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Testimony Before the District of Columbia Council
Committee on Health
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Public Roundtable:
The Oversight, Capacity, and Quality of In-Patient Psychiatric Facilities
and the Continuum of Behavioral Health Care in the District of Columbia

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Introduction

Good Morning, Chairperson Henderson and members of the Committee. My name is Kim Daulton, and I am a Ward 5 resident. I am testifying today on behalf of Children's Law Center, where I am the Director of Social Work. I have been practicing social work in the District of Columbia since 2004, starting as a Community Support Worker at a DBH Core Service Agency, and went on to be a child welfare social worker and supervisor before coming to Children's Law Center. The social work team at Children's Law Center works with both our Guardian Ad Litem and Healthy Together attorneys to assess client needs and identify appropriate interventions, including behavioral health services.[1]

Thank you for the opportunity to testify about inpatient psychiatric facilities and the continuum of behavioral health care in the District. Children's Law Center's clients include children who are in foster care, students with special education needs or health conditions, and caregivers who need legal support. Across our client communities, our attorneys and social workers spend a significant number of hours trying to identify and coordinate much-needed behavioral health services through the public system.

In my testimony, I will discuss how gaps in the behavioral health system[2] can lead to the escalation of behavioral health issues, repeated crises, acute inpatient psychiatric hospitalizations, and in some cases arrest and involvement in the delinquency system for youth in the District. These gaps include insufficient access to community-based

behavioral health services, inadequate crisis response systems, poor discharge planning and post-discharge services, and lack of both intermediate and long-term intensive treatment programs in DC.

The District's Continuum of Care is Inadequate and Exacerbates the Need for Inpatient Services

<u>For Many Youth Being Connected With Community Services is Onerous, Inefficient, and Creates Barriers to Care</u>

Our clients often struggle to find community-based behavioral health services due to protracted referral and intake processes, poor communication between teams supporting the child, and long waitlists for an appointment. For a child to access services through the public behavioral health system, they must go through a Core Service Agency (CSA). The Department of Behavioral Health (DBH) will administratively link a youth with a CSA to receive community support services or Community Based Intervention (CBI) services[3], and in many cases psychiatry/medication management. Therapy is also an option through the CSA. After DBH assigns a CSA to a youth, the CSA reaches out to the youth or to someone on that youth's team, typically within 2-10 days. Then, the CSA will conduct a lengthy intake, assessment, and diagnostic. This includes filling out forms and consents, which are sometimes more than 30 pages long. After the forms are completed, intake begins with administrative staff. The youth will then do a diagnostic assessment with a clinician, after which the clinician will make recommendations on services to be provided.

By the time this is completed, the youth has had to recall trauma and share an immense amount of information with multiple new people. Moreover, during this time, the youth remains without services until the CSA can assign them to a therapist or other appropriate services. We have had clients who have been administratively linked to a CSA and completed the necessary intake, but then had to wait months to be assigned a therapist and begin services. In our experience, this process has been onerous, inefficient, and is a barrier to our clients receiving services in a timely manner.

<u>Community Level Services are Inadequate to Meet the Needs of Youth in the District</u>

When youth actually begin to receive services from a CSA, we have been met with inadequate services for those in the foster system. One client, after waiting months to be assigned a therapist, was eventually assigned a therapist. The client then did not have any video or in-person sessions for two years, instead receiving only sporadic, unscheduled phone calls, which meant that the client could be in the middle of another activity and might miss the opportunity for therapeutic support. The client was not notified when the therapist was out on extended leave, or when they eventually left the CSA altogether. This created a significant level of distrust and emotional turmoil for the client. In another case, a client was working with a Community Support Worker (CSW), who is meant to provide a lower level of support than CBI. The CSW suddenly stopped responding to the client and the team, which prompted the client to ask for a higher level of support, and the client's team thought that CBI services would be a good fit. Several

different individuals on the team reached out to the CSA that the client was linked to begin the intake process for CBI services; however, we never received a response. It was over a month later that we learned from DBH that this CSA no longer provided CBI. In the meantime, the client had a behavioral incident where the police were called. It is critical that youth receive consistent communication from providers so that services are not delayed or disrupted.

The Crisis Response System in the District is Under resourced and Does Not Meet the Needs of Youth

When youth are not connected with appropriate, timely therapeutic support in the community, their behavioral health often worsens and can result in crisis situations requiring immediate and intensive interventions to stabilize the youth. In crisis response, we are again met with an under-resourced and inadequate system. The Child and Adolescent Mobile Psychiatric Service (ChAMPS) is one of the few crisis response options in DC specifically for youth.[4] ChAMPS used to be available to callers 24 hours a day, seven days a week, but DBH reduced the scope of the contract last year to exclude nights and weekends, instead using the Crisis Response Team (CRT)—who are not specialized for youth crisis response— to cover those times for youth.[5]

Even during business hours, in our experience, response times from ChAMPS are often very long. In multiple instances, when ChAMPS has been called for our clients, they have not been available or have not shown up for hours, resulting in 911 calls, emergency hospitalizations, and unnecessary interactions with police.[6] We have clients become

involved with the juvenile legal system due to behavioral health crises because instead of ChAMPS responding, the police did. Police interaction can be traumatizing for our clients. We have also had instances where no one responds to support our clients in crisis. In one case, a Court Appointed Special Advocate (CASA) had to take a client in an Uber to the emergency department because ChAMPS was not available.

We have also experienced first-hand how inadequate crisis response impacts placement for youth in foster care. As we frequently testify to, the District continues to experience a placement crisis, especially for foster youth with high behavioral health needs.[7] We have heard directly from foster parents that while they were once willing to be a placement for a youth, they are not anymore because of the lack of crisis response in the District. For foster parents, the delay in response greatly impacts their ability to feel supported in caring for youth with high behavioral health needs. Placement instability results in distrust amongst our clients and ruptured community connections. Having timely, appropriate crisis response not only stabilizes a client's behavioral health but also stabilizes their placement.

<u>The District Lacks the Appropriate Supports to Bridge the Exit From Acute Psychiatric Care</u>

It is clear to us that youth in crisis need specialized, dedicated, and timely responses to connect them to appropriate level of care.[8] For some, this may require hospitalization. Last year, CFSA reported that 25 children had one or more episodes of psychiatric hospitalization, and 12 children were in a Psychiatric Residential Treatment

Facility (PRTF).[9] In our experience, when a client is either hospitalized or admitted to a PRTF, there are many factors that make it difficult for a youth to exit this level of care successfully.

Crisis moments are an opportunity for change, and when clients are stabilized in the hospital but don't receive services in a timely manner after being discharged, their conditions can quickly deteriorate.[10] The short-term stabilization and treatment provided in the hospital setting cannot comprehensively treat their underlying issues, and without the appropriate follow-up, we miss a window of opportunity to truly stabilize and support the child while also providing supports and resources to their families and caregivers to help maintain their child's stability. Youth sometimes go in and out of hospitalization, sometimes with just days between each stay, because they do not receive meaningful post-discharge services after leaving the hospital. This cycle of hospitalization can be traumatizing and disruptive for youth and their families.[11]

Poor communication at discharge not only results in poor outcomes for youth, but also an exorbitant amount of wasted time and frustration for all those responsible for their care. For example, we had a client who was prescribed medication during inpatient hospitalization which required bloodwork, yet the discharge summary failed to include both that the bloodwork was necessary and that it did not occur during the inpatient hospitalization – leading to days of back and forth between the team and various providers to understand whether bloodwork still needed to occur and what next steps

should be taken to keep the youth stable. During these extremely stressful times for youth – many of whom have faced complex traumas – we should be ensuring that transitions are managed competently and efficiently by the various entities and individuals providing care.

While we understand hospitals to be an acute setting, it is often the only place where a youth has the services, supervision, and observation needed to meaningfully assess their needs and monitor their response to interventions like new medication. We are therefore concerned when youth are discharged after presenting as stable, in the hospital, for a very brief amount of time due to medication – without sufficient time to address side effects and to allow the time it takes for the medication to be fully working. Many of our clients can be apprehensive about medication in general and addressing side effects is important for the medication treatment to be sustainable. On the flip side, there are concerns that clients are held past clinical necessity due to CFSA's inability to find them a placement. We must strike the balance of ensuring that youth are fully stabilized while in the hospital setting and are released to an appropriate placement as soon as they are ready to do so. Yet the District's lack of intermediate levels of care services, which provide structured programming and treatment, including therapy, psychoeducational sessions, medication monitoring, and observation, creates a critical gap in supporting youth during this important transition time.

Intermediate levels of care services function as a "bridge" between inpatient and community-level services. Intensive Outpatient Programs (IOPs), Partial Hospitalization Programs (PHPs), and Bridging Clinics are models of intermediate-level care for youth that are transitioning from inpatient or residential care or who are not responding to community-based treatment.[12] These programs are often less traumatic than hospitalization, since they are less restrictive and allow youth to stay more connected with family, school, and other important aspects of their community and support system. They can help to prevent or reduce the length of psychiatric hospitalizations[13] and have been shown to improve psychological symptoms.[14]

The lack of any intermediate-level services also leads to more teens entering foster care, as it is common for teens to come into care after they are either discharged from a hospitalization – or are not admitted in the first place – and their parents don't feel they have the support to meet their child's needs. There is nowhere in the District for teens who are not stable enough to be home, but not *unstable* enough to be kept in the hospital.[15] Therefore, we sometimes have to turn to PRTFs, which for some clients are appropriate, but for others can become a last-ditch effort to "support" a client with high behavioral health needs. The lack of intermediate-level services also exacerbates the already strained capacity of community-based services, which hospitals must recommend for youth being discharged because no step-down or bridging programs exist in DC.

For clients who would likely benefit from longer-term inpatient psychiatric services at a PRTF, there is no local PRTF in the District. Clients often have often been left with no choice but to go to residential treatment facilities hundreds of miles away, far from their families, schools, and community supports.[16] And because many PRTFs give admission preference to residents of the state in which the facility is located, DC youth are at a further disadvantage in being able to access that level of care at all.

Moreover, youth who go to out-of-state PRTFs face additional barriers to successful discharge planning and implementation. In the majority of our cases where a youth is in a PRTF, we have been unable to get behavioral health services set up in the community ahead of discharge. In at least one case, this was because DBH required the child to be in-person in DC to even begin intake. It is a set up for failure to remove youth from a 24/7 structured and therapeutic milieu and put them directly into a community setting with little structure and no supportive services. We have had at least one client discharged from a PRTF without even a CSA, much less a provider, assigned to continue much-needed treatment and medication management. This means that there is little chance the child can get an appointment with a psychiatrist quickly enough to refill their supply of medication and receive needed ongoing treatment. Having a local PRTF would facilitate youth more successfully re-integrating into their community by allowing regular engagement with family and other community connections to practice implementing de-escalation and other skills learned at the PRTF and see where

adjustments need to be made to their behavioral health plan before they leave this intensive setting.

Recommendations for Improving the Continuum of Care in the District to Better Support Children and Youth's Behavioral Health

In 2021, Children's Law Center co-authored a report called *A Path Forward – Transforming the Public Behavioral Health System for Children, Youth, and their Families in the District of Columbia*, which details the obstacles and incomplete infrastructure in our current system. The recommendations most pertinent to this testimony relate to building out missing services in the continuum of behavioral health care and strengthening care coordination. *A Path Forward* makes several recommendations for to help close continued, persistent gaps in intermediate and community-level care. First, *A Path Forward* recommends that DC pursue "bridge" services modeled after the Children's Comprehensive Psychiatric Emergency Program (CCPEP) in New York City, which would address key needs including "step down" services for youth who are being discharged from emergency rooms and inpatient psychiatric units, and a crisis stabilization unit with extended observation.[17] Second, *A Path Forward* recommends establishing a pathway for creation and payment of certified community behavioral health clinics (CCBHCs), which are clinics designed via federal legislation to provide a comprehensive range of mental health and SUD services to under-resourced individuals.[18] Finally, *A Path Forward* also recommends establishing a local PRTF to prevent children and youth from having to travel out of state to Maryland, Virginia, or

often farther distances to seek needed services.[19] Based on our experiences and research, establishing CCPEP, CCBHC, and a local PRTF would improve the behavioral health continuum of care in the District.

The District also needs to improve care coordination to support youth who are entering and exiting inpatient psychiatric services. We recommend using the National Care Coordination Standards for Children and Youth with Special Health Care Needs (CYSHCN) which outlines guiding principles and core components of effective care coordination for children and their families.[20] *A Path Forward* also recommends increasing training and reimbursement for clinical and nonclinical providers, maximizing the use of peer specialists and community health workers, and requiring up-to-date provider directories.[21] Finally, we recommend increasing funding for ChAMPS and preserving a dedicated non-police response for behavioral health crisis calls for youth.[22]

We want our clients – and all DC children – to be able to access the appropriate interventions and supports that meet their needs. I truly believe an ounce of prevention is worth a pound of cure. For this to happen – and to ensure the effectiveness of acute crisis intervention and stabilization – we must have a functioning public behavioral health system with adequate capacity and a full continuum of services. Thank you for the opportunity to testify on this important topic. I am happy to answer any questions from the Committee.

[1] Children's Law Center attorneys represent children who are the subject of abuse and neglect cases in DC's Family Court. CLC attorneys fight to find safe homes and ensure that children receive the services they need to overcome the trauma that first brought them into the child welfare system. Additionally, Children's Law Center's (CLC) medical-legal partnership removes non-medical barriers to children's health and well-being—barriers such as poor housing conditions and lack of appropriate special education. Children's Law Center attorneys work from offices located inside pediatric clinics across DC, adding a lawyer to the health care team. Children's Law Center, About Us, *available at*: https://www.childrenslawcenter.org/content/about-us.

[2] A Path Forward, at p. 80. This chart is helpful to understand the continuum of care in the District.

[3] A CBI provider is ideally more available for a client, meeting with them 2-3 times per week, and is also supposed to be available if the client has a behavioral health crisis.

[4] Catholic Charities, Child and Adolescent Mobile Psychiatric Service, *available at*: https://www.catholiccharitiesdc.org/program/champs-child-and-adolescent-mobile-psychiatric-service/.

[5] DBH, FY 2023 Performance Oversight Responses, responses to Q44(h), *available at*: https://lims.dccouncil.gov/Hearings/hearings/247.

[6] Bread for the City v. District of Columbia, Civil Action No. 23-01945-ACR. *See* Press Release, American Civil Liberties Union (ACLU), *Lawsuit Challenging Armed Police Response to Mental Health Emergencies in Washington, D.C. to Proceed*, September 10, 2024, *available at*: https://www.aclu.org/press-releases/lawsuit-challenging-armed-police-response-to-mental-health-emergencies-in-washington-d-c-to-proceed. "The lawsuit contends that the District's emergency response system discriminates against people with mental health disabilities by deploying armed police officers to address the vast majority of mental health crises while sending trained medical professionals to most other health emergencies."

[7] Tami Weerasingha-Cote, Testimony Before the District of Columbia Council Committee on Facilities and Family Services, (February 21, 2024), *available at*: https://childrenslawcenter.org/wp-content/uploads/2024/02/TWeerasingha-Cote_Childrens-Law-Center-Testimony-for-Feb.-21-2024-CFSA-Oversight-Hearing_FINAL-002.pdf.

[8] Substance Abuse and Mental Health Services Administration, National Guideline for Child and Behavioral Health Crisis Care, *available at*: https://store.samhsa.gov/sites/default/files/pep-22-01-02-001.pdf.

[9] CFSA, FY2023 Performance Oversight Responses, response to Q76, *available at*: https://lims.dccouncil.gov/Hearings/hearings/253.

[10] "In this [2010] study, close to three-quarters of the rehospitalizations were experienced during the first year. The risk of rehospitalization was highest during the first 30 days following a first psychiatric hospitalization and remained elevated until about 90 days post-discharge… It underscores the vulnerability of youth psychiatrically hospitalized during the immediate post-discharge period and supports the need for explicit linkages between inpatient psychiatric care and community-based outpatient services… Rehospitalizations indicate that a youth continues to be in crisis." *See* James S, Charlemagne SJ, Gilman AB, Alemi Q, Smith RL, Tharayil PR, Freeman K. Post-discharge services and psychiatric rehospitalization among children and youth. Adm Policy Ment Health. 2010 Sep;37(5):433-45. doi: 10.1007/s10488-009-0263-6. PMID: 20063073; PMCID: PMC3077529. "Poor discharge practices and discontinuity of care can put children and youth at heightened risk for readmission, among other adverse outcomes." *See also* Chen A, Dinyarian C, Inglis F, Chiasson C, Cleverley K. Discharge interventions from inpatient child and adolescent mental health care: a scoping review. Eur Child Adolesc Psychiatry. 2022 Jun;31(6):857-878. doi: 10.1007/s00787-020-01634-0. Epub 2020 Sep 4. PMID: 32886222; PMCID: PMC9209379; Jabbarpour YM, Raney LE. Bridging Transitions of Care From Hospital to Community on

the Foundation of Integrated and Collaborative Care. Focus (Am Psychiatr Publ). 2017 Jul;15(3):306-315. doi: 10.1176/appi.focus.20170017. Epub 2017 Jul 12. PMID: 31975864; PMCID: PMC6519545.
[11] "Repeat hospitalizations disrupt social support and school performance and result in greater stimaitization for youths and their families." *See* Edgcomb JB, Sorter M, Lorberg B, Zima BT. Psychiatric Readmission of Children and Adolescents: A Systematic Review and Meta-Analysis. Psychiatr Serv. 2020 Mar 1;71(3):269-279. doi: 10.1176/appi.ps.201900234. Epub 2019 Dec 11. PMID: 31822241. *See also* Chen A, Dinyarian C, Inglis F, Chiasson C, Cleverley K. Discharge interventions from inpatient child and adolescent mental health care: a scoping review. Eur Child Adolesc Psychiatry. 2022 Jun;31(6):857-878. doi: 10.1007/s00787-020-01634-0. Epub 2020 Sep 4. PMID: 32886222; PMCID: PMC9209379.
[12] *A Path Forward*, at p. 88.
[13] "Within our classification schema, all types of post-discharge services reduced the risk of rehospitalization… the risk of rehospitalization was lowered 75-76% for youth who received a combination of intensive and nonintensive mental health services, those receiving only nonintensive outpatient mental health services, and those receiving other support services." *See* James S, Charlemagne SJ, Gilman AB, Alemi Q, Smith RL, Tharayil PR, Freeman K. Post-discharge services and psychiatric rehospitalization among children and youth. Adm Policy Ment Health. 2010 Sep;37(5):433-45. doi: 10.1007/s10488-009-0263-6. PMID: 20063073; PMCID: PMC3077529. *See also A Path Forward,* at p. 77; Jabbarpour YM, Raney LE. Bridging Transitions of Care From Hospital to Community on the Foundation of Integrated and Collaborative Care. Focus (Am Psychiatr Publ). 2017 Jul;15(3):306-315. doi: 10.1176/appi.focus.20170017. Epub 2017 Jul 12. PMID: 31975864; PMCID: PMC6519545.
[14] *How an Adolescent Partial Hospitalization Program Works*, Newport Academy, December 17, 2018, *available* at: https://www.newportacademy.com/resources/treatment/adolescent-partial-hospitalization-program/; Lenz SA, Del Conte G, Lancaster C, et al. Evaluation of a partial hospitalization program for adolescents. 2014. Counseling Outcome Research and Evaluation. 2014;5(1):3-16. doi.org/10.1177/2150137813518063; Gerson R, Havens J, Marr M, et al. Utilization patterns at a specialized children's comprehensive psychiatric emergency program. Psychiatr Serv. 2017;68(11):1104-1111. doi:10.1176/appi.ps.201600436. Jabbarpour YM, Raney LE. Bridging Transitions of Care From Hospital to Community on the Foundation of Integrated and Collaborative Care. Focus (Am Psychiatr Publ). 2017 Jul;15(3):306-315. doi: 10.1176/appi.focus.20170017. Epub 2017 Jul 12. PMID: 31975864; PMCID: PMC6519545.
[15] *A Path Forward*, at p. 77, 88.
[16] *A Path Forward,* at p. 80, 88, 218.
[17] *A Path Forward,* at p. 77.
[18] *A Path Forward,* at p. 61, 74.
[19] *A Path Forward,* at p. 93.
[20] *A Path Forward,* at p. 75-76.
[21] *A Path Forward*, at p. 59-61, 96, 115.
[22] Amber Rieke, Children's Law Center Testimony before District of Columbia Committee on Health, (April 10, 2024), *available at*: https://childrenslawcenter.org/wp-content/uploads/2024/04/A-Rieke_Committee-on-Health_DBH-FY25-Budget-Testimony_FINAL.pdf.