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Introduction

Good morning Chairman Alexander and members of the Committee on Health and Human Services. My name is Rebecca Brink. I am a Senior Policy Attorney at Children's Law Center[1] and a resident of the District. I am testifying today on behalf of Children's Law Center, which fights so every DC child can grow up with a loving family, good health and a quality education. With 100 staff and hundreds of pro bono lawyers, Children's Law Center reaches 1 out of every 8 children in DC's poorest neighborhoods – more than 5,000 children and families each year. Many of the children we see through our cases -- children in the foster care system or receiving special education services -- wouldn't need our help if it wasn't for their unmet mental health needs. Even when these children have an attorney, my colleagues still cite the struggle to connect them to appropriate mental health services as one of the greatest barriers 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.

Introduction

Over the past year, Director Baron and his staff have continued to work diligently to build and improve programs and services. I want to thank Steve Baron, who is retiring at the end of this month, for his wonderful service to the District. We appreciate all the work he done for the past nine years and wish him well. I also want to recognize Marie Morilus-Black who recently stepped down as the Director of Child

and Youth Services at DBH. Ms. Morilus-Black has boundless energy and is always willing to work on interagency solutions with a spirit of collaboration. We look forward to working with Marie in her new role at the Child and Family Services Agency.

DBH Should Embrace Its Role as the District-Wide Mental Health Authority

At the beginning of this new Mayoral Administration, and with a new Director of Behavioral Health about to being his or her tenure, my main message is this: what the District's children really need is for DBH to embrace its role as the leading mental health authority for the entire city. Rather than slowly growing its own programs, and then reporting on how these programs are performing, DBH should set a broad-reaching and fast-paced agenda for how to improve the mental health of *all* children in the District. And then DBH should create a complete children's mental health system and drive change across various government agencies, the Medicaid managed care organizations and community partners.

93,000 children and youth under 21 years of age are enrolled in the District's Medicaid program.[2] DBH notes on its website that it is estimated that as many as 20% of children and adolescents may have a mental health disorder that can be identified and require treatment.[3] This translates to over 18,000 of the children on Medicaid in DC having a mental health disorder that can be identified and requires treatment.[4] Yet, the Department does not report on the total number of children receiving mental health services. It only reports on the children it serves, which is only 4,200 children (0-18) in

FY14.[5] That is 4.5% of children who are Medicaid beneficiaries.[6] The number of children DBH is serving has remained stagnant for three years.[7] This is despite all the initiatives and new services that DBH has brought to the District.

The DBH only reports on the number of children being served through its Mental Health Rehabilitation Services (MHRS) system; the Department doesn't report any data or outcomes about the children who receive services through a Medicaid managed care organization (MCO). This past year, MCOs have increased the number of children receiving mental health services, but we know that not all the children who need help are receiving it. I will discuss this further during the oversight hearing for the Department of Health Care Finance (DHCF). While DHCF is directly responsible for oversight of the MCOs, DBH, as the behavioral health agency, should also consider the services provided to MCO beneficiaries a critical part of its job. DBH itself states that its mission is to "develop, manage and oversee a public behavioral health system for adults, children and youth and their families…"[8] Services provided by the Medicaid MCOs are part of this public behavioral health system and the system would be strengthened if DBH took a more comprehensive view.

Too Many Children Receive Poor Quality Services

Currently, DBH reports a great deal of data about their own programs and services. Unfortunately, while there are some excellent providers and services available, too many children are still receiving mediocre services. A recent example

from one of CLC's clients illustrates this point. Two teenage children and their mother were engaged in therapy. When their therapist left the mental health provider, the family was left without a therapist for four months. During these months the mother's depression worsened and the family dynamics escalated. The mother told her community support worker that she was overwhelmed by depression and family challenges. Sadly, this mother then attempted suicide in front of her children, was psychiatrically hospitalized, and now the children have been placed in a foster home. We regularly see children waiting many months to receive services and high turnover among clinicians. We also routinely see other significant problems, such as clinicians who do not have the skill to engage children or their caregivers, a lack of communication among team members, and clients suffering because of the poor quality of care. These are children and families who have been traumatized enough -- the professionals in our system owe them better.

DBH's own data backs up the experience of my colleagues. In DBH's FY13 Community Service Review (CSR) process (the most recent year for which a system-wide review was conducted)[9] only in 70% of cases did reviewers find that the system performed "in the acceptable range."[10] DBH's Provider Scorecards also reveal mediocre results for many of the Core Service Agencies.[11] None of the 11 CSAs that serve children received the top scores of five or four stars.

Mental health treatment must be timely in order to be effective. In FY14 it took an average of 18 days from the time a child was enrolled in a Core Service Agency to the date the child was first seen for treatment.[12] MHRS regulations require that CSAs provides consumers with an appointment within seven business days of referral.[13] A child's condition deteriorates when he or she goes without services and such long waits are damaging. Timeliness of service is especially important for children being discharge from a psychiatric hospitalization. Unfortunately, only 61%[14] of children discharged from an acute care hospital received a community-based service within a week (a decrease from the 67% rate in FY13).[15] Follow-up care is critically important to ensure that children are receiving required treatment and medication and aren't unnecessarily readmitted to the hospital.

Good Programs are Underutilized

Although there are now ten evidence-based practices[16] for children offered in the District, many of the families who need these services are not being connected to them. DBH and CFSA are doing a great deal of work on trauma, yet only half of the slots for Trauma-Focused Cognitive Behavioral Therapy were utilized last year.[17] And in July 2013, DBH heralded a new service, Transition to Independence Process (TIP), which provides supports and services to transition-age (14-29) youth with mental health concerns as they move into adulthood and face issues such as education, housing and employment. TIP fills an important service gap for these transition-age youth, yet only

75% of its slots were utilized last year.[18] We would expect to see a waitlist. Last year, we were hopeful that DBH was poised to provide better substance abuse services for youth. This summer providers were trained to implement the Adolescent Community Reinforcement Approach (A-CRA) a behavioral intervention used to treat alcohol and substance use disorders. But in FY14 only 37 children received A-CRA treatment. [19] We understand this is a new program, and it will take time for it to reach its full capacity, but this slow start is disappointing as we know so many youth who could be benefitting from these treatment options.

It is also important to note that while these evidence-based practices are an important part of our system, only a total of 1,117 children received such a service last year. That is only 1.2% of the children who are enrolled in Medicaid.[20] DBH needs to do a better job connecting children to these services and then expand them significantly to meet the known need.

Positive Steps & Improvements

Although I have just highlighted some major challenges facing DBH, there have been some key accomplishments this year as well. I will highlight two of these improvements in my testimony today: 1) the DC Collaborative for Mental Health in Pediatric Primary Care; and 2) the new functional assessment tool being utilized by several child-serving agencies.

DC Collaborative for Mental Health in Pediatric Primary Care

DBH has been a strong member of the DC Collaborative for Mental Health in Pediatric Primary Care. This project is a public/private partnership that includes 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 in Pediatrics project (DC-MAP) to provide consultations to pediatricians who are treating patients with mental health needs within their primary care practice. Much progress has been made in both of these projects this year and DBH staff has been integral in this work. Through the leadership of Children's National, almost 150 pediatricians and their staff (representing 75% of children on Medicaid) participated in a nine-month learning collaborative where they learned about a variety of mental health topics and how to implement the new screening tools.[21] Pediatricians are now well-prepared to ensure children's mental health issues are detected early and that they receive the proper referrals and treatment.

We thank you, Councilmember Alexander, for your important role in ensuring the Mental Health Access in Pediatrics project became a reality. As you know, the goal of this project is to provide consultations to pediatricians who are treating patients with

mental health needs within their primary care practice. DBH found $500,000 in their FY15 budget for this project and thanks to your legislation (*Behavioral Health System of Care Act of 2014)* the program will now be a permanent part of the children's mental health system. The contract for the DC-MAP is expected to be awarded within the next 30 days and we hope the program will begin soon thereafter.[22]

New Functional Assessment Tool

All of the District's child-serving agencies have agreed to use the same functional assessment tool, the Child and Adolescent Functional Assessment Scale (CAFAS).[23] 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. Currently, DBH, the Department of Youth Rehabilitation Services and several Department of Human Services child-serving programs are implementing the tool.[24] During FY15, the Child and Family Services Agency will be implementing the tool for all children in CFSA care. DBH is working with DCPS and the charter schools on how to develop a pilot project to use the tool in the schools.

All of the agencies are also working on how to develop a shared data warehouse so that they can share the information from the CAFAS with various providers across agencies.[25] 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.

Conclusion

In conclusion, I applaud DBH for the positive steps they have taken this year to improve the children's mental health system. I also hope that in this coming year DBH will more fully embrace its role as the leading mental health authority for the entire city. There are several ways the Department should do this. First, they should ensure that all of their existing programs are being fully utilized so that spots in promising, new programs are not left unused. Secondly, they should create ambitious plans for how to scale-up programs to meet existing need. For example, the School-Based Mental Health program currently only serves 36% of the District's public schools. DBH is piloting a universal intake form that can be integrated into all social service agency intakes that will help staff identify mental health needs and make good referrals. But only three agencies have piloted the intake form. This pilot needs to be brought to scale and reach the dozens of social service agencies across the District. These are just a few examples of how to reach our shared goal of providing high-quality services to the thousands of children in the District with mental health needs. Thank you again for the opportunity to testify. I am happy to answer any questions.

[1] Children's Law Center fights so every child in DC can grow up with a loving family, good health and a quality education. Judges, pediatricians and families turn to us to be the voice for children who are abused or neglected, who aren't learning in school, or who have health problems that can't be solved by medicine alone. With 100 staff and hundreds of pro bono lawyers, we reach 1 out of every 8 children in DC's poorest neighborhoods – more than 5,000 children and families each year. And, we multiply this impact by advocating for city-wide solutions that benefit all children.

[2] Department of Health Care Finance, District of Columbia's Managed Care End-of-Year Performance Report (July 2013-June 2014), 3 (Feb. 2015). http://dhcf.dc.gov/page/dhcf-policies-and-publications

[3] Department of Behavioral Health website states: "It is estimated that as many as one in five children and adolescents may have a mental health disorder that can be identified and require treatment." http://dbh.dc.gov/service/children-youth-and-family-services

[4] 20% of the 93,000 children and youth on Medicaid equals 18,600 children and youth.

[5] Department of Behavioral Health, Mental Health Expenditure and Service Utilization Report (MHEASURE), 5 (Jan. 15, 2015). Report on file with Children's Law Center.

[6] 4,200 children (0-17) received mental health services out a total of 93,000 children (0-21) on Medicaid. DBH considers "children" 0-17 and DHCF considers "children" (0-20); due to this discrepancy in the way each agency reports its data we can't calculate the exact percentage.

[7] Department of Behavioral Health, Mental Health Expenditure and Service Utilization Report (MHEASURE), 5 (Jan. 15, 2015). Report on file with Children's Law Center.

[8] See: http://dbh.dc.gov/page/about-dbh

[9] As of FY14, DBH will only be conducting Community Service Reviews of the entire system every other year. During FY14, rather than review the entire system, DBH conducted a targeted review of 12 child/youth cases receiving Wraparound Services. Department of Behavioral Health, FY14-15 Performance Oversight Questions, Question Q96.

[10] Human Systems and Outcomes, Inc., 2013 Report on Children and Youth Served by the District of Columbia Department of Mental Health, 6 (June 2013). http://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/Dixon%20Settlement%20Agreement%202013%20Report%20on%20Children%20and%20Youth.pdf

[11] The FY14 Provider Scorecard will not be available until June. Department of Behavioral Health, FY14-15 Performance Oversight Questions, Question 95. The FY13 Scorecard is available on DBH's website at: http://dbh.dc.gov/page/provider-scorecard

[12] Department of Behavioral Health, FY14-15 Performance Oversight Questions, Question 52. Note that the data provided in response to Question 52 only covers the services provided to children that were billed to MHRS and not those billed to the MCOs.

[13] D.C.M.R. §22A-3411.5(f).

[14] Department of Behavioral Health, FY14-15 Performance Oversight Questions, Question 53.

[15] Department of Behavioral Health, FY13-14 Performance Oversight Questions, Question 9.

[16] Department of Behavioral Health, FY14-15 Performance Oversight Questions, Question 83.

[17] In FY14 the annual capacity for Trauma-Focused Cognitive Behavioral Therapy was 249 slots and 127 were utilized, which is 51%. Department of Behavioral Health, FY14-15 Performance Oversight Questions, Question 83.

[18] In FY14 the annual capacity for Transition to Independence was 527 slots and 393 were utilized, which is 74.5%. Department of Behavioral Health, FY14-15 Performance Oversight Questions, Question 83.

[19] There are 396 slots available for Adolescent Community Reinforcement Approach. Department of Behavioral Health, FY14-15 Performance Oversight Questions, Question 83.

[20] 1,117 youth children received evidence-based practices during FY14. Department of Behavioral Health, FY14-15 Performance Oversight Questions, Question 83. 93,000 youth are enrolled in Medicaid. Department of Health Care Finance, District of Columbia's Managed Care End-of-Year Performance Report (July 2013-June 2014), 3 (Feb. 2015).

[21] Department of Behavioral Health, FY14-15 Performance Oversight Questions, Question 45.

[22] Department of Behavioral Health, FY14-15 Performance Oversight Questions, Question 45.

[23] Department of Behavioral Health, FY14-15 Performance Oversight Questions, Question 59. Agencies are also using a companion assessment tool, the Preschool and Early Childhood Functional Assessment Scale (PECFAS), for younger children when appropriate.

[24] The DHS programs which are currently implementing the CAFAS are Parent and Adolescent Support Services (PASS) and Alternative to the Court Experience (ACE). Department of Behavioral Health, FY14-15 Performance Oversight Questions, Question 59.

[25] Department of Behavioral Health, FY14-15 Performance Oversight Questions, Question 59.