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Testimony Before the District of Columbia Council
Committee Health and Human Services
February 4, 2016

Performance Oversight Hearing
Department of Behavioral Health

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INTRODUCTION

Good morning Chairman Alexander and members of the Committee on Health and Human Services. My name is Sharra E. Greer. I am the Policy Director of 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.

I appreciate this opportunity to testify regarding the performance of the Department of Behavioral Health (DBH) over this past year. Many of the children we work with – children in the foster care system or receiving special education services – only need our help because their mental health needs have gone unaddressed. Even our well-trained lawyers have difficulty connecting children to appropriate mental health services and cite the lack of timely, quality and appropriate mental health services as one of the greatest barriers to success for our children.

DBH has new leadership. As you know, Dr. Tanya Royster began in August of 2015 and thus has only had a short time to assess DBH and develop a plan for reform. Our meetings with her and her impressive background as a manager and as a child and adolescent psychiatrist give us hope that she will help bring needed focus and expertise to children's mental health in the District.

Dr. Royster has indicated that she sees DBH as the leading mental health authority for the entire city. This is consistent with DBH's stated mission to "develop, manage and oversee a

public behavioral health system for adults, children and youth and their families…"[2] We welcome this new vision and believe the failure of DBH to embrace this role has led to many of the problems we face today. DBH has traditionally focused on slowly growing its own programs, rather than working with its sister agencies to set an agenda for how to improve the mental health of *all* children in the District. Through the leadership of Mayor Bowser, Deputy Mayor Brenda Donald and Dr. Royster, this has been changing, and in the past year we saw more steps towards an integrated system and collaboration across agencies and with the community.

There are significant challenges. Approximately 101,000 children and youth under 21 years of age enrolled in the District's Medicaid program.[3] DBH notes that as many as 20% of children and adolescents may have a mental health disorder that can be identified and require treatment.[4] This means that more than 20,000 of the children on Medicaid in DC likely have a mental health disorder that can be identified and requires treatment.[5]

It is unclear how many children in DC are receiving mental health treatment, how much treatment they are receiving and whether it is appropriate treatment. Neither DBH nor any other agency reports about and monitors all children receiving mental health services through DC Medicaid. DBH does report on and monitor the children being served through its Mental Health Rehabilitation Services (MHRS) system and a few other programs which they run. In FY15, 5,065 children ages 0-20 received a service through MHRS which is the same as the number served in FY14.[6] DBH also runs and monitors a few other programs that serve children, including the Early Childhood Mental Health Consultation Program – Healthy Futures, Parent Infant Early Childhood Programs (PIECE) and the High Fidelity Wraparound

Program.[7] The largest is the School Mental Health Program (SMHP). SMHP served close to 2,300 children in FY15.[8] Although the Department does not review or monitor services received through a Medicaid managed care organization (MCO), which serve the overwhelming majority of children in DC, we know from the Department of Health Care Finance that in FY15 over 11,000 received some mental health service through their MCO.[9]

This fragmented data makes clear that DBH does not manage or oversee a cohesive system. In fact, some number of children are double counted and receive services through MHRS, their MCO and SMHP, so it is unclear how many children in total are receiving services or what services they are receiving. There is also very little or no assessment of the appropriateness, length or effectiveness of the services received.[10] The limited assessment of services that exists indicates performance falls well short of goals and is declining.[11]

DISTRICT WIDE ASSESSMENT TOOL

DBH and other District agencies have taken some promising steps toward a more integrated system. One is the implementation of the Child and Adolescent Functional Assessment Scale (CAFAS)/Preschool and Early Childhood Functional Assessment Scale (PECFAS). DBH leads this effort. This tool allows child serving agencies to evaluate a child's needs and monitor progress in a uniform way.[12] This is an essential step to allowing successful care coordination across agencies and providers. Progress on implementation of this tool has been significant. As of November 1, 2014 the CAFAS/PECFAS was implemented across all DBH providers.[13] On July 1, 2015 the CAFAS/PECFAS was implemented for both in home and out of home youth served by CFSA.[14] In the coming year OSSE, and some DCPS and DCPCS schools will begin to implement the tool.[15] In addition in FY16 a data warehouse will be begin

to be implemented which will allow data sharing across the agencies and providers. All of these are strides towards a more coherent system.

MENTAL HEALTH SERVICES IN SCHOOLS

A recent initiative, and one that could have profound effects if achieved, is a move towards working with the education agencies on providing mental health services in schools. The *South Capital Street Memorial Amendment Act of 2012* required that a comprehensive plan with a strategy for expanding early childhood and school based behavioral health programs and services to all schools be developed by SY2016-2017. DBH has focused its efforts to fulfill this requirement by expanding the SMHP. Although the plan is for SMHP to be in 70 schools by the end of the school year, SMHP is still only in approximately 31% of schools in DC.[16] In addition to this program, some individual DCPS and charter schools provide mental health services through full-time staff and contracts with service providers. Unfortunately, there is no comprehensive list of the services available to the public and it is our understanding that no government agency has such a list.

DBH reports this has begun to change. In December 2015, a meeting with DBH, DCPS, DCPCSB, Department of Health (DOH) and community partners was convened to explore vision, current resources and services, and resources required to expand programs.[17] DBH reports that through a collaboration between DBH, DOH, and schools there will be a School Health Needs Assessment which would include the "resource mapping and mapping of current mental health and substance use screening portals in the District."[18] This would then lead to a truly comprehensive plan for school based mental health. This is an exciting development that we hope is made a priority and moves quickly from plan to action.

COLLABORATIVE INNOVATION

There have also been good and creative cross agency collaborations. One good example is the Wayne Place Project. Wayne Place provides transitional housing and life skills development for youth and young adults and is the result of a partnership between DBH and CFSA. Residents of Wayne place are homeless young adults age 18-24 who are aging out of the foster care system or exiting the children's mental health system and lack sufficient family support to successfully transition into adulthood.[19] This is a creative new way to attempt to address the nationwide problem of aging out youth becoming homeless.

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.

Significant progress has been made in both of these projects this year, and DBH has been integral to this work. The pediatric practices serving 80% of the children on Medicaid have now been trained on a variety of mental health topics, including how to implement the mental health screening tool adopted in DC.[20] In addition, DBH worked with DHCF to establish a new code for the screening which encourages pediatricians to screen children by

allowing them to bill separately for it. The Medicaid code also records the results of the screen so that the government can track whether children are being referred for and receiving the appropriate services.[21]

In FY15 the Mental Health Access in Pediatrics project became a reality. We thank you, Councilmember Alexander, for your important role in securing passage of the *Behavioral Health System of Care Act of 2014*, which will ensure that this the program will now be a permanent part of the children's mental health system. DC-MAP began providing services to a pilot group of pediatricians in May, 2015 and became available to all DC pediatricians and their staff in September, 2015.[22] The program is staffed collaboratively by Children's National Health System and MedStar Georgetown University Hospital.[23]

QUALITY AND TIMELINESS OF SERVICES REMAINS AN ISSUE

Having a coherent and coordinated system that is overseen by a lead agency is essential; however, even a coordinated system fails if it does not provide timely, quality services. This continues to be a significant problem. Those who do receive services often get poor quality treatment. We regularly see high turnover among clinicians, clinicians who do not have the skill to engage children or their caregivers, and a lack of communication among team members.

DBH's own data reflects the experience of my colleagues. DBH's FY15 Child and Youth Community Service Review (CSR) concluded there was a decline in practice performance.[24] In only 67% of cases did reviewers find that the system performed "in the acceptable range."[25] Further, 12% of cases received the lowest possible scores.[26] DBH's Provider Scorecards also reveal mediocre results for many of the Core Service Agencies.[27] Only one of the 14 CSAs that serve children received the top scores of five or four stars. Simply getting a service is not

enough. The reality is that the poor quality of care means that mental health problems persist or exacerbate.

Mental health treatment must also be timely in order to be effective. We regularly see children who have waited many months to receive services. In FY15 it took an average of 20 days from the time a child was enrolled in a Core Service Agency (CSA) to the date the child was first seen for treatment.[28] This is up from an average of 18 days in FY14.[29] MHRS regulations require that CSAs provides consumers with an appointment within seven (7) business days of referral.[30] A child's condition deteriorates when she goes without service. Such long waits have damaging consequences. Timeliness of service is especially important for children being discharged from psychiatric hospitalizations. Unfortunately, only 61% of children discharged from an acute care hospital received a community-based service within a week.[31] Follow-up care is critically important to ensure that children are receiving required treatment and medication and aren't unnecessarily readmitted to the hospital.

Sadly, we see exactly this situation with our clients. For example, we work with an elementary age child with significant trauma history and severe emotional disorders, who has been psychiatrically hospitalized multiple times. No meaningful discharge planning has occurred each time. In addition, after waiting over three months for a community support worker and seven months for a therapist, she was assigned by the DBH CSA to an unlicensed therapist who was not prepared for this child's level of needs. After only a few months, the child's functioning deteriorated to the point that she was inappropriately handcuffed during a mental health crisis. Instead of providing more intensive services to assist the child's recovery from the trauma, the therapist then started to decrease services, citing self-fatigue. In part

because she was not getting appropriate services, the child has had several more psychiatric hospitalizations.

There has been some progress on timeliness of services. DBH has staff co-located at CFSA and the five Collaboratives who are responsible for screening children and youth at-risk of removal and those removed from their homes.[32] The number of days on average between screening and the receipt of the first service has reduced to 24 days in FY15 from 47 days in FY14.[33] In addition, during FY15, DBH and CFSA created a protocol where Choice Providers attend meetings within 24 hours of a child being removed. The goal is to decrease the time between removal and service initiation as well as to address the trauma experienced by the child. DBH, CFSA and the Choice Providers meet monthly to address barriers and track and monitor the process. The initial results of this new protocol are promising.[34]

Given the problems with timely service provision, the expectation is that programs would be at capacity and have wait lists. However, programs continue to be underutilized. Although there are now several evidence-based practices 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 Trauma-Focused Cognitive Behavioral Therapy still is significantly underutilized.[35] This is also true for 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 over 100 slots are vacant as of FY16.[36] This is true for many other services. DBH needs to do a better job

connecting children to these services and then expand them significantly to meet the known need.

Conclusion

In conclusion, DBH continues to take positive steps 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. 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] See: http://dbh.dc.gov/page/about-dbh.

[3] Department of Health Care Finance, FY15-16 Performance Oversight Questions, Question 50.

[4] 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

[5] 20% of the 102,000 children and youth on Medicaid is 20,400.

[6] In FY14 5,037 children in this age range received an MHRS service. Department of Behavioral Health, FY15-16 Performance Oversight Questions, Question 85.
[7] Department of Behavioral Health, FY15-16 Performance Oversight Questions, Question 41.
[8] Department of Behavioral Health, FY15-16 Performance Oversight Questions, Question 69.
[9] Department of Health Care Finance, FY15-16 Performance Oversight Questions, Question 50.
[10] See Department of Behavioral Health, FY15-16 Performance Oversight Questions, Question 99.
[11] Department of Behavioral Health, FY15-16 Performance Oversight Questions, Question 99.
[12] The Child and Adolescent Functional Assessment Scale ("CAFAS") assesses day-to-day functioning of youth ages 5 to 19 across critical life subscales and determines how the youth's functioning has changed over time. The results of the CAFAS can be used to make decisions about the level of care, type and intensity of treatment, placement, and need for referral. The Preschool and Early Childhood Functional Assessment Scale ("PECFAS"), used for children ages 3 to 7, is similar to the CAFAS and informs decisions about the need for services or additional specialized assessment, type and intensity of treatment, readiness for school, and specialized services needed for educational success. *See* http://www2.fasoutcomes.com/Content.aspx?ContentID=38.
[13] Department of Behavioral Health, FY15-16 Performance Oversight Questions, Question 41.
[14] Department of Behavioral Health, FY15-16 Performance Oversight Questions, Question 11
[15] Department of Behavioral Health, FY15-16 Performance Oversight Questions, Question 41.
[16] Department of Behavioral Health, FY15-16 Performance Oversight Questions, Question 65. This is an increase from 64 schools in SY14-15 and 52 SY13-24. Department of Behavioral Health, FY14-15 Performance Oversight Questions, Question 66. Department of Behavioral Health, FY13-14 Performance Oversight Questions, Question 59. *See also* http://osse.dc.gov/sites/default/files/dc/sites/osse/publication/attachments/2012%20LEA%20by%20LEA%20%26%20School%20by%20School%20Level%20Reports.xlsx
[17] Department of Behavioral Health, FY15-16 Performance Oversight Questions, Question 62.
[18] Department of Behavioral Health, FY15-16 Performance Oversight Questions, Question 62.
[19] Department of Behavioral Health, FY15-16 Performance Oversight Questions, Question 59.
[20] Department of Behavioral Health, FY15-16 Performance Oversight Questions, Question 43.
[21] See Department of Behavioral Health, FY15-16 Performance Oversight Questions, Question 43.
[22] Department of Behavioral Health, FY15-16 Performance Oversight Questions, Question 55.
[23] See http://www.dcmap.org/
[24] Department of Behavioral Health, FY15-16 Performance Oversight Questions, Question 98.
[25] Department of Behavioral Health, FY15-16 Performance Oversight Questions, Question 98 Attachment.
[26] Department of Behavioral Health, FY15-16 Performance Oversight Questions, Question 98 Attachment.
[27] http://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/webpage.%20Provider%20Scorecard%20FY%202014_0.pdf
[28] Department of Behavioral Health, FY15-16 Performance Oversight Questions, Question 47.
[29] 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.
[30] D.C.M.R. §22A-3411.5(f).
[31] Department of Behavioral Health, FY15-16 Performance Oversight Questions, Question 48.
[32] Department of Behavioral Health, FY15-16 Performance Oversight Questions, Question 46.
[33] Department of Behavioral Health, FY15-16 Performance Oversight Questions, Question 46.
[34] Department of Behavioral Health, FY15-16 Performance Oversight Questions, Question 52.
[35] For FY16 DBH reports the annual capacity for Trauma-Focused Cognitive Behavioral Therapy was 96 slots and 57 were utilized. Department of Behavioral Health, FY15-16 Performance Oversight Questions,

Question Q 82. 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. FY15 data does not seem to be provided.

[36] In FY16 the annual capacity for Transition to Independence was 532 slots and 406 were utilized. Department of Behavioral Health, FY15-16 Performance Oversight Questions, Question 82. 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. FY15 does not seem to be available.