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Department of Mental Health

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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 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.

DC children struggling to address a myriad of problems in their families, schools and community have a paucity of quality mental health services to assist them. Approximately 80,000 children are enrolled in the District's Medicaid program.[2] DMH has estimated that between 14-20% of children in the District have an emotional or behavioral disorder.[3] Yet, DMH is serving just slightly over 5% of children in the District through its Mental Health Rehabilitative Services (MHRS) and Medicaid Managed Care Organization (MCO) system.[4] And these are children who 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. By comparison, Maryland reports that almost 9% of Medicaid youth under the age of 18 receive a service through its public mental health system.[5]

The District's failure to provide adequate mental health services to our children has a long history, but during the past several years we have seen DMH make many positive improvements. Much credit is 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.

Over the past year, DMH has expanded or launched several pilot programs that are intended to expand the array of services available to children. DMH has offered training sessions and recruited providers to offer several much needed evidenced-based services. Two DMH providers now offer Trauma Focused Cognitive Behavioral Therapy, and another two offer Family Functional Therapy, two evidenced-based services previously unavailable. DMH has announced that in the upcoming months it will begin training providers in two other evidenced-based services which are currently unavailable, Parent-Child Interaction Therapy and Child-Parent Psychotherapy for Family Violence.[6]

DMH continues to expand the Children and Adolescent Mobile Psychiatric Service (ChAMPS) which served 41% more children in FY10 than in FY09[7]. We also commend DMH for its school-based mental health program (now in 59 schools) and for their increased utilization rates for school year 2009-2010.[8] DMH has also responded to the community need for more psychiatric services by creating a Children's Psychiatric Practice Group with three psychiatrics who are available to see children on an emergency basis for medication management and other services. 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] DMH is also running the Early Childhood Mental Health Consultation project which has placed mental health specialists in 27 child care centers across the District. These clinicians are able to offer training to staff, services to children and parents and

provide necessary referrals.[10] These types of community-based, collaborative work is an essential component of a robust children's mental health system.

Finally, DMH has taken steps this year to improve its Wraparound Pilot project, which has kept many children out of residential placements. Notably, the number of children in CFSA custody placed in psychiatric residential treatment facilities (PRTFs) has been reduced significantly in the past year.[11] 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. We look forward to DMH continuing to streamline and improve this process in the coming year.

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 programs; therapeutic summer 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. DMH data from the first quarter of FY11 found that 73% of children that were removed from their home had mental health needs.[12] However, in FY10 only 360 CFSA children were referred to and received mental health diagnostic assessment and treatment from a Choice Provider, the network of six CSAs that specifically provide diagnostic, clinical and support services to children in the care and custody of CFSA.[13] Seven hundred and ninety four children entered

foster care[14] -- meaning that 316 children who needed mental health services were not seen by a Choice Provider.[15] It is unclear if and where these children received services. Clearly, DMH and CFSA have much work to do to ensure that the vast majority of children involve with CFSA are getting the mental health services they need.

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 which is indicative of a lack of coordination and proper case management. DMH must also ensure that the services offered by the Choice Providers are available not only to children in foster care (who have fee-for-service Medicaid), but to other children in the child welfare system but living at home. This means ensuring that the Choice Providers accept children enrolled in each MCO, that the MCOs are aware of the services and that they refer children to them when appropriate.[16] Additionally, many of the services provided by the Choice Providers, including the new evidenced-based services, are funded through local dollars thus this is not a sustainable model.[17] We understand DMH and the Department of Health Care Finance are exploring whether these 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 50% of children discharge from an inpatient hospital had an outpatient appointment within a week.[18] Follow-up care is critically important to ensure that children are receiving necessary treatment and medication and aren't readmitted to the hospital unnecessarily. Timeliness of services is also a problem for non-hospitalized children seeking services from DMH;

Only 50% of children received a service from a Core Service Agency within a month after they were enrolled in MHRS. And it's important to remember children are eligible for MHRS services in the first place because of their *severe* mental health needs.[19] A child's condition deteriorates when he or she goes without services and such long waits are unacceptable. There is a vast difference in the performance of CSAs – for example, one was able to see 88% of its newly referred patients within a month whereas another only saw 21%. DMH must identify what is working at the highest performing CSAs and work with the lower performing ones to improve their ability to quickly see patients.

DMH must also ensure services are high-quality. Each year DMH goes through a Consumer Service Review (CSR) process required by the *Dixon* lawsuit through which sample cases are selected for review and scored in a variety of categories. Last fiscal year, only in 49% of these cases did reviewers find that the system performed "in the acceptable range."[20] 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 are pressed for time and do not talk to each other or to the child's caregivers, teachers and other key adults and 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, an increase of just 10 slots from FY09, and served a total of 217 youth. Despite hundreds of youth remaining in out-of-home placements,[21] the program was not able to expand in FY11 due to funding limitations; this 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 FY10, of the 167 youth served by the school wrap pilot, 100% were diverted from a PRTF. Of the 50 youth in the community wrap pilot, 69% were diverted from PRTFs.[22] DMH states that the cost of a PRTF ranges from $250,000-$150,000 per year whereas the cost of wraparound support provided in the community ranges from $20,000-$27,000 per youth.[23]

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. The FY10 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. 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 (DMH's mental health delivery system) 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, the Department of Health Care Finance 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. 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. This report was finally just released through its inclusion in DMH's response to the Committee's oversight questions. Unfortunately, while the report does a good job describing the current bifurcated mental health system and the problems it leads to; it does not offer any concrete solutions. The GW report calls for DHM and its sister agencies to meet and come up with a plan.

Last year, DMH began the process of creating a three to five year Children's Plan. We were actively engaged in this process and hoped it would lead to conversations about how to reform the system and end with a detailed document which set forth concrete plans, outcomes and timelines. However, those systemic reform conversations did not fully materialize and a final version of the Plan was never released. DMH is also working on a larger System Redesign Plan, which we understand may include some of the ideas presented in the drafts of the Children's Plan. We are encouraged that this larger group is tackling some major systemic issues such as the need for easier certification processes for providers, improving reimbursement rates and reducing the number of youth admitted to PRTFs. Unfortunately, the latest recommendation we've seen relating to the mental health carve-out is yet again calling for a workgroup to be convened to study this issue. The children of DC cannot wait another year -- or two or three -- for a solution to this problem. 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 new Deputy Mayor for Human Support 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;[24] this is particularly troubling given the expansive right to services children have under federal Medicaid law.[25] 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.

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[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 70-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] Department of Health Care Finance, *Monthly Enrollment Report* (January 2010). Non-SSI Children: 72,363; Specialized MA Children: 7,162.

[3] Christine Ferguson et al., The George Washington University, School of Public Health & Health Services, Department of Health Policy, *Mental Health Carve Out Assessment* at 2. Available in DMH's responses to the Health Committee's FY10 Oversight Questions, Question 71.

[4] Dennis R. Jones, Court Monitor, Report to the Court (*Dixon v. Fenty),* Exit Criteria 5 at 7 (January 27, 2011).

[5] Christine Ferguson et al., The George Washington University, School of Public Health & Health Services, Department of Health Policy, *Mental Health Carve Out Assessment* at 3.

[6] Department of Mental Health's (DMH) responses to the Health Committee's FY10 Oversight Questions, Question 34.

[7] DMH's responses to the Health Committee's FY10 Oversight Questions, Question 51.

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

[9] DMH's responses to the Health Committee's FY10 Oversight Questions, Question 71

[10] DMH's responses to the Health Committee's FY10 Oversight Questions, Question 71.

[11] DMH's responses to the Health Committee's FY10 Oversight Questions, Question 68. DMH states that the number of CFSA youth in PRTFs has been reduced from 112 in FY09 to 47 to date in FY11, a reduction of 58%.
[12] DMH Child & Youth Services Division, Data Presentation at DC Children's System of Care Committee (Feb. 23, 2011). DMH staff co-located at CFSA aim to screen all children initially removed from their homes or who re-enter foster care. In Oct-Dec. 2011, DMH screen 52 out of 103 eligible children. Out of these 52 children, 38 (73%) had screenings which indicated mental health needs. These numbers lead to several important follow up questions: 1) how quickly these 73% of children are getting services; 2) what services they are receiving; 3) why 50% of children were not even screened.
[13] DMH's responses to the Health Committee's FY10 Oversight Questions, Question 63.
[14] Child and Family Services Agency (CFSA), *Annual Public Report FY2010* at 19.
[15] Out of 794 children, only 360 were seen at a Choice Provider, leaving 434 unseen. DMH has found that 73% of children entering care have mental health needs; 73% of 434 is 316. It is also important to note that there does not seem to be any DMH data on how many of the 2092 children living in CFSA out-of-home care and the approximately 2000 children receiving in-home services from CFSA last year received mental health services from a Choice Provider or other CSA (CFSA, Annual Public Report FY2010 at 19; CFSA, *Monthly Trend Analysis Report*, December 2008 at 5 (February 15, 2009)).
[16] D.C. Citizens Review Panel, *Meeting the Mental Health Needs for Abused & Neglected Children: Findings and Recommendations regarding the District of Columbia Government's Implementation of the 2007 Department of Mental Health and Child & Family Services Agency Mental Health Needs Assessment* at 7 (February 2010).
[17] DMH's responses to the Health Committee's FY10 Oversight Questions, Question 63.
[18] Dennis R. Jones, Court Monitor, Report to the Court (*Dixon v. Fenty),* Exit Criteria 17 at 8 (January 27, 2011).
[19] DMH's responses to the Health Committee's FY10 Oversight Questions, Question 91 attachment.
[20]Dennis R. Jones, Court Monitor, Report to the Court (*Dixon v. Fenty),* Exit Criteria 4 at 7 (January 27, 2011).
[21]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).
[22] DMH's responses to the Health Committee's FY10 Oversight Questions, Question 64.
[23] DMH's responses to the Health Committee's FY10 Oversight Questions, Question 64.
[24] Rand Corporation, Rand Health, *Technical Report: Health and Health Care Among District of Columbia Youth*, 112 (2009)
[25] 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).