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Introduction

Good morning Chairman Gray and members of the Committee on Health. 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 9 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. Appointment delays, disorganization, and high staff turnover rates plague many of the Core Service Agencies that provide needed mental health services to Medicaid-eligible children.

The challenge in reaching these children is significant. Approximately 101,000 children and youth under 21 years of age enrolled in the District's Medicaid program.[2] DBH notes that as many as 20% of children and adolescents may have a mental health

disorder that can be identified and require treatment.[3] 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.[4]

Although the quality of mental health services remains difficult to assess, there are efforts that have been underway over the past year to increase access. I will now discuss progress and continued challenges in several areas.

School-Based Mental Health

One of the best ways to improve access to mental health care is to provide services where children are. Counseling services in school or at the school building can make a huge difference for the children who need them. In addition, prevention services and lower level services can be provided in the school to help children from escalating and needing high level and acute services.

DBH is taking substantial steps toward redesigning its own School Mental Health Program (SMHP). DBH was behind in its implementation of the *South Capitol Street Memorial Amendment Act of 2012*. The Act 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. Until last year, DBH had very slowly been expanding SMHP by adding additional DBH clinicians to schools. In FY16, the SMHP operated in 68 DC Public and DC Public Charter Schools, but this is only approximately 31% of the schools in DC.[5]

DBH decided last year to change its approach. The Agency, last spring, convened a Behavioral Health Working Group bringing together DBH, the Office of the State Superintendent of Education (OSSE), DC Public Schools (DCPS), the DC Public Charter School Board (DCPCSB), Friends of Choice in Urban Schools (FOCUS), child advocates and other government and community partners. CLC is a part of this working group.

The Working Group's plan is still in draft form. The proposed approach shows promise. While not final, the goal is to maximize available resources and ensure there is no disparity between similarly situated schools and child development centers. DBH school-based clinicians, will perform universal screening and prevention activities. Resources from school personnel along with community mental health providers will provide early intervention and treatment services. This goal is to have a realistic plan to ensure that every child in every school will have access to all levels of services.

While the plan needs to be finalized, and an implementation plan completed, the shift to a coordinated model makes sense. We are hopeful this can be completed and launched for SY2017-2018. This coordinated expansion should help increase access and prevent behavioral and mental health issues from escalating to a crisis point.

High-Fidelity Wraparound

The High-Fidelity Wraparound program in the District is going through a crisis. In January 2017, the Care Management Entity, DC Choices, gave approximately four

weeks' notice of its intent to cease providing wraparound services at the conclusion of its contract. As of February 2017, High-Fidelity Wraparound is not currently being offered in the District.

The High-Fidelity Wraparound model is an established care coordination and family support model that seeks to mobilize all supports and services to maintain children with emotional or behavioral difficulties safely in their communities.[6] In the District, High-Fidelity Wraparound was a collaboration between DBH, the Child and Family Services Agency (CFSA), the Department of Youth Rehabilitative Services (DYRS), and OSSE, funded with local dollars; and the sole Care Management Entity in the District has been DC Choices.[7] The program is designed to provide individualized and child- and family-driven planning, monitoring and coordination of services, and linkage to non-Medicaid reimbursable services, supports or interventions through flexible funding. The High-Fidelity Wraparound process is offered, in part, to divert youth from entering Psychiatric Residential Treatment Facilities (PRTFs). In FY16, 96% of the 319 youth who participated avoided placement in a PRTF.[8]

With the abrupt closure of DC Choices, the children using the services have been left without a needed service. DBH staff report that OSSE was proposing to stop participation in High-Fidelity Wraparound as of FY18, and the notice of potential reduction in contract amount led DC Choices to decline to renew its contract. Needless

to say, this abrupt cessation of the service has caused substantial confusion for families, and has left many without this useful tool in stabilizing at-risk youth.

For example, CLC client Shawn, a sixteen-year-old who has no contact with either of his biological parents, was benefiting tremendously from clinical mentoring, a specialized, non-Medicaid reimbursable service funded through wraparound flexible funds. Shawn built a very trusting relationship with the clinical mentor that really helped the team better support, understand, and case plan for this client. However, with the abrupt closing of DC Choices, this client has lost yet another important figure and will likely internalize it as a reflection of his worth and value in the world and to others. The clinical mentor did not, due to the abrupt closing of DC Choices, have an opportunity to terminate services in a clinically appropriate and thoughtful manner. At this time, the team continues to search for replacement funding; however, in the meantime, this is another unnecessarily broken attachment.

It is our understanding that DBH is trying to ensure that services continue for these families. In addition, they are working to find a way to provide additional funds for services formerly contracted through the DC Choices under the "flexible funds" provision of the wraparound contract.[9] While these stop gap measures are important, a new provider needs to be put in place as soon as possible. DBH staff have reported that DBH has begun the procurement process to solicit a new provider.[10] We urge DBH to complete this process expeditiously so that this service can resume.

Inpatient Access and Outpatient Continuity of Care

Supporting youth with severe mental health needs in the community requires the availability of high-quality crisis services. In the past several years, the District has made strides in making community-based crisis services available, such as the Child and Adolescent Mobile Psychiatric Service (ChAMPS). But, children in crisis also need the opportunity for high-quality acute inpatient psychiatric hospitalization, if warranted. Over the past year, the dearth of available inpatient beds for children and adolescents in the District has become a substantial challenge. Although Children's National Medical Center and the Psychiatric Institute of Washington both offer inpatient psychiatric services for children, the limited number of beds in each hospital—combined with renovation efforts that have also limited space—has posed major challenges. The hospitals, in turn, have reported that community-based providers, case managers, and even judges have directed children to their psychiatric units who are unworthy of admission. Multiple CLC clients have been denied beds in inpatient units for being "too violent" or "affiliated with DYRS," despite displaying behaviors that suggest psychiatric acuity. And, for children who have mental health needs that severely impair their safety in the community but are not at the acuity level required for placement in a full-scale psychiatric unit, the District lacks any partial hospitalization programs or subacute units for children. DBH, as the leading mental health authority in the District, should continue to take a leadership role in bringing stakeholders

together, not only to resolve challenges regarding inpatient psychiatric hospitalization but also to ensure coordination between hospital and community-based providers.

The kind of coordination necessary is exemplified in DBH's Continuity of Care policy.[11] The policy requires that an acute care facility notify DBH of the admission of a Medicaid enrollee, and DBH must inform the acute care facility of the enrollee's Core Services Agency (CSA). The policy further requires the CSA provider to have face-to-face contact with the youth in the hospital and participate in discharge planning.

Unfortunately, in FY15, the most recent year data is available, only 61% of children discharged from an acute care hospital received a community-based service within a week.[12] Follow-up care is critically important to ensure that children are receiving required treatment and medication and are not unnecessarily readmitted to the hospital. DBH has recognized this unacceptably low number over the course of the last year, but has not implemented any policy or practice changes to increase this percentage.

Again, DBH should take the lead in ensuring that our CSAs and other community-based mental health providers coordinate with inpatient psychiatric units to prevent children from falling through the cracks during a particularly crucial moment.

Quality and Timeliness of Services in General

Having a coherent and coordinated system that is overseen by a lead agency is essential. In DC, this is a challenge, because the system is fragmented. 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.[13] 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. The largest is the School Mental Health Program (SMHP). SMHP served close to 2,300 children in FY15.[14] However, DBH 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 (DHCF) that in FY15 over 11,000 received some mental health service through their MCO.[15] DBH has reported increased efforts to collaborate with the MCOs regarding ways to improve collaboration and care coordination for children and youth.[16] We continue to urge more steps towards an integrated system and collaboration across agencies and with the community. If the proposed changes to the SMHP to become a CSMHP are successful,

that would be a significant step in the right direction. More needs to be done to achieve a cohesive system.

In addition to coordination, a successful system needs 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.[17] In only 67% of cases did reviewers find that the system performed "in the acceptable range."[18] Further, 12% of cases received the lowest possible scores.[19] DBH's Provider Scorecards also reveal mediocre results for many of the Core Service Agencies.[20] Only one of the 14 CSAs that serve children received the top scores of five or four stars.[21] 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 FY16, it took an average of 33 days from the time a child was enrolled in a Core Service Agency (CSA) to the date the child was first seen for a Diagnostic Assessment, the first step toward accessing services through a CSA.[22] This was up from an average of 18 days in

FY15.[23] MHRS regulations require that CSAs provide consumers with an appointment within seven (7) business days of referral.[24] A child's condition deteriorates when he/she goes without service. Such long waits have damaging consequences.

There has been 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.[25] The number of days, on average, between screening and the receipt of the first service has been reduced to 13 days in FY17.[26]

In addition, as required by the *South Capitol Street Memorial Act of 2012*, DBH has recently hired an Ombudsman Program Officer for Children and Youth.[27] The new Ombudsman Program Officer is making strides in developing a new complaint, grievance, and technical assistance response system for aggrieved mental health consumers, and coordinating with the preexisting Office of Consumer and Family Affairs and Office of Accountability within DBH. We are hopeful that increased support for, as well as scrutiny of, the provision of community-based mental health services will lead to increases in utilization, timeliness and quality.

Conclusion

In conclusion, DBH continues to take positive steps to improve the children's mental health system, but challenges remain. DBH should continue efforts to increase collaboration and care coordination across systems that serve youth with mental health

concerns. Thank you again for the opportunity to testify. I am happy to answer any questions.

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[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 9 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] DHCF FY15 Performance Oversight Responses, Q50.

[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 102,000 children and youth on Medicaid is 20,400.

[5] DBH FY16 Performance Oversight Responses, Q25.

[6] See, DBH Policy: High Fidelity Wraparound Care Planning Process, *available at* http://dbh.dc.gov/node/876552.

[7] DBH FY16 Performance Oversight Responses, Q37.

[8] DBH FY16 Performance Oversight Responses, Q37.

[9] DBH FY16 Performance Oversight Responses, Q32.

[10] DBH FY16 Performance Oversight Responses, Q30.

[11] *See* DBH Policy: Continuity of Care Practice Guidelines for Children and Youth, *available at* http://dbh.dc.gov/node/242892.

[12] DBH FY15 Performance Oversight Responses, Q48. DBH FY16 Performance Oversight Responses Q74, "Data to track the services provided to children post discharge from inpatient psychiatric hospitalization is not currently available. The Children's National Health System (CNHS) voluntarily provided discharge data to DBH. As a result DBH could track children and youth who were discharged. In FY16 the CNHS stopped providing this data because they determined to do so was in violation of the Health Insurance Portability and Accountability Act (HIPAA)."

[13] In FY14 5,037 children in this age range received an MHRS service. DBH FY15 Performance Oversight Responses, Q85. This data was not requested in oversight FY16.

[14] DBH FY15 Performance Oversight Responses, Q69. This data was not requested in oversight FY16.

[15] DHCF FY15 Performance Oversight Responses, Q50.

[16] DBH FY16 Performance Oversight Responses, Q79.

[17] DBH FY15 Performance Oversight Responses, Q98. This is the most recent CRS, See DBH FY16 Performance Oversight Responses Q46.

[18] DBH FY15 Performance Oversight Responses, Q98 Attachment.

[19] DBH FY15 Performance Oversight Responses, Q98 Attachment.

[20] See, MHRS FY2015 Provider Scorecard, *available at* http://dbh.dc.gov/node/1196082.

[21] Youth Villages, a non-CSA specialized provider that serves children and their families, was added to the scorecard for FY15 and also received four stars.
[22] DBH FY16 Performance Oversight Responses, Q72.
[23] DBH FY15 Performance Oversight Responses, Q20, Q47.
[24] §22-A D.C.M.R. 3411.5 (f).
[25] DBH FY16 Performance Oversight Responses, Q21, Q72.
[26] DBH FY16 Performance Oversight Responses, Q20.
[27] DBH FY16 Performance Oversight Responses, Q24.