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Testimony before the District of Columbia Council
Committee on Health
February 25, 2014

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

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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 face a range of challenges, from the lingering effects of abuse and neglect, to complex mental health needs, to the need for a variety of services to put them on the path to long-term stability. I appreciate this opportunity to testify regarding the performance of the Deputy Mayor for Health and Human Services, whose office is essential to ensuring that agencies work together to meet the needs of poor children and families in the District.

Introduction

For many of the children and families we work with, the services and supports they need span the offerings of multiple agencies and private providers. Determining the role of each respective agency and ensuring proper coordination among agencies are important responsibilities that the Deputy Mayor must fulfill. Further, when effective interagency coordination saves the District funds, the Deputy Mayor can take the lead in ensuring that money is re-invested into new services and supports for children and families. This role of ensuring that savings are properly reinvested has become particularly important in recent years, as the Child and Family Services Agency (CFSA) has continually seen its budget drained through a series of re-programmings to other agencies, as well as a substantial budget cut for

FY 14.[2] We urge the Deputy Mayor to take a leadership role in ensuring that any savings that CFSA realizes through the decrease in its foster care population are reinvested into specific prevention services for fragile families and improving access to mental health services for children in or at risk of entering the child welfare system.

Today I will testify about three areas in which coordination is especially important – home visiting, prevention services for at-risk families, and mental health services for children in the child welfare system.

Home Visiting

Children born in the District face a number of risk factors in early childhood that are associated with poor health and other negative outcomes. Roughly 30% of all children between the ages of zero and five live in poverty,[3] and 15% of all live births in the District in 2010 were to mothers under the age of 21.[4] These are both well above the national averages of 21% and 9%, respectively.[5] Studies show that children born and raised in poverty are at risk for a range of challenges, including poor prenatal care, inadequate nutrition, low quality childcare, and exposure to trauma, abuse, and violent crime, among other things.[6] Children born to young parents are more likely to be born into poverty and with health concerns (including premature birth and low birth weight).[7] These risk factors have the potential to lead to developmental and other delays if left unaddressed. In short, there are thousands of children in the District who are at risk for health issues and developmental delays, and are in need of further support in order to avoid, or at least mitigate, the poor health outcomes associated with poverty.

It is for these children that quality home visiting programs can make a life-altering difference. Home visiting is a simple idea with a big payoff: send a trained professional to visit

regularly with a new or expecting parent to provide education and support. Home visiting programs cover a number of areas, including educating parents about their children's developmental milestones, teaching parents how to build strong parent-child attachments, ensuring that parents know how to obtain medical care for their children, and helping parents access services they need in order to build their parenting capacity.[8] Several studies have shown the positive impacts of home visiting programs in a variety of areas, including improved pre-natal health, improved birth weight and growth in babies, improved parent-child interactions, improved performance in measures of child development, and decreased frequency of abuse and neglect.[9] More recent research has shown that home visiting can have a positive impact on a child's level of school readiness at the level of kindergarten and reduce the frequency of retention in first grade.[10] Programs benefit not only children, but parents as well, as studies have shown that mothers who receive home visiting experience fewer subsequent pregnancies, increased rates of return to (or continuation in) school, and less criminal behavior and parental impairment due to substance abuse.[11] Ultimately, quality home visiting programs can play a vital role in supporting families early in children's lives, thereby preventing more intensive and disruptive interventions later.

There have been some positive developments in the growth of DC's home visiting programs in the last year. In 2012, the District was awarded a $4.5 million competitive federal grant to expand existing home visiting services and make structural improvements that will allow for continued expansion.[12] While, as this Committee is aware, there were considerable delays in the contracting and procurement process, this January, providers were awarded contracts under the grant to expand evidence-based home visiting services. The grant should

expand the capacity of existing home visiting programs using the evidence-based Healthy Families America model by about 400 families, increasing the combined capacity of evidence-based home visiting programs in the District from about 600 families to over 1,000.[13] We are excited to see that, after considerable delay, the District is taking advantage of the opportunity to expand home visiting, and look forward to future development in the coming year.

Additionally, the D.C. Home Visiting Council, an on-going partnership among D.C. agencies, providers, and family-serving organizations, has worked to make it easier for families to locate home visiting services in the District, including launching a website that identifies all existing home visiting programs in D.C. and gives visitors information about home visiting and its benefits.[14]

However, while recent developments in home visiting have been promising, there are challenges ahead that will require further inter-agency collaboration to address, and we hope that the Deputy Mayor will facilitate this collaboration. First, the Home Visiting Council estimates that, given the high numbers of children living in poverty in D.C., there are far more young children in the District who could benefit from home visiting programs, especially evidence-based programs. Additionally, while the federal grant is a welcome boost in resources for home visiting providers, it is not a permanent funding source. In short, D.C. will need to find funding sources that, over the long-term, sustain and expand home visiting so that it reaches the maximum number of families who would benefit from it. This will require continued interagency collaboration among the Department of Health (DOH), CFSA, and the Office of the State Superintendent of Education (OSSE), the agencies that currently fund home visiting.

As the District seeks to ensure the expansion and sustainability of home visiting, it will also need to ensure that there is an on-going process for evaluating the effectiveness of home visiting programs in meeting the needs of children and families. As part of the MIECHV federal grant, DOH will allocate resources towards an extensive evaluation of the Healthy Families America program. We are hopeful that DOH, in partnership with other agencies who fund and rely on home visiting programs, will work with providers to expand evaluation of other models currently used in District home visiting programs.

Prevention

One of the more exciting developments in recent years has been the continued transformation of the District's child welfare system under the leadership of CFSA Director Brenda Donald. Over the last two years, CFSA has shifted to a service model in which the agency works with increasing numbers of families in their homes and communities, linking them to local services so that children do not ultimately have to be removed and placed into foster care. The District's foster care population has dropped substantially, from 1,827 at the end of FY 11 to 1,215 as of December 31, 2013.[15]

As CFSA has made this transition, it has recognized the need for substantial improvements in prevention services for at-risk families, and has embarked on a cross-agency effort to expand the network of community-based services across the District to serve our most fragile families. Next quarter, with the help of the Department of Behavioral Health (DBH), CFSA plans to co-locate four mental health specialists in the Healthy Families/Thriving Communities Collaboratives to conduct assessments for both mental health and substance abuse issues and to connect families to resources.[16] Additionally, with assistance from DOH,

CFSA plans to locate infant and maternal health specialists in all five Collaboratives.[17] The Agency is also in the process of directly partnering with other providers – including the Mary's Center for Maternal and Child Care for home visiting and father-child attachment services – to fill identified service gaps.

We are excited to see this level of cooperation among CFSA, DBH, DOH, and private provider organizations, and commend the leadership of all of these agencies for working together to improve services to at-risk families. We look forward to seeing how this initiative progresses in the coming year and hope it can be a model for other similar partnerships. As these agencies continue to implement their joint vision for improved prevention services, we urge the Deputy Mayor to ensure that CFSA and its partners have adequate resources, and that savings from decreased use of foster care are directed toward this growing prevention network.

Mental Health Services in the Child Welfare System

As we have noted in the past, the delivery of timely, appropriate, and effective mental health services for children is a challenge that crosses over multiple agencies and simply cannot be overcome without interagency collaboration. This is particularly true for children who are in the District's foster care system and need mental health services in order to remain stable in their foster homes and safely exit the system to permanency. Children in foster care are in the custody of CFSA, yet must receive services from a system of community-based providers that CFSA does not itself maintain.

For all of the positive changes that we have seen in the child welfare system over the last year, the timely identification of foster children's mental health needs, as well as the timely

linkage to appropriate providers, remains an area of grave concern. Between FY 11 and FY12, there was a sharp decrease (from 56% to 25%) in the percentage of children who received mental health screenings within 30 days[18] of entering foster care.[19] While this percentage increased slightly in FY 13, to about 34%,[20] it remains below the level reported for FY 11 – a level that was hardly ideal, given that child who enter foster care have experienced significant trauma and often need some form of mental health services to cope with the effects of abuse, neglect, and removal.[21]

Delays in screening children for mental health needs can have significant consequences for them in foster care. Not only do these delays prevent foster children from being linked to needed services, they leave caregivers and professionals unprepared for behavioral/emotional problems, which can in turn lead to foster care placement disruptions and the overuse of temporary crisis services such as psychiatric hospitalization. Indeed, over the same period of time that the rate of timely mental health screenings declined, the number of foster children hospitalized at psychiatric facilities remained stubbornly high (117 children were hospitalized in FY 11, 141 in FY 12, and 127 in FY 13)[22] even as the overall foster care population declined by 500 children between FY 11 and FY 13.[23] Although the available data do not allow us to determine how many hospitalizations could have been prevented by timely screening and services, they paint a picture of a service delivery system that does little of identify children's needs on the front-end but employs extremely disruptive behavioral interventions later.

CFSA has made strong efforts over the last year to improve its response to the mental health needs of children in foster care. It has adopted Trauma Systems Therapy (TST) as a model for making the District's child welfare system more trauma-informed, and spent the last

year training social workers, foster parents, guardians *ad litem*, and other professionals and stakeholders on the effects of trauma on children. These efforts should aid social workers and other professionals in the day-to-day management of cases, as well as in making appropriate referrals. However, if CFSA is to meet the broader challenge of identifying and responding to children's mental health needs early, it will have to work closely with DBH, as well as the core services agencies directly, to ensure that all youth who enter care – or who experience significant events while in care – receive timely screenings, followed by a quick transition to services that match their needs.

We hope that the Deputy Mayor's Office can help facilitate this coordination and ensure that there are resources available to meet the need. As I noted in my introduction, mental health services for children in foster care (as well as children at risk of entering foster care) is an area into which savings from decreased foster care rolls should be directed. Reinvestment is important – both for children who are on the brink of entering care and for the high-needs children who remain in the foster care system even as the population declines.

Conclusion

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

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[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] In FY 13, more than $21 million in funds were reprogrammed away from CFSA to other agencies. This followed roughly $13.8 million in reprogramming in FY 12. CFSA FY 14 Responses to the Human Services Committee's

Oversight Questions, Q3. CFSA FY 13 Responses to the Human Services Committee's Oversight Questions, Additional Question, p. 51.

[3] Department of Health, *Maternal Infant & Early Childhood Home Visiting Program* (2012), p. 6. http://www.dcfpi.org/wp-content/uploads/2012/11/ProjNarrative-1.pdf

[4] *Id*., at 7.

[5] *Id*., at 6-7.

[6] *Id*., at 6.

[7] *Id*., at 7.

[8] Home Visiting Council, *Home Visiting Questions & Answers.* http://www.dchomevisiting.org/wp-content/uploads/2013/11/DCHVC_br_FNLlo.pdf

[9] American Academy of Pediatrics, *The Role of Home-Visitation Programs in Improving Health Outcomes for Children and Families* (1998). http://pediatrics.aappublications.org/content/101/3/486.full

[10] Libby Dogget, *New Research Strengthens Home Visiting Field*, Zero to Three, p. 7-8 (January, 2013). http://zerotothree.org/zttjournal/new-research-strengthens-home-visiting.pdf

[11] *See*, *supra*, note 9.

[12] The competitive grant was awarded by the U.S. Department of Health and Human Services' Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program.

[13] *See*, *supra,* note 3, Department of Health, *Maternal Infant & Early Childhood Home Visiting Program* (2012), p. 5.

[14] The Home Visiting Council's website can be found at http://www.dchomevisiting.org/

[15] CFSA FY 14 Responses to the Human Services Committee's Oversight Questions, Q31.

[16] CFSA FY 14 Responses to the Human Services Committee's Oversight Questions, Q1.

[17] *Id.*

[18] Per CFSA policy, an initial mental/behavioral health screening is supposed to occur within 30 days of a child or youth coming into care. CFSA Program Policy: Initial Evaluation of Children's Health, Procedure F.

[19] CFSA FY 12 Responses to the Human Services Committee's Oversight Questions, Q20; CFSA FY 13 Responses to the Human Services Committee's Oversight Questions, Q9.

[20] CFSA FY 14 Responses to the Human Services Committee's Oversight Questions, Q9(a). Note that CFSA reports a 50%, screening rate. However, this is only after excluding children deemed not eligible for screening – either by virtue of being too young or because of problems obtaining parental consent. In prior years, the agency did not make these exclusions in reporting its initial screening rates. Without exclusions, the rate is 34%.

[21] CFSA's FY 11 statistics, which show that 60% of youth screened that year were identified as needing some form of mental health services, suggest that a significant number of children who enter foster care do so with mental health needs. CFSA FY 12 Responses to the Human Services Committee's Oversight Questions, Q30.

[22] CFSA FY 12 Responses to the Human Services Committee's Oversight Questions, AttachmentQ30_FY 11CFSA Programs Utilization Update Quarter 4, "Mobile Crisis Services (Child/Youth); CFSA FY 13 Responses to the Human Services Committee's Oversight Questions, Q9(e); CFSA FY 14 Responses to the Human Services Committee's Oversight Questions, Q9(s).

[23] CFSA FY 14 Responses to the Human Services Committee's Oversight Questions, Q31.