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 12, 2013

Performance Oversight Hearing
Department of Mental Health
& Office of the Deputy Mayor for Health and Human Services

Judith Sandalow
Executive Director
Children's Law Center

Good morning Chairman Alexander 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 2,000 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) and Deputy Mayor for Health and Human Services over this past year.

Deputy Mayor for Health and Human Services

We advocated for the Mayor to create the office of the Deputy Mayor for Health and Human Services and we are pleased B.B. Otero is in this position. The Deputy Mayor's office has a critical role in improving the coordination of services by the many agencies that are tasked with delivering services to children and families. There are so many issues which cross over agencies where the Deputy Mayor's leadership is extremely valuable. For example, while DMH has a large role in children's mental health, the vast majority of our children are served by Medicaid managed care organizations, which are monitored by the Department of Health Care Finance. Determining which agency is responsible for children's mental health outcomes and ensuring proper coordination between the two is the important responsibility of the Deputy Mayor. When money is saved because children are served through community-base mental health programs rather than expensive, high-end facilities like hospitals and residential programs, the Deputy Mayor can take the lead in ensuring that money is re-investing into services and supports for those children and families.

Preventing child neglect is another issue that doesn't squarely fall into one agency's responsibility. While CFSA responds once a child is reported to have been abused or neglected, preventing abuse and neglect – and the poverty that too often precipitates such abuse and neglect – is a more diffused responsibility and a place where the Deputy Mayor's leadership can make a huge difference.

Department of Mental Health

Over the past year, DMH has continued its good work in building and improving individual programs and practices. Despite these good steps, the bottom line is that DC children still struggle to access high-quality mental health services – especially the most appropriate services at the right time. While we have some excellent pilots and evidence-based treatment options, they are still too small and too hard to access; the basic framework of a high functioning system is still missing.

Introduction

Over 92,000 children and youth under 21 years of age are enrolled in the District's Medicaid program.[2] . Nationally, 12.4% of children aged six to 17 years old who receive Medicaid have mental health conditions.[3] One the main problem we face here in the District is that it is even difficult to assess how many children are receiving mental health services. The data is not regularly communicated in easy to understand and meaningful ways. In 2012, DMH reported they were serving seven percent of children in the District through their Mental Health Rehabilitative Services (MHRS) and Medicaid Managed Care Organization (MCO) system.[4] Using the 2012 figure, this means that almost 5,000 children who need mental health services were not getting them. And many of the approximately 6,000 children who were reported to get services were not receiving the right services. Instead, they were 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. This February, DMH reports that they have increased the number of youth receiving MHRS services by 18% from 2009 to 2012[5]. That seems like good news, but

doesn't present a full picture because it doesn't include information from the MCOs. From 2009 to 2010, the last year the MCOs reported their utilization data, the number of children treated by managed care providers shrank by 16%.[6]

As you can see, we must cobble together the data we are given. But even without the robust data that the District ought to have, it is very clear from my organization's experience of representing thousands of families each year that our system is still quite broken. My colleagues spend dozens of hours to get children connected to appropriate mental health services. Each social worker, clinician and intake worker tells them a different story about whether a child is eligible for a certain service and who to call to make a referral. They are told services don't exist when they do and children and families face long waits for care. I worry greatly about how children without advocates fare in our overly complex system.

Positive Steps & Improvements

Although I have just laid out some major challenges the District's mental health system is facing, we are seeing many positive improvements as well. Much credit is due to Director Steve Baron and also to Director of Child and Youth Services, Marie Morilus-Black, who clearly articulates an understanding of the problems to be overcome and the key steps to success. We greatly appreciate Ms. Morilus-Black's energy and willingness to collaborate with the community and to engage with other agencies to work on interagency solutions.

In 2012, DMH received a System of Care Expansion Grant from the U.S. Department of Health & Human Services' Substance Abuse and Mental Health Services Administration.[7] The overarching goal of this four year grant is to improve and expand the System of Care for children and families with mental health needs. The goals of the grant are quite broad – they range from expanding early identification of mental health needs, to developing a comprehensive array of services and increasing access to them, to ensuring that the system is family-driven. One of the best

things to come from this process so far is a commitment from the Administration to implement a strategy to re-invest the dollars saved when children don't use intensive, high-end placements (such as residential facilities, private special education schools and therapeutic foster care) in additional community-based services.[8] We look forward to seeing this re-investment strategy in the Mayor's FY14 budget.

DMH has also made progress this past year recruiting and training providers to offer several much needed evidenced-based practices. To ensure that training providers translates into improved outcomes for children, DMH must address the system's current difficulty in timely identifying and 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 DHCF to receive Medicaid reimbursement for several new services (such as Functional Family Therapy, which became Medicaid reimbursable as of October 1, 2011) 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.

The current evidence-based services are:

- Four providers now offer Functional Family Therapy
  - 224 youth received this service in FY12
  - As of October 2011, this service is Medicaid reimbursable
- Two providers offer Parent Child Interaction Therapy
  - 52 children were referred to the service in FY12
- Five providers offer Trauma-Focused Cognitive Behavioral Therapy
  - Training was just completed in January 2013

    - 116 families were served during the training period in FY12.
    - DMH is working with DHCF to get this service billable to Medicaid
- Child Parent Psychotherapy
    - Five agencies attended training which began in May 2012.
    - 16 children were served in FY12 and 25 have already been served in FY13.
    - DMH is working with DHCF to get this service billable to Medicaid
- Multi-Systemic Therapy and Multi-Systemic Therapy for Problem Sexual Behavior
    - Both of these are offered by one provider, Youth Villages. [9]

DMH continues to offer more services which reach children in their natural environments such as childcare centers and schools. DMH is running the Early Childhood Mental Health Consultation project, for example, which places mental health specialists in 25 child care centers across the District. These clinicians train staff, provide services to children and parents and make necessary referrals.[10] This type of community-based, preventive, collaborative work is an essential component of a robust children's mental health system. DMH's school-based mental health program (currently in 52 schools) provided clinical services to more than a thousand students in the 2011-2012 school year[11] DMH also continues to expand and improve its Parent Infant Childhood Enhancement Program, which provides treatment to infants, toddlers, young children and their parents who are experiencing social, emotional and behavioral difficulties.[12] This clinic is now offering two evidence-based practices, Parent Child Interaction Therapy and Child Parent Psychotherapy-Trauma Focus, in addition to its other treatment options.[13]

DMH also increased the number of children served through its High Fidelity Wraparound Program. In FY12 a total of 282 children and their families were served, an increase of 71 children from last year.[14] Over half of the children served were those attending full services schools through DCPS; and 98% of these children remained in public schools.[15] Of the youth in the community Wraparound Program, 73% were diverted from Psychiatric Residential Treatment Facilities (PRTFs).[16] In addition to keeping the cohort of youth in the Wraparound Program out of PRTFs, DMH has also partnered with other District agencies to continue to reduce the entire number of

youth who are admitted to PRTFs.[17] In December 2012, there were only 66 youth in a PRTF, a 57% decrease when compared to the census data for May 2011. The average length of stay for these youth has also decreased from 11.1 months in FY11 to 8.3 months during the first quarter of FY13.[18]

Unfortunately, there is no corresponding information in how the children diverted from PRTFs through the Wraparound Program or other means, 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. It is a positive step that in January 2013 DMH began convening monthly multi-agency discharge planning meetings to ensure youth are linked to appropriate community-based services and also review the status of youth previously discharged. We hope that DMH will report on the outcome of these meetings and the status of youth who have been discharged.

Challenges Still Remain

None of the progress I've described above will truly be able to take root 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. Mental health services are funded through three MCOs – two of which are likely going to switch in May -- fee-for-service Medicaid and a separate MHRS system overseen by DMH. 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 shift directly to Medicaid. DMH uses a network of core service agencies to provide their mental health services. 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.

To be reimbursed through Medicaid for providing mental health treatment to children, providers must be credentialed with multiple entities. To treat all children within DC's Medicaid system, providers must credential separately with each of the three MCOs and be licensed by DMH as a free-standing mental health clinic and as specialty provider. To offer these children a full continuum of care requires a provider to credential with at least seven and up to eleven payers.[19] On top of this, the credentials must be renewed annually.[20] Meeting these requirements is a time-consuming process and is often cited 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.

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. In recent months, however, we have seen DMH work closely with the DHCF in trying to ensure the new MCOs will do a better job of providing mental health services. The Request for Proposal (RFP) that was used to solicit bids from the MCOs included new language regarding the MCOs' responsibilities for behavioral health, including making it easier for mental health providers who are already credentialed with DMH to become part of the managed care organizations' networks.[21] The RFP also sets forth many things that the MCOs may be required to track and report – for example, that the MCO comply with all reporting requirements related to DHCF's monitoring of the child health component of the Medicaid program, called the EPSDT benefit.[22] Assuming this language is formalized in the contract, it will then be up to DMH and DHCF – and this Council – to insist that the MCOs follow these requirements. The MCOs are receiving millions of taxpayer dollars and caring for some of our most vulnerable children. We urge DMH to work with DHCF to hold the MCOs accountable for providing necessary mental health services to our children.

There are other areas where the District must make significant improvement to its mental health service delivery, particularly for some of our most vulnerable children. 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.[23] DMH has mental health clinicians on site at CFSA to conduct mental health screens, but in FY12, only 25% of children entering foster care received a mental health screen within 30 days,[24] down from 56% in FY11.[25] DC law[26] and CFSA's own policy[27] require these screenings within 30 days of the child coming into care. A lack of timely screening is a substantial impediment to children receiving necessary and appropriate mental health services. CFSA has set an aggressive target of screening 90% of children in FY13, and I hope they will share with the Council the steps they are planning to take to achieve this goal.

Mental health treatment must be timely in order to be effective. Unfortunately, only 61%[28] of children discharged from an inpatient hospital had an outpatient appointment within a week (an improvement over the 47% rate from 2011).[29] 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; in FY11 and the beginning of FY12, 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.[30] MHRS regulations require that CSAs provides consumers with an appointment within seven business days of referral.[31] 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 FY12 Consumer Service Review (CSR) process (required by the Dixon lawsuit), in only 65% of cases did reviewers find that the system performed "in the acceptable range."[32] While this is a slight improvement over last year, we can hardly celebrate that the quality was "acceptable" in just two thirds of the cases. DMH's Provider Scorecards also reveal mediocre results for many of the Core Service Agencies.[33] DMH scored eleven CSAs that serve children and none of them received the top score of five stars; one received four stars and two received three stars. Unfortunately, this 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. During FY13 DMH is working extensively with several CSAs to improve their practice and hope this leads to concrete improvements for children. [34]

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 solid foundation of family, health and education. We are the largest provider of free legal services in the District and the only to focus on children. Our 80-person staff partners with local pro bono attorneys to serve more than 2,000 at-risk children each year. We use this expertise to advocate for changes in the District's laws, policies and programs. Learn more at www.childrenslawcenter.org.

[2] 92,720 totally individuals are eligible for EPSDT services. U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, Form 416 Annual EPSDT Participation Report, FY 2011 (most recent available).

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

[4] In March 2012, DMH 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 was reported as 5.48%. Dennis R. Jones, Court Monitor, Report to the Court (*Dixon v. Fenty),* Exit Criteria 5, 7 (January 27, 2011).

[5] DMH Director Steve Baron Presentation to Children's Law Center (February 15, 2013).

[6] Medical Care Advisory Committee, Behavioral Health Subcommittee, *FY2011 Year-End Report and Recommendations,* 3 (April 18, 2012).

[7] DMH FY12 Oversight Question 47.

[8] DMH FY12 Oversight Question 47.

[9] DMH FY12 Oversight Question 70.

[10] DMH FY12 Oversight Question 45

[11] DMH FY12 Oversight Question 53.

[12] DMH FY12 Oversight Question 46.

[13] DMH FY12 Oversight Question 46.

[14] DMH FY12 Oversight Question 57

[15] DMH FY12 Oversight Question 57

[16] DMH FY12 Oversight Question 57

[17] DMH FY12 Oversight Question 51

[18] DMH FY12 Oversight Question 51

[19] District of Columbia Behavioral Health Association, *Towards a True System of Care: Improving Children's Behavioral Health Services in the District of Columbia, Part 2 of 2* (2009).

[20] DC Behavioral Health Association, *Memo to the DC Council Committee on Health on the South Capitol Street Memorial Tragedy Act, Section 606: Credentialing of Behavioral Health Providers* (2011).

[21] Department of Health Care Finance, *Request for Proposal for Managed Care Organizations*, C.8.2.8.8, 89 (2012).

[22] Department of Health Care Finance, *Request for Proposal for Managed Care Organizations*, C.6.10.1.1, 70 (2012).

[23] CFSAFY12 Oversight Question AttachmentQ30_FY11CFSA Programs Utilization Update Quarter 4, Mental Health Screenings Conducted by DMH Clinical Staff at CFSA.

[24] CFSA FY13 Oversight Question 9(b). The information about the percentage of mental health screenings accomplished within 30 days is not completely clear. The attachment to Q16 states that the "FY12 baseline for children/youth getting a mental health screening" is 49%, but it doesn't state the timeline for this screening so it unclear if these are screenings within 30 days of entry or some other time period.

[25] CFSA FY12 Oversight Question 30(c)

[26] "All children in the custody of the Agency shall, to the extent that it is not inconsistent with a court order, receive a behavioral health screening and, if necessary, a behavioral health assessment within 30 days of initial contact with the Agency or a placement disruption." DC Code § 4-1303.03e

[27] CFSA, Policy: Initial Evaluation of Children's Health, Section F.1, 8 (May 17, 2011).

[28] DMH FY12 Oversight Question 9, Attachment.

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

[30] DMH FY11 Oversight Question 48.

[31] D.C.M.R. §22A-3411.5(f)

[32]DMH FY12 Oversight Question 9, Attachment.
[33] DMH FY12 Oversight Question 68. Scorecard is available on DMH's website.
[34] DMH FY12 Oversight Question 86.