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Testimony Before the District of Columbia Council
Committee on Health
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Public Oversight Hearing:

The Department of Behavioral Health

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Introduction

Good morning, Chairman Gray and members of the Committee. My name is Sharra E. Greer. I am the Policy Director 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 nearly 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. Children's Law Center is also a Co-Chair of the Strengthening Families Through Behavioral Health Coalition. Our coalition is committed to ensuring DC's behavioral health care system for children, youth, and families provides timely access to high-quality, consistent, affordable, and culturally responsive care that meets their needs and enables them to thrive.

I appreciate this opportunity to testify regarding the performance of the Department of Behavioral Health (DBH) over this past year. The focus of my testimony today will be on the ability of our children to access quality behavioral health services in a timely and consistent manner. My testimony will begin with a brief background on the behavioral health needs of DC's children before and during the pandemic. Next, I will discuss one of DBH's most significant accomplishments this past year – supporting a swift transition to telehealth for behavioral health services. My testimony will then address the strengths and weaknesses of DBH's current array of behavioral health

services for children. Finally, I will address the ongoing transition to a fully managed Medicaid program. My testimony will not include a discussion of the school-based mental health expansion program because my colleague, Tami Weerasingha-Cote, is providing separate testimony focused on that program.[2]

DC Children's Behavioral Health Needs Have Been Exacerbated by the Pandemic

The mental and behavioral health of DC's children and youth have been concerning for quite some time. As we have testified consistently for years, tens of thousands of children in the District likely have an identifiable mental health disorder that requires treatment, but year after year, the data shows that only a fraction of these children actually receive mental health services.[3]

Analyses from the most recent Youth Risk Behavior Survey, which was released by the Office of the State Superintendent of Education (OSSE) in Spring 2020, provides a distressing pre-pandemic snapshot of the behavioral health of youth in the District. For instance:

- Depressive symptoms were prevalent, with over 6,000 high school students estimated to be feeling sad or hopeless almost every day for at least two weeks in the past year.[4]
- An alarming number of children in the District also reported having suicidal ideation and/or attempting suicide, with notably higher rates in children who identify as lesbian, gay, and bisexual. Specifically, 14% of middle school

students and 15% of high school students attempted suicide in the past year, cumulatively representing over 5,000 children.[5]

- Among the high school students who reported having felt sad, empty, hopeless, angry, or anxious, only one in every four students was generally able to get the help they needed, reflecting great unmet behavioral health needs among children in the District.[6]

At Children's Law Center, we encounter children with unmet behavioral needs all too often. Many of the children we work with – children in the foster care system or receiving special education services – only need our help because their behavioral health needs have gone unaddressed. Even our well-trained lawyers have difficulty connecting children to appropriate behavioral health services and cite the lack of timely, quality and appropriate behavioral health services as one of the greatest barriers to success for our children.

The pre-pandemic behavioral health situation was already troubling, but the ongoing COVID-19 pandemic is exacerbating unmet behavioral needs among children in the District. Children are dealing with unprecedented levels of disruption, isolation, and toxic stress due to remote schooling, the loss of social connections and activities, changes in their parents' lives (including job losses) and illness and death from COVID in their families and community. These ongoing changes are impacting children's behavioral health:

- A national survey found that 14% of parents with children age <18 reported worsening behavioral health for their children, while 27% of parents reported worsening mental health for themselves.[7]
- Early research has noted high rates of irritability, clinginess, distraction, and fear among children, as well as increases in substance use among adolescents.[8]
- A recent District survey revealed that the COVID-19 pandemic was disproportionately impacting those who were already low-income, resulting in struggles to meet basic needs and causing great stress, fear, and anxiety for families.[9]

Considering that most mental health disorders begin in childhood,[10] the psychological issues stemming from this pandemic can have lasting health and economic impacts on the DC population if the behavioral health needs of children and families are not adequately addressed in a timely manner. We commend DBH for their pandemic-related responses, including their promotion of the Access Helpline as a warm line for those experiencing distress and the introduction of the "Wellness Wednesday" parent support group.[11] However, greater efforts will be needed to address the devasting behavioral health consequences related to the pandemic.

DC's behavioral health system for children and families has been inadequate to meet their needs for a very long time. Now, more than ever, we need to strengthen and

expand the array of behavioral health services available for children and families. Access to quality, consistent, and timely behavioral health services is an essential component to our children's ability to fully recover from this pandemic and thrive.

Implementation of Telehealth Has Improved Access to Behavioral Health Services

The rapid shift to telehealth has enabled numerous children and families to continue accessing critical behavioral health services. We applaud DBH for its role in the swift implementation of telehealth in the District, including supporting providers, coordinating information-sharing, providing authorization for telehealth services, and facilitating rule changes. Research has found that the benefits of "telemental health" (providing mental and behavioral health services through technology) include improved access, reduced costs, and flexibility for clients and service providers.[12] Given the advantages of telemental health services, DBH should establish any organizational structures and/or procedures needed to sustain the delivery of high-quality, evidence-based, and equitable telemental health services in the long-term. One such change is the establishment of mechanisms for monitoring and evaluating telemental health services to ensure that they meet ethical and quality standards.

While we strongly support sustaining telehealth, there are caveats surrounding its benefits for children in the District, which warrant special attention and investigation by DBH. One recent study examining the use of telemental health services during COVID-19 found that telemental health services (especially for psychotherapy) was less

preferred as a service delivery method for children than adults.[13] Another study noted that there are both therapeutic limitations of telemental health for children (challenges assessing and treating severe clinical presentations) and physical limitations (challenges in access to reliable technology and confidential spaces), with the latter being exacerbated for children from socioeconomically disadvantaged families.[14] In light of these caveats, although we commend DBH for its work to facilitate the use of telemental health services during the pandemic, we urge DBH to also continue building capacity in their in-person programs for children.

DBH Must Sustain and Expand Behavioral Health Services for Children

With the pandemic continuing to drive ever-increasing behavioral health needs among children, the inadequacies of DC's behavioral health system for children are more apparent than ever. Our system lacks both breadth and depth – it does not include the full spectrum of services our children need, and for the services we do have, the capacity is insufficient to meet the need.

At Children's Law Center, we see the impact of this broken system on our clients firsthand. Many of our clients struggled to access behavioral health services over the past year – from basic intakes, to individual and family therapy sessions, to medication management appointments, to intensive outpatient mental health services. More often than not, the problem was a lack of providers – either the service needed was unavailable, or the waitlist for an appropriate provider was prohibitively long. Further,

high turnover among behavioral health providers negatively impacted our clients' ability to maintain consistent services.

DBH must develop and implement a long-term strategy to strengthen the behavioral health care system for children and families. In particular, we recommend sustaining and expanding existing programs such as DC MAP, Healthy Futures, ChAMPS, and ASTEP, in addition to building out additional programs to fill the gaps in DBH's service array.

DC MAP and Healthy Futures Successfully Reach Children Where They Are

DC MAP

Funded by DBH since 2015, DC MAP is a program designed to improve mental health integration within pediatric primary care by providing pediatricians who have mental health-related inquiries about specific children real-time phone access to psychiatrists, psychologists, social workers, and care coordinators.[15] DC MAP also provides education and technical assistance to pediatricians regarding how to identify and address mental health issues in the primary care setting – improving pediatricians' abilities to assess patients and treat patients with anxiety and mood disorders. The program also facilitates referrals and coordination for patients who need community-based specialty services.[16] Through these multiple mechanisms, DC MAP supports integrated mental health care within pediatric primary care settings, which research has repeatedly shown can improve service delivery and patient health outcomes and reduce

costs.[17] We view DC MAP as a cost-effective and innovative program that helps to address the mental health needs of the District's children early with a population-based, prevention framework by reaching them where they are through their pediatricians.

Over the past six years, DC MAP has received over 4,250 consultation requests regarding 3,745 unique patients. A majority of DC MAP's consultation requests are for children covered by DC Medicaid – demonstrating that the program provides invaluable support to DC's most vulnerable children and their families.[18] Since the start of the pandemic, the need for DC MAP's services has become even more pronounced. Providers and care coordinators report that symptoms have been more acute and more time-sensitive, and many cases have been more complex, requiring involvement from multiple clinicians on the team. Depression, anxiety, and ADHD are the three most commonly reported concerns. There has also been an increase in requests for grief counseling as well as behavioral and parenting support for children and families that are struggling.

With the dramatic growth in the program's utilization over the past six years, and the increased need for these services caused by the pandemic, DBH's continued support for DC MAP is essential. Unfortunately, DBH's five-year contract with DC MAP ended in February 2020. Although funding for DC MAP has been extended at the current level, the length of the extension is unknown, and DBH has not indicated when the next RFP will be released. We commend DBH for its support for this vital program

to date but urge DBH and the Council to ensure DC MAP is fully funded for FY2021 and beyond so that this critical program continues to be a resource for pediatricians in the District and reaches more children every year.

Healthy Futures

Healthy Futures is another program that is contributing to the integration of behavioral health services in settings where children are already present. Healthy Futures provides early childhood mental health consultation services to child development centers and home childcare providers, as well as directly to children and families. These services are provided by a mental health professional with the goal of building the capacity of childcare providers to reduce challenging behaviors and promote positive social emotional development in infants and toddlers. Healthy Futures provides two primary types of consultation services:

- Programmatic consultation, which is focused on building the capacity of the teachers on behalf of all children in their classes, and
- Child-specific consultation, which is focused on those young children in need of individualized services as well as facilitating referrals for community-based services.

The program is expanding in 2021. It is anticipated that by the end of the year, the program will serve nearly 135 child development centers, providing services to staff and directors on a weekly basis. DBH is well on its way to this goal. With the onset of

the COVID-19 pandemic, the program has successfully transitioned to providing consultations virtually, although engagement has been impacted by technology challenges. Healthy Futures has also been responsive to the stress the pandemic is causing parents and childcare providers by shifting focus to provide support in more practical ways, such as offering workshops on self-care for parents and staff.

Programs like DC MAP and Healthy Futures that target children in their natural context support early identification (and thereby, treatment) of behavioral health issues, potentially circumventing escalation to severe behavioral health problems over the lifetime of beneficiaries. In the long-term, effective implementation of these programs can result in decreases in behavioral health service utilization and related costs. We urge DBH and the Council to ensure that Healthy Futures continues to be funded and, in FY2022, is funded to continue its expansion into all the Child Developmental Centers.

We commend DBH for its continued support of DC MAP and Healthy Futures. We urge DBH, however, to work towards increasing the stability and capacity of these programs by making long-term commitments and investments in them. This is particularly important considering the pandemic-related increase in children's behavioral health issues that caregivers, educators, and pediatricians are likely to encounter now and in the near future.

ChAMPS Supports Children in Crisis, But a Broader Spectrum of Services is Needed

Currently, DBH contracts out emergency mobile psychiatric services for children and youth through Anchor Mental Health, an agency of Catholic Charities, which administers the Children and Adolescent Mobile Psychiatric Service (ChAMPS) Program. ChAMPs provides mobile crisis interventions to youth aged 6 to 17, including screening for mental health and substance use needs, crisis stabilization, and referral to appropriate resources.[19] Services are provided in the community, schools, or in homes. In FY2020, ChAMPs provided services to 710 children and youth. In FY2021, to date, 114 youth and children have been served.[20] These numbers are significantly lower than the previous year's numbers, indicating lower utilization of the service, perhaps due to the pandemic.[21]

The role of the police in crisis intervention for children should also be highlighted. A recent investigation identified mental health as one of the main non-criminal reasons for dispatching DC police, but also noted 77% of officers in the DC Metropolitan Police Department have not taken a course in crisis intervention.[22] Intervention by police who have no crisis intervention training can lead to use of violence instead of the appropriate de-escalation techniques, which can have tragic outcomes for some children. We have seen this with our own clients – some as young as five-years old – who have been traumatized by police involvement in response to behavioral health issues.

DC's crisis services for children and crisis response in traditional and public charter schools are currently being evaluated by Child Trends, an independent research organization focused on issues affecting children and youth.[23] It is likely that this ongoing evaluation will highlight shortcomings of the District's crisis response to children. We urge DBH to pay close attention to recommendations emerging from the report and engage with stakeholders in implementing changes to strengthen ChAMPS and any other relevant programs.

A crisis continuum of care (which should encompass screening and assessment, mobile crisis response, crisis stabilization services, residential crisis services, psychiatric consultation, referrals and warm hand-offs to community-based services, and continuing care coordination) is crucial to deescalate mental crises in children and improve their treatment outcomes.[24] Implementation of a high-quality crisis continuum of care in the District can help avoid the use of more restrictive and costly interventions.[25] While DBH has established a mobile crisis response for children, many other elements of the crisis continuum of care remain missing. Notably, the District has no local psychiatric residential treatment facilities (PRTFs). These facilities serve as an alternative to hospitalization for children or as a step-down setting following hospitalization.[26] Without access to the full crisis continuum of care, children may not receive the most appropriate treatment, which could result in greater service utilization (and costs) due to longer recovery times and/or relapses. Relatedly, the children who

do not meet the criteria for inpatient hospitalization but still need more intensive services than provided in traditional outpatient programs are unable to get the necessary level of care.

The recent reported increases in self-harming behavior among children as young as first grade and hospitalizations following calls to the ChAMPS youth mental health crisis hotline reflect a devastating rise in behavioral health crises among children in the District.[27] This rise in behavioral health crises suggests that prevention and early intervention programs are not being accessed, which requires family engagement efforts by DBH. Now, more than ever, DBH must maintain crisis services but also address the gaps in their crisis response system for children.

Additional Programs Are Needed to Address Youth Substance Use Disorders

The 2019 Youth Risk Behavior Survey data suggests that substance use among children in DC is problematic, with at least one in every five high school students reporting marijuana use or at least one drink of alcohol in the past month.[28] This is corroborated by 2021 statistics from Mental Health America, which rank DC third among all states for the highest prevalence of youth with substance use disorder.[29] While the effect of the COVID-19 pandemic on the pre-existing high prevalence of substance use in DC youth is currently unknown, experts postulate that the pandemic places youth at increased risk of substance use disorder and overdose.[30]

DBH provides substance abuse treatment services to youth and their families through the Adolescent Substance Abuse Treatment Expansion Program (ASTEP). ASTEP utilizes the Adolescent Community Reinforcement Approach (A-CRA) in their treatment of youth, which is currently the only evidence-based program authorized under the terms of DC's Medicaid program, even though the criteria for applying A-CRA exclude many District youth. The ASTEP program has three providers, Hillcrest, Latin American Youth Center, and Federal City, which have continued to provide services during the pandemic. Unfortunately, the number of youth receiving substance use disorder services decreased substantially during FY2020, with only 24 youth receiving services – compared with 72 youth receiving services in FY2019.[31] According to DBH's oversight responses, the agency is engaged in more focused efforts to increase enrollment of youth in substance use disorder services, resulting in some small improvements in enrollment during FY2021, to date.[32]

Given that Mental Health America estimates that 2,000 youth in DC had a substance use disorder in the past year, however, it is clear that ASTEP is not reaching all children who need it. A number of our clients have also reported challenges with accessing treatment for children. We urge DBH to develop a strategy for reaching all District children who need treatment for substance use disorders, and we strongly recommend that this strategy include authorizing the use of additional evidence-based programs beyond A-CRA.

Beyond treatment and recovery services, DBH oversees prevention services through four DC prevention centers that cover all eight wards.[33] Throughout FY2020, the prevention centers cumulatively held 225 activities across the city, reaching nearly 10,000 individuals – a precipitous drop compared to the previous year, in which they reached over 33,000 individuals.[34] Continuation of evidence-based programs from prevention centers are crucial to guard against the development of substance use disorders among youth in the District, especially in times of increased risk. Delivery of these programs may need to be adapted to pandemic conditions, but we strongly urge DBH to sustain prevention programs and increase engagement.

DC Children Continue to Struggle to Access Behavioral Health Services in a Timely Manner

Behavioral health treatment must be timely in order to be effective. We regularly work with children who have waited months to receive services. According to DBH, children and families seeking mental health services through DBH must first be referred or connected to a specific Core Service Agency (CSA) and then enrolled with that CSA. Once a child is enrolled with a CSA, then the CSA determines the appropriate care based on a Diagnostic Assessment, which is an intensive clinical and functional evaluation of the patient's mental health condition.[35] Although Mental Health Rehabilitation Services (MHRS) regulations governing certification standards for CSAs require that CSAs provide consumers with an intake appointment within seven (7) business days of the initial referral,[36] DBH reports that for children the average number

of days between enrollment and the receipt of a diagnostic assessment in FY2020 was 22 days.[37] This number shows no improvement compared to FY2019 – it is not even close to the seven-day requirement laid out in the MHRS regulations and falls far short of the timeliness needed to serve children effectively.[38]

The initial delay in receiving the diagnostic assessment is compounded by subsequent delays in delivering the services identified as necessary by the diagnostic assessment. DBH's answers to this year's oversight questions did not provide data in response to questions regarding how much time elapses between diagnostic assessment and the implementation of the services identified in the treatment plan or break down timeliness data by MHRS service type. The data that was provided confirms the experiences of our colleagues and fellow advocates who struggle to obtain clinical mental health services for children who need them. For example, DBH reports that for children involved in the foster care system, the average number of days between identifying children as needing mental health services and providing them with those services was an astounding 41 days.[39] This is a slight improvement from FY2019, when the average time to receiving the first service was 50 days[40] – but still falls drastically short of what these particularly vulnerable and traumatized children need. DBH has significant work to do to decrease the long wait times children and families are experiencing when they seek behavioral health services. We urge DBH to prioritize this work and close the gap between when families search for help and when they receive it.

DBH Must Minimize Disruption to Families During Changes to Medicaid Programs

There are several ongoing changes that can affect access to and quality of behavioral health services for children in the District. First, the shift to new Medicaid managed care contracts became effective in October 2020, with hundreds of thousands of people being switched to different plans.[41] Also, the Department of Health Care Finance (DHCF) began transitioning over 19,000 individuals currently in the Medicaid fee-for-service program to the Medicaid managed care program.[42] This transition will affect many children, including the entire current and former foster care population. However, in December 2020, a judge ruled that the award of the new managed care contracts violated procurement laws, requiring DHCF to reassess contracts.[43] This may result in people being switched to different plans again.[44] Another major change is that DHCF plans to include behavioral health services as covered benefits in the District's managed care contracts beginning in FY2023, with the purpose of improving coordination and providing whole-person care.[45] With these multiple ongoing changes, it is imperative that children and families' behavioral health services remain consistent without disruption or loss of services. While the transition to new plans will largely be DHCF's responsibility, we urge DBH also make a concerted effort to keep families informed of where and how they can continue to access their behavioral health services.

Conclusion

Behavioral health services are vital for children in DC and for some children, these services can mean the difference between life and death. Behavioral health services must be sustained and scaled-up where possible, given that the existing unmet behavioral health needs of DC's children are further exacerbated by the pandemic. In these challenging times, we must invest more in behavioral health services, not less.

Thank you for the opportunity to testify today. I welcome any questions the Committee may have.

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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 advocate 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 nearly 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] Tami Weerasingha-Cote, Children's Law Center, Testimony Before the District of Columbia Council Committee on Behavioral Health, (February 12, 2021).

[3] Approximately 100,000 children and youth under 21 years of age are enrolled in the District's Medicaid program. DHCF FY2018 Performance Oversight Responses, Q31, *retrieved from*: https://dccouncil.us/wpcontent/uploads/2019/04/dhcf.pdf. DBH notes that as many as 20% of children and adolescents may have a mental health disorder that can be identified and require treatment. Department of Behavioral Health, *Children, Youth, and Family Services website*: "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." *Retrieved from*: https://dbh.dc.gov/service/children-youth-and-family-services. This means that more than 20,000 children covered by Medicaid in DC likely have a mental health disorder that can be identified and requires treatment, but year after year, the data shows that far fewer publicly insured children in DC receive mental health services. DHCF FY2018 Performance Oversight Responses, Q31 (Of the 101,707 children enrolled in Medicaid, 12,968 children – approximately 13% - received behavioral health services), *retrieved from*: https://dccouncil.us/wp-content/uploads/2019/04/dhcf.pdf; DHCF FY2017 Performance Oversight Responses, Q40 (Of the 98,929 children enrolled in Medicaid, 11,964 children – approximately 12% - received behavioral health services); DHCF FY2016 Performance Oversight Responses, Q39 (Of the 101,359 children enrolled in Medicaid, 16,219 children – approximately 16% - received behavioral health services), *retrieved from*: https://dccouncil.us/wp-content/uploads/2018/budget_responses/Binder1_Part7.pdf.

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