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Committee on Health
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Performance Oversight Hearing
Department of Behavioral Health

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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 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 Behavioral Health (DBH) over this past year.

Over the past year, DBH has continued its good work in building and improving individual programs and practices. Working with its sister agencies, they have made strides in improving the overall children's mental health system. Despite these good steps, the bottom line is that there is insufficient capacity and families still have a hard time finding quality services.

Introduction

97,000 children and youth under 21 years of age are enrolled in the District's Medicaid program.[2] For years, one of the main problems we've faced is that it is

difficult to assess how many children are receiving mental health services. This year, both DBH and the Department of Health Care Finance (DHCF) have made progress in reporting more useful and transparent data. Approximately 7% of children (0-20) received a service through DBH's Mental Health Rehabilitation Services (MHRS) or a Medicaid managed care organization in FY12.[3] (Numbers for FY13 are still being prepared). Nationally, however, 12.4% of children aged six to 17 years old who receive Medicaid have mental health conditions.[4] This suggests that almost 5,000 District children who need mental health services are not receiving them. And, for the 7,000 children who are reported to receive a service, we do not know if they were receiving the correct treatment or all the services to which they are entitled or need to truly improve their health and quality of life.

The responsibility for providing mental health services does not only fall on DBH alone. They share this responsibility with the Department of Health Care Finance (DHCF) and the managed care organizations. The data and our experience makes clear that the MCOs have not been doing a good job at providing the mental health treatment which they are contractual obligated to provide children. I will speak about this in more detail during tomorrow's DHCF hearing. Today, I will focus on DBH, which is also failing to serve all the children who need its services, despite all of the many good programs it runs and new services they have brought to the District during the past few years. At a time when we know the number of children who need services is quite

high, the Department reports that the number of children served from 2012 to 2013 actually *decreased* by 1%. From 2011 to 2012 the number of children served remained stagnant.[5]

Positive Steps & Improvements

Although the District's mental health system continues to underserve the community, there are many positive improvements to report this year. Much of this success is due to Director Steve Baron and the Director of Child and Youth Services, Marie Morilus-Black, who clearly understand the problems the system is facing and the key steps to success. We greatly appreciate Ms. Morilus-Black's energy, willingness to work on interagency solutions and spirit of collaboration.

In October 2013, the Department of Mental Health and the Addiction Prevention Recovery Administration were merged to form the new Department of Behavioral Health. The creation of this unified Department and Director Baron's goal that all DBH providers will be able to treat individuals with co-occurring mental health and substance abuse disorders is a great step forward.

Another important change this year was an increase to MHRS provider rates, based on funds DBH sought and received during the FY14 budget process. On December 30, 2013, MHRS rates were raised an average of 15%[6] as the result of a comprehensive rate setting review during which DBH worked closely with providers. These rates increases, of course, only apply to the MHRS rates and do not affect the

rates paid by the MCOs. However, DBH is also focusing on improving mental health services delivered by the MCOs. DBH leadership is meeting regularly with MCO mental health staff to discuss issues relating to mental health, including discussions about the MCO's low mental health reimbursement rates.[7] DBH was also involved in drafting the MCO contracts and, as a result, the contacts contain stronger language regarding the MCO's obligations to provide mental health services. Hopefully this will translate soon into improved services for children enrolled in the MCOs.

In 2012, DBH received a System of Care Expansion Grant from the U.S. Department of Health & Human Services' Substance Abuse and Mental Health Services Administration.[8] 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 System of Care Project (also known as the DC Gateway Project) and its leadership team has propelled forward and supported many improvements to the children's mental health system this year. I will highlight three of these improvements in my testimony today: 1) DC Collaborative for Mental Health in Primary Care; 2) new interagency collaborations and; 3) new treatment options.

DC Collaborative for Mental Health in Primary Care

DBH has been a strong member of the DC Collaborative for Mental Health in Primary Care. This project is a public/private partnership including Children's Law Center, Children's National Health System, American Academy of Pediatrics,

Georgetown University, DBH, DHCF and the Department of Health. It aims to improve the integration of mental health in pediatric care through two programs. First, by ensuring pediatricians are screening children for mental health needs using standardized screening tools. And second, by launching a Mental Health Access Project to provide consultations to pediatricians who are treating patients with mental health needs within their primary care practice. DBH staff, along with staff from DHCF, has been integral in getting both of these projects off the ground. We hope there will be funding in DBH's FY15 budget to support the Mental Health Access Project so that this important initiative can begin next fall. Councilmember Alexander, I know these projects are very important to you as well, and I thank you for introducing the *Behavioral Health System of Care Act of 2014 (B20-0676)* to ensure the Mental Health Access Project is codified into law and becomes a lasting part of our children's system.

New Interagency Collaboration

This year we have seen a new level of interagency collaboration in the area of children's mental health. All of the child-serving agencies (DBH, CFSA, DYRS, DHS, CSS, DCPS, DCPCS) have agreed to use the same functional assessment tool, the Child and Adolescent Functional Assessment Scale (CAFAS). DBH, DYRS and DHS will begin using the tool in April with DBH rolling it out in all of its Core Service Agencies by October 2014.[9] The CAFAS is a tool that clinicians can use every 90 days to assess the impact of their services on the functioning of the child and family. Given that children

see different providers and are involved with many agencies and systems, it is a huge step forward to have a common tool which allows us to have the ability to measure outcomes and to assess if services and treatments are actually effective. All of the agencies have agreed to purchase the tool and to share the cost of two positions (a training coordinator and a data analyst) to support ongoing implementation across the District and the development of a data warehouse to store and share the data.[10] All of the agencies should adhere to the roll-out schedule they have committed to and ensure the CAFAS is adopted District-wide by FY15.

DBH and CFSA have also taken new, positive steps to bring mental health providers into CFSA's work. Choice Providers, a select group of Core Service Agencies, are working with CFSA to ensure that children are more quickly connected to mental health services when they come into the child welfare system. Mental health providers are now invited to attend CFSA's Review Evaluate and Direct (RED) Team and Family Team Meetings (FTM) processes.[11] DBH staff is tracking whether having mental health providers engaged earlier in the process will increase children's timely access to care.[12] We know that children and families almost always need mental health services when they are entering the child welfare system, so this new, enhanced partnership is promising.

DBH is also using CFSA Title IV-E flexible funding to hire four mental health specialists who will be located at Healthy Family/Thriving Communities Collaborative

sites and will provide mental health services and referrals. We hope this will lead to even more families getting services before their situation escalates into a crisis.

DBH has recognized that many children in the community simply can't find their way into the mental health system at all. In an effort to ensure that more social service providers, who are not mental health workers, are informed about mental health issues and how to referral individuals, the DC Project Gateway Access Workgroup is piloting a universal intake form that can be integrated into all agency intakes and can be independently completed.[13] Intake workers will be trained to engage the family member, identify the need for further mental health assessment, and provide the further referrals. The form and the associated training are currently being provided at three agencies. If the family consents, the form will be shared with other agencies to decrease the need for families to constantly repeat their story. This new approach is promising, and we urge DBH to evaluate the pilot and expand it quickly if it is successful.

New Treatment Options

The District continues to add to its array of evidence-based practices. This July several providers began offering Transition to Independence Process (TIP). TIP provides supports and services to transition-age (14-29 year old) youth with mental health concerns as they move into adulthood and face issues such as education, housing and employment.[14] There is a lack of services for this age group, so TIP helps to fills a

necessary void. Additionally, in June the District will begin the process to train and certify individuals as Family Peer Support Specialists.[15] DBH will be working with DHCF to ensure this new service can also be reimbursed by Medicaid and thus be sustainable.[16]

Challenges Still Remain

Despite the many positive changes this past year, challenges still remain for the children's mental health system. While I've highlighted some areas of improved interagency coordination above, overall the District is still far from having the seamless system our families need. I want to highlight several key problems: 1) good programs are underutilized because the system remains too complicated; 2) quality is uneven; and 3) outcomes for youth diverted from residential treatment are unknown.

Good Programs are Underutilized

Although there are now six evidence-based practices offered in the District,[17] all the families who need these services are not being connected to them. For example, in February 2013, we were told that across the District there were 300 slots for Trauma-Focused Cognitive Behavioral Therapy, yet only 40 were being utilized.[18] And in December 2013, we were told there were the new Transition to Independence Process (TIP) had a capacity of 595, but only 295 young adults were enrolled.[19] There are so many children, youth and families who could be benefitting from these treatment options. But, as these enrollment numbers illustrate, it is still too complicated for

children and families to find proper services and treatments. Even Core Service Agencies don't always know about all the programs within the DBH system – and they are part of the same system. Experienced lawyers on my staff have to speak to numerous people and agencies before we can get a child the proper services and it often takes weeks, and sometimes months, before a child can begin treatment.

Quality is Uneven

While there are some excellent providers and services available, children are often receiving mediocre services. In DBH's FY13 Consumer Service Review (CSR) process in only 70% of cases did reviewers find that the system performed "in the acceptable range."[20] While this is an improvement over last year, we can hardly celebrate that the quality was "acceptable" in just over two thirds of the cases. DBH's Provider Scorecards also reveals mediocre results for many of the Core Service Agencies.[21] DBH scored ten CSAs that serve children, and none of them received the top scores of five or four stars; one received three stars and three received two stars. Unfortunately, this performance did not surprise me, since my colleagues frequently complain of the poor quality services provided to our child clients. It is not just the quality of services provided which are a problem. We often learn of assessments that do not happen in a timely or complete manner and children suffering from major mental health conditions and trauma who are left untreated for months. Also, 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 DBH is committed to improving teaming and we hope to see the tangible effects of this commitment demonstrated through improved outcomes for children.

Mental health treatment must be timely in order to be effective. Unfortunately, only 67%[22] of children discharged from an inpatient hospital had an outpatient appointment within a week (an improvement over the 61% rate from 2012).[23] 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 DBH; in FY13 it took an average of 21 days between the time a child was enrolled at a Core Service Agency and the date the child was first seen for treatment.[24] MHRS regulations require that CSAs provides consumers with an appointment within seven business days of referral.[25] 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.

Outcomes for Youth Diverted From Residential Treatment Are Unknown

DBH and its sister agencies have made impressive strides reducing the number of children entering Psychiatric Residential Treatment Facilities (PRTFs). In FY13, DBH

increased the number of children served through its High Fidelity Wraparound Program to 337, an increase of 55 from last year.[26] Approximately half the children were referred by the schools; and 100% of these children remained in public schools.[27] Of the youth in the community Wraparound Program, 92% were diverted from PRTFs.[28]

In addition to keeping the cohort of youth in the Wraparound Program out of PRTFs, DBH has also partnered with other District agencies to continue to reduce the entire number of youth who are admitted to PRTFs.[29] During FY13 there were 128 youth in PRTFs, a 26% decrease when compared to 173 youth who were admitted to PRTFs during FY12.[30] While this reduction seems impressive at first glance, unfortunately, there is no corresponding information on how the children diverted from PRTFs or those discharged and returned to their homes and communities, are now faring. We do have some data, however, which we can use to provide clues as to how these children fare when they return home -- and it's not encouraging. For example, only 39% of youth discharged from PRTFs received community-based interventions (CBI) once they returned to the community.[31] CBI is just the type of intense service one would expect to see almost every child who leaves PRTF be receiving. The well-being of those children, not just lowered utilization numbers, is, of course, how we can truly measure success. We hope this year DBH will do a more intense study of how children diverted or discharged from PRTF are faring in the community three, six and twelve months afterwards and what other services they may need to ensure their success.

In conclusion, we applaud DBH for the many positive steps they have taken this year to improve the children's mental health system. Every year, our system becomes stronger. In the coming year, we hope to see easier access to high-quality services continue to improve. Thank you again for the opportunity to testify. I am happy to answer 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] Department of Health Care Finance, District of Columbia's Managed Care Quarterly Performance Report (July 2013-September 2013), 3 (Feb. 2014).

[3] Data analysis prepared by Katherine Rogers, Associate Director
Division of Research and Rate-Setting Analysis Department of Health Care Finance. DMH data extracted 7/23/13; DHCH encounter data extracted 5/28/13 (July 2013). In FY12 7,349 children age 0-20 received a either a MHRS or a MCC service. This is 7.57% of the 97,000 children enrolled in Medicaid.

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

[5] Department of Behavioral Health, Mental Health Expenditures and Services Utilization Report, 5, (Jan. 15, 2014). The number of children (0-17) served by the Department of Behavioral Health in FY2012 was 4,187 and the number if FY13 was 4,126. The report also notes that there was a 0% decrease from 2011 to 2012.

[6] DBH FY13 Oversight Responses, Question 64.

[7] DC Gateway SOC Expansion Implementation Progress Report (Sept. 2013).

[8] DBH FY 13 Oversight Responses, Question 47.

[9] DBH FY13 Oversight Responses, Question 52.

[10] DC Gateway SOC Expansion Implementation Progress Report (Sept. 2013).

[11] Department of Behavioral Health, Provider Bulletin 96, CSA Response to CFSA Initial Referrals (Jan. 8, 2013).

[12] DBH FY13 Oversight Responses, Question 51.

[13] DBH FY13 Oversight Responses, Question 47.

[14] Carol Zahm, Kendra Fitzgordon, System of Care DC Gateway Update, powerpoint presentation to the DBH, Children's Roundtable (May 3, 2013).

[15] DBH FY13 Oversight Responses, Question 47.

[16] The District already has peer support specialists who are trained to work with adults who are paid by Medicaid. Modifications just need to be made to allow the new family-trained specialists to also be able to be reimbursed for their services.

[17] DBH FY13 Oversight Responses, Question 47. The six services are Functional Family Therapy, Trauma Focused Cognitive Behavioral Therapy, Child Parent Psychotherapy for Family Violence, Multisystemic Therapy (and MST for Problem Sexual Behavioral and MST for Emerging Adults), Parent Child Interaction Therapy and Transition to Independence (which is not listed in Q47). This year, Trauma-Focused Cognitive Behavioral Therapy and Child Parent Psychotherapy for Families Affected by Violence both became Medicaid reimbursable services. DBH FY13 Oversight Responses, Question 56.

[18] Department of Behavioral Health, Children's Roundtable Meeting (Feb. 13, 2013).

[19] DC Gateway Project, Management & Implementation Meeting Minutes (Dec. 19, 2013).

[20] DBH Community Service Review Unit, 2013 DBH Child/Youth CSR Results, 6 (Dec. 6, 2013).

[21] DMH FY13 Oversight Question 75. The FY2012 Scorecard is available on DBH's website.

[22] DBH FY13 Oversight Responses, Question 9, Attachment 1.
[23]DMH FY12 Oversight Responses, Question 9, Attachment.
[24] DBH FY13 Oversight Responses, Question 48.
[25] D.C.M.R. §22A-3411.5(f).
[26] DBH FY13 Oversight Response, Question 63.
[27] DBH FY13 Oversight Response, Question 63.
[28] DBH FY13 Oversight Response, Question 63.
[29] DBH FY13 Oversight Response, Question 57.
[30] DBH FY13 Oversight Response, Question 57.
[31] DBH FY13 Oversight Response, Question 42. 32 youth or 39% received CBI once they returned to the community. In 2009, just 7% of youth discharged from PRTFs received a CBI service, so DBH is making notably progress in this area.