of Health and Human Services, Center for Medicare and Medicaid Services, Form CMS-416: Annual EPSDT Participation Report (April 13, 2011).

[3] Embry Howell, *Access to Children's Mental Health Services Under Medicaid and SCHIP,* Urban Institute, 5 (2004).

[4] DMH has reported to CLC that they are now providing mental health services to 7% of children enrolled in Medicaid, although this number is not recorded in any document. In the last Dixon Court Report the number is reported as 5.48%. Dennis R. Jones, Court Monitor, Report to the Court (*Dixon v. Fenty),* Exit Criteria 5 at 7 (January 27, 2011).

[5] Department of Mental Health's (DMH) responses to the Health Committee's FY11 Oversight Questions, Question 50.

[6] Department of Mental Health's (DMH) responses to the Health Committee's FY11 Oversight Questions, Question 50.

[7] DMH's responses to the Health Committee's FY10 Oversight Questions, Question 56.

[8] DMH's responses to the Health Committee's FY11 Oversight Questions, Question 77.

[9] DMH's responses to the Health Committee's FY11 Oversight Questions, Question 8, Attachment 4.

[10] DMH's responses to the Health Committee's FY11 Oversight Questions, Question 47.

[11] DMH's responses to the Health Committee's FY11 Oversight Questions, Question 45

[12] DMH's responses to the Health Committee's FY11 Oversight Questions, Question 52

[13] DMH's responses to the Health Committee's FY11 Oversight Questions, Question 52

[14] DMH's responses to the Health Committee's FY11 Oversight Questions, Question 54

[15] DMH's responses to the Health Committee's FY11 Oversight Questions, Question 61

[16] CFSA's response to the Human Services Committee's FY12 Oversight Questions, AttachmentQ30_FY11CFSA Programs Utilization Update Quarter 4, "Mental Health Screenings Conducted by DMH Clinical Staff at CFSA."

[17] CFSA FY 2012 Performance Oversight Responses, AttachmentQ30_FY11CFSA Programs Utilization Update Quarter 4, "Mental Health Screenings Conducted by DMH Clinical Staff at CFSA."

[18] DMH's responses to the Health Committee's FY11 Oversight Questions, Question 63.

[19] Dennis R. Jones, Court Monitor, *Report to the Court: Dixon v. Gray*, Exit Criteria No. 17, 8 (July 26, 2011).

[20] DMH responses to the Health Committee's FY11 Oversight Questions, Question 48.

[21] D.C.M.R. §22A-3411.5(f)

[22]Dennis R. Jones, Court Monitor, Report to the Court (*Dixon v. Fenty),* Exit Criteria 4 at 7 (July 26, 2011).

[23] DMH's responses to the Health Committee's FY10 Oversight Questions, Question 64

[24] DMH's responses to the Health Committee's FY11 Oversight Questions, Question 61.

[25]Jennifer Lav. *Out of State, Out of Mind: The Hidden Lives of D.C. Youth in Residential Treatment Centers,* University Legal Services, Inc. at 3 (June 22, 2009).

[26] DMH's responses to the Health Committee's FY11 Oversight Questions, Question 61.

[27] DMH's responses to the Health Committee's FY11 Oversight Questions, Question 61.

[28] DMH's responses to the Health Committee's FY11 Oversight Questions, Question 61.

[29] DC Choices, Wraparound DC Report, FY 2009-2010. There is no publicly available FY2010-2011 report. See http://choicesteam.org/choicesreports.html

[30] In a carve-out model, the MCOs would no longer have responsibility for any mental health services and either DMH or another entity, such as one specialty managed behavior health care organization, would run the mental health services for all Medicaid beneficiaries.

[31] Christine Ferguson et al, The George Washington University Department of Health Policy, *Mental Health Carve Out Assessment.*

[32] DMH's responses to the Health Committee's FY11 Oversight Questions, Question 27, Attachment. DMH received a System of Care Expansion Grant from the U.S. Department of Health & Human Services' Substance Abuse and Mental Health Services Administration and in January 2012 began a strategic planning process focused on improving the mental health system for children and families in the District.

[33] Rand Corporation, Rand Health, *Technical Report: Health and Health Care Among District of Columbia Youth*, 112 (2009)
[34] Early Periodic Screening, Diagnosis and Treatment (EPSDT) requires a comprehensive health care benefits package for all Medicaid-eligible children under age 21. 42 USC § 1396 (a)(43).