dc's CHILDREN'S LAW CENTER family. health. education.

501 3rd Street, NW · 8th Floor
Washington, DC 20001
T 202.467.4900 · F 202.467.4949
www.childrenslawcenter.org

Testimony Before the District of Columbia Council
Committee on Health and Committee on Facilities and Family Services
December 6, 2023

Public Hearing:
Bill B25-0500, Alternative Restorative Therapy Options for Youth Amendment Act of 2023 and Mental Health in the Child Welfare System

Megan Conway
Senior Attorney and Policy Liaison
Children's Law Center

Introduction

My name is Megan Conway, and I am a Senior Attorney and Policy Liaison at Children's Law Center. Children's Law Center believes every child should grow up with a strong foundation of family, health and education and live in a world free from poverty, trauma, racism and other forms of oppression. Our more than 100 staff – together with DC children and families, community partners and pro bono attorneys – use the law to solve children's urgent problems today and improve the systems that will affect their lives tomorrow. Since our founding in 1996, we have reached more than 50,000 children and families directly and multiplied our impact by advocating for city-wide solutions that benefit hundreds of thousands more.

Thank you for the opportunity to testify today about my clients' experiences and the obstacles we encounter navigating the behavioral health and child welfare systems together. I just celebrated ten years with Children's Law Center in October. In over a decade in this role, I have seen consistent barriers when clients need to connect to services in the public system. My testimony will note challenges related to 1) intake, 2) wait times, and 3) the availability and accessibility of qualified providers. I hope I can illuminate the pain points where improvements can be made, so that children – and caregivers – involved with CFSA can connect to essential behavioral health services.

The Process of Finding a Provider for Required Services is an Ordeal

A child or caregiver is referred for behavioral health services through a variety of pathways. For children, an evaluation by CFSA often indicates that therapy is needed. For caregivers, CFSA may recommend, or the court may order, participation in therapy as a requirement to

reunify with their children. The Assessment Center, located in the Superior Court and contracted through DBH, conducts court-ordered assessments for family court involving child welfare, juvenile justice forensics and domestic relations. These assessments often serve as the road map for CFSA's expectations of a parent and are incorporated into case planning and "reasonable efforts" determinations. My colleagues and I have noticed, in our collective review of hundreds of psychological and psychiatric evaluations, that many of the recommendations are repetitive and are not well-tailored to the specific needs of the client. For example, evaluations will recommend a therapy modality when the person's case file shows they have already tried it and their team concluded it was inadequate. When an intervention is court ordered, it is especially important for it to be individualized and clinically appropriate for the individual in question.

It is also varied where services may be sought – whether within CFSA's Office of Well-Being (OWB), a Department of Behavioral Health Core Service Agency (CSA), in the Medicaid provider network, and/or through private providers. Tracking down the service can be an ordeal for my clients. Imagine a teen trying to wade through the bureaucracy in the midst of major life upheaval, to get a service they may or may not want. The majority of clients and caregivers start out being referred to a DBH CSA via the Access HelpLine – where they may be told to go back to CFSA – or they have to search for a provider through Medicaid.

Once a provider for a needed service is eventually identified, the next hoop is the intake process. The wait for the intake appointment may be weeks or months out in the future. It then requires the wherewithal to complete the diagnostic assessment with one person, initial

psychiatric meeting with another, wait for recommendations, then wait to get linked to someone new for the therapy. There does not appear to be a centralized entity for intakes that can see which providers have current availability and schedules appointments. There is no centralized waitlist – which would greatly simplify the process.

In my view, the intake process at DBH is poorly attuned for teenagers and young children in these circumstances. They have often internalized a message that the problems in the family are their fault and that *they* need to be fixed. When a teenager is motivated, the process between saying "yes" and sitting down with a therapist should not take weeks or months. This is the same for adults, but they tend to be more willing to persevere through administrative headaches to fulfil court orders than children. The administrative burden is entirely different in the rare occasion that we are able to find therapy outside of the public system, which demonstrates that it can be done more effectively.

The Extreme Wait Times to see a Therapist Are Detrimental to My Clients

When a family is in crisis, every single day waiting for services matters, but my clients consistently experience extremely protracted waits to see a therapist. Two of my young clients recently waited over ten months to be connected to a therapist. Another client – a parent – was court-ordered to participate in individual therapy to reunify with their children. They waited six weeks to be linked to a CSA and complete the intake process, then waited at least four months to be assigned a therapist. At that point, they tried to expedite their ability to get services – they were very motivated to get their children back and this was a court ordered prerequisite to reunifying – and tried to switch CSAs. They completed the necessary process

to connect, again, but were on a waitlist for another four-to-five months. Finally, they were assigned a therapist, and started to build a rapport. Then the therapist quit and left the CSA, and the client was returned to the waitlist. After nearly a year, they were back at the beginning. It's important to keep in mind that, per federal law, if a parent does not reunify with their children within 15 months, the government must move to terminate the parental rights and work toward adoption.[1]

It is common for my clients to wait for many months; the waitlists for more specialized programs can last years. High staff turnover forces people to start over, from the beginning, with new clinicians every few months. This leaves a case unresolved, but not frozen in time. Long waits can lead to further distress and deterioration of conditions.

Across providers, it is specifically difficult to find appointments after school or business hours, with no weekend availability. For example, a client's parent who works full-time, 8am-6 pm, struggled to find court-ordered family therapy that works for their schedule. DBH and CFSA did find one therapist willing to do evening appointments, but only virtually. Unfortunately, my client, a teenager, really struggles to focus and engage virtually, and has asked for in-person therapy. Apparently, very little exists to accommodate parents who are employed during traditional work hours.

There are Simply not Enough Quality Providers Available

When a child or parent is highly motivated to get therapy, they should be able to get it. When it is ordered by the court, they should be able to get it. I have been regularly disappointed by the inability of the public system to meet my clients' needs, whether for therapy, substance use

treatment, or domestic violence interventions. While I have seen some excellent therapeutic providers help clients and caregivers make progress, I have seen many more examples over ten years when the needed service did not exist, when clinician turnover let my patients down, when in-person therapy was impossible to find, and when licensure changes eliminated an entire service type.

These families need and deserve highly trained, experienced mental health clinicians. In several instances, clients have been let down by clinicians falling short of expectations. One of my teenage clients – who really wanted therapy – would often get texts canceling her weekly appointments. Another client was referred to a therapist for weekly therapy to address severe anxiety, and the therapist went on leave without anybody else assigned to cover their case. This therapist returned after several months, but then left the agency. After two years of being linked to a core service agency for therapy, there was never a video call or in-person session.

While virtual therapy can expand access for some, it does not work for most young clients, especially reluctant adolescents who need significant rapport building. Virtual therapy is often all that is available to my clients, though community-based therapy used to be the norm and seemed much more beneficial. CSA therapists are difficult to reach or to engage in full team treatment meetings, or to consult when needed. There are no dialectical behavior therapy (DBT) providers, no multisystemic therapy (MST) providers, and barely any family therapy providers.

Licensure changes and obstacles can also pose difficulties. Recently, the new requirement that Community-Based Intervention (CBI) workers have a master's degree virtually eliminated CBI as an available service. Before 2022, I had CBI workers on over half my cases. Today, I have none.

Given the choice, I always advocated for a CFSA OWB therapist because it seems like the intake process is quicker than CSAs, and there is lower turnover among therapists than elsewhere. It is historically easier to reach them. However, as my colleagues from Children's Law Center have testified, there should not be a separate, siloed behavioral health system within CFSA. Providers for all kinds of needed services should be accessible in the wider system to families before, during and after CFSA. Something must be done to address the turnover and workforce shortages that lead to long waits and disappointing experiences.

I would also like to suggest a more user-friendly process – or a centralized place – to navigate public providers and which services they provide, with real time availability and relevant contact information.

Conclusion

The behavioral health system for children should deliver high-quality mental health and substance use services that meet the needs of children and families in DC, but that is not the norm for my clients. Whether services are court-ordered or voluntary, for kids or adults, they should be evaluated appropriately, referred thoughtfully, connected easily, and delivered effectively.

Thank you for the opportunity to testify on these important issues. I am happy to answer any questions you may have.

1 The Adoption and Safe Families Act of 1997 ("ASFA"), 42 USC 675 (5)(E)