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

Testimony Before the District of Columbia Council
Committee on Health and Committee on Facilities and Family Services
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Public Hearing:
Bill B25-0500, Alternative Restorative Therapy Options for Youth
Amendment Act of 2023 and Mental Health in the Child Welfare System

Children's Law Center
Tami Weerasingha-Cote, Senior Supervising Policy Attorney
Amber Rieke, *A Path Forward* Project Lead

**Introduction**

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 the scale and scope of unmet behavioral health needs of the District's foster children and their families, as well as B25-0500, the Alternative Restorative Therapy Options for Youth Amendment Act of 2023 ("ART Bill"), which seeks to address one aspect of those needs.

Each year, Children's Law Center attorneys serve as guardians *ad litem* for several hundred children in foster care and protective supervision – more than half of all children in the care and custody of the Child and Family Services Agency (CFSA).[1] As a result, we see firsthand the multitude of behavioral health needs our clients experience and the impact on them when access to appropriate treatment services is delayed or denied. We also see our clients' birth parents, foster parents, and kin caregivers similarly struggle to access behavioral health services, which ultimately impacts the well-being and stability

of the child because it creates sometimes insurmountable obstacles to reunification, adoption, or an otherwise stable living and caregiving situation. These are not new problems. The harms our clients have experienced for years due to the District's broken and fragmented public behavioral health system have compelled Children's Law Center to make behavioral health system reform a top priority for close to a decade.[2] We've partnered with organizations across the city, as well as government agencies and the Council, to identify and address the gaping holes in our public behavioral health system and continuum of care.[3] We are extremely pleased that the Committees on Health and Facilities and Family Services have joined forces today to focus – and hopefully take decisive action – on this issue.

The bill before the Committees today seeks to improve foster youth's access to behavioral health services by requiring CFSA to provide children in care with alternative forms of expressive therapy.[4] Although we support this effort to increase foster youth's access to services, we must emphasize that the responsibility to ensure all children who receive their health benefits through Medicaid – including foster children – have access to the best and most therapeutically appropriate behavioral health treatments, services, and interventions rests with the District's health agencies – the Department of Behavioral Health (DBH), the Department of Health Care Finance (DCHF), and the Department of Health (DC Health).[5] Although CFSA has built some capacity to provide behavioral

health services to foster youth itself, CFSA cannot compensate for DC's broken public behavioral health system.

To assist the Committees with understanding the behavioral health needs of foster youth and what can be done to better meet these needs, our testimony today will: (1) briefly describe our clients' need for and struggle to access behavioral health services; (2) provide feedback on the proposed legislation; (3) explain why CFSA cannot and should not be considered a substitute provider of behavioral health services for foster youth; and (4) identify concrete steps the Committees and the Council can take to improve the specific aspects of the behavioral health system that are most significantly impacting our foster youth.

**Youth in Foster Care Experience a Vast Array of Unmet Behavioral Health Needs**

Children who have been removed from their parents and placed into foster care due to substantiated allegations of abuse and neglect almost universally experience significant trauma that impacts their mental and behavioral health.[6] This trauma – due to conditions existing prior to their removal or to the removal itself – may or may not result in a diagnosable mental health condition, but the majority of children in care need behavioral health supports to address the pain and stress they have experienced. They also need support to help them and their caregivers (birth parents or others) work through relationship challenges, achieve stability and permanency, and exit CFSA's custody.[7]

After reviewing several hundred of our most recent cases, we found that more than a third of our clients had at least one diagnosed mental health condition, including ADHD, depressive disorders, anxiety disorders, bipolar disorders, trauma and stressor related disorders (like PTSD), dissociative disorders, and/or disruptive, impulse-control, and conduct disorders. Of these clients, many presented with ongoing emotional and behavior dysregulation and some with suicidal thoughts, problem sexual behaviors, and histories of sexual abuse.[8] Further, approximately twenty percent of our clients had additional behavioral health needs that were not captured by a specific mental health condition diagnosis, including anger issues, incontinence, recurring nightmares, substance abuse, grief, disordered eating and/or they were witness to or victim of violence.[9] An additional quarter of our clients had suspected mental health conditions but were not formally diagnosed.[10]

Although our clients are arguably amongst the children with the greatest and most urgent need for behavioral health services, our clients frequently struggle to access some of the most basic behavioral health services our system should be able to provide them – including quality individual and family therapy, substance abuse treatment, and medication management appointments.

The most significant obstacle to our clients accessing critical services is the lack of behavioral health care providers in the District's health system. Our clients are frequently

unable to find providers offering the services they need – or if they manage to find a provider, the waitlist for an appointment is prohibitively long.

Even when our clients successfully connect with a provider, they encounter issues of quality and cultural competence (issues that are both rooted in the overall lack of providers), as well as frequent turnover. Post-pandemic, many providers are unwilling to provide services in-person or outside of regular business hours – another problem reinforced by the shortage of providers. The services our clients need most – therapy and counseling – rely on interpersonal connections. Providers with appropriate language skills and cultural competence are critical to these services being successful. Frequent turnover, inconsistent provider availability, and lack of in-person services also make it very hard for children to stay engaged with their services – and as a result many of our clients ultimately give up on finding the behavioral health services they need.

**The Proposed ART Bill Seeks to Increase Access to Services, But Foster Youth Need Access to the Full Range of Therapy Modalities that Support Healing**

There are a multitude of behavioral health interventions that children and families may need. For different diagnoses and patients, there are best practices for treatment.[11] For example, episodic trauma is a different treatment route than complex trauma. What is appropriate for a five-year-old is different when they are ten. Some techniques lend themselves to virtual visits better than others.[12]

Ultimately, when a child and family need any kind of therapeutic intervention, it must not only be available, but also high-quality and appropriate for the age, culture, and language of the patient.[13] Any service on the continuum of care must also consider the social environment of the patient. For children, who have limited control over their environment, successful therapy should also support the young person's caregivers and family functioning. Services are not one-size-fits-all.[14]

The proposed ART Bill recognizes the importance of ensuring children in foster care have access to a range of therapies that support managing mental health challenges or healing from difficult experiences. Specifically, the proposed legislation requires CFSA to: (1) "connect all children who are assessed as being in need of behavioral health care to an appropriate behavioral health service," and (2) "make available to children in the agency's custody alternative forms of therapy," including art therapy, music therapy, drama therapy, dance or movement therapy, and narrative therapy.[15]

Children's Law Center supports this effort to expand access to appropriate treatments for children with behavioral health needs. The proposed legislation, however, requires clarifications regarding its scope and the mechanisms by which services will be delivered.

To ensure the legislation is appropriately scoped to the intended population, we recommend revising the language requiring CFSA to connect "all children" to behavioral

health services to clarify that CFSA is required to connect "all children in the care and custody of the Agency."

Second, the proposed legislation should clarify how the Agency shall "make available" the listed alternative therapies. If the obligation to ensure access to expressive therapies is to fall on CFSA, the bill needs to be more specific about how the agency will facilitate this access. It does not seem realistic or efficient to hire full-time therapists in each of these five modalities – plus supervisors of the same training – within the Office of Well-Being. The cost of alternative therapies should be covered by Medicaid, but the District has so few providers that offer these modalities and even fewer who accept Medicaid. This means that the cost of these services will likely need to be paid for with local dollars. Access could potentially be created through a contract with an existing private provider – or funds could be made available to pay for private practice services. In any case, if the intent of the proposed legislation is to require CFSA to provide access to alternative therapies outside of the public behavioral health system (i.e., not through the District's Medicaid program), then it should specify the mechanism by which CFSA is supposed to provide these services and ensure all necessary funding is provided.

One final note – the list of behavioral health services our clients struggle to access is far more extensive than the alternative therapies listed in the proposed legislation. Ultimately, we want our clients – and every child in the District – to be able to access the most appropriate therapeutic intervention or service that will meet their behavioral

health needs. This means that all children must have access to all services, treatments, and programs. For this to happen we must have a functioning public behavioral health system with a full continuum of services and adequate capacity to meet the needs of the District's children.

**Although CFSA Provides Some Behavioral Health Services, CFSA Cannot Compensate for DC's Broken Public Behavioral Health System**

In 2018, CFSA's Office of Well-Being redesigned its mental health services program with the twin goals of: (1) ensuring timely and accessible services; and (2) centralizing mental health assessments, direct therapy, and medication management.[16] OWB's therapeutic team includes a clinical supervisor, four licensed therapists, and a licensed psychiatric nurse practitioner.[17] This team conducts initial assessments and screenings, provides short-term mental and behavioral health services, and makes referrals for longer-term or higher level therapeutic services.[18] This team also provides emergency therapeutic services to children in crisis.[19]

Recognizing that many foster children and their families need behavioral health services beyond what the in-house team can support, and seeking to facilitate quicker access to these services, in 2019, CFSA contracted with mental health provider MBI Health Services to provide out-patient therapeutic services for CFSA- involved children, youth, parents, and caregivers.[20] It is notable, however, that although MBI has capacity

to serve 150 children and 75 parents or caregivers, during FY 2021, MBI served only 12 clients referred by CFSA; and during the first half of FY 2022, MBI only served 8 clients.[21]

Despite these efforts by CFSA, the vast majority of behavioral health services needed by CFSA-involved children and families must be provided by DC's network of providers who accept Medicaid. It is simply not possible for CFSA alone to develop the in-house capacity needed to meet all the behavioral health needs of CFSA-involved children and families. To expect this would be akin to expecting CFSA to build a separate healthcare system to meet all the physical health needs of CFSA-involved children and families.

There are also significant drawbacks to CFSA serving as a direct provider of behavioral health services to foster children and their families. First, there is a basic trust issue that arises from children (and sometimes their birth parents) receiving therapy from the Agency that separated them in the first place. Children may not feel safe to fully share about their experiences, if they are concerned that what they tell their CFSA clinicians will influence their case.

Second, although CFSA's therapists provide some services to families, their services primarily focus on children in care.[22] This means that in most cases, birth parents and caregivers are not integrated into the child's treatment program, even though caregivers control the child's environment and family therapies can be very impactful. Further, many birth parents and caregivers who need their own mental health services to

stabilize relationships with the child or even to reunify with their children, aren't eligible to receive services from the Agency, even when they struggle to access required services in the broader health system. We need continuity of care and services for all members of the family to serve the child's stability and well-being.

Third, CFSA's in-house services are intended to be short-term, lasting only until the child is connected with a Medicaid provider in the community, or until the child's case closes. This is not ideal under either circumstance. Transitioning a foster child to a Medicaid provider after six or twelve months of services disrupts the therapeutic relationship. It requires the child to start over and share their trauma again with a new provider. Alternatively, if the child's case closes, they lose access to CFSA's in-house services at a time of major transition and when they are most likely to need that service.

Finally, CFSA's in-house team is small. It is unlikely they will be able to meet the needs of every foster child. For example, we had a client who needed to work with a male therapist – but CFSA's in-house team did not have a male clinician, so our client was unable to engage in CFSA's services.

We note these limitations not to disparage CFSA or their clinicians, but to underscore that the nature and reach of the in-house structure is limited. We appreciate the efforts the Agency has made to address the critical shortage of behavioral health services for our clients. The Agency, however, should not have to create a secondary public behavioral health system in-house to meet the needs of children in the District's

care. It is the District's health agencies – DBH, DHCF, and DC Health – who are primarily responsible for ensuring the District's network of Medicaid providers is sufficiently deep, broad, and high-quality to meet the needs of all the District's children – including foster children.

**Underlying Systemic Challenges Must Be Addressed to Give Foster Youth and Their Families Meaningful Access to the Full Continuum of Behavioral Health Care**

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*.[23] It is the product of extensive collaboration, research and stakeholder input. Our report charts the obstacles and details the incomplete infrastructure in our current system. It also offers a map for improvement, with 94 concrete recommendations to create a future where services are not only available, but timely, high quality, culturally appropriate, equitable, and sustainable. The analysis and recommendations within *A Path Forward* are organized in the six domains that the World Health Organization identifies as necessary to a functioning public health system: leadership and governance, financing, workforce, service delivery, information and communications, and technology. The major issues related to today's discussion of why our clients cannot get what they need include, in brief:

- workforce shortages among behavioral health professionals of all kinds.
- insufficient and unsustainable financing for public behavioral health services.

- scarcity of necessary services and facilities, especially catering to intermediate and acute levels of need.
- deficiency of publicly available data on the prevalence of behavioral health conditions or treatment, program effectiveness, or workforce information to inform planning.
- siloing where coordination should occur – between agencies, among providers, and between providers and the government.

The report was released in December 2021, during major transitions in public health and care delivery. Alongside the disruptions of the COVID-19 public health emergency, the District government increased investment in school-based behavioral health programs, integrated behavioral health into managed care contracts, and successfully applied for a Medicaid waiver to cover additional services. These investments show a commitment to tackling key structural and funding barriers.

The District must keep moving toward the goal: an effective and complete continuum of care that includes promoting behavioral health, prevention of mental illnesses and substance use disorders, early identification, treatment, recovery and rehabilitation services, and long-term supports, for every age and every ward. To get there, we call on the District in the year ahead to:

- **Commit to producing a strategic plan for children's behavioral health**, calling on the full behavioral health apparatus and relevant stakeholders, including

government agencies, community groups, clinicians, hospital, primary care and other service providers, public and private insurance, schools and educators, advocates, families, and youth in the District.

- **Maintain investments in prevention and early intervention programs** such as HealthySteps and School-Based Behavioral Health, to increase support available from skilled, caring adults.
- **Build services and facilities specifically for youth**, including residential substance use disorder (SUD) treatment, partial hospitalization programs, a "bridge clinic" and/or psychiatric residential treatment beds.
- **Share program evaluations, data, and processes** to inform planning and delivery, and implement the recommendations generated in our report and many others, including government groups like the Mayor's Healthcare Workforce Task Force and the DC Auditor.[24]
- **Invest in deliberate workforce development and retention, and explore more inclusive staffing models** across all position types to improve access to services across the system.
- **Increase reimbursement rates from CFSA, DBH and Medicaid** to better support an adequate and diverse network of child-serving providers.

***Commit To Producing a Strategic Plan for Children's Behavioral Health***

Just as a clinician will diagnose a patient and tailor a detailed treatment plan, our ailing behavioral health system needs a full workup. DC's former Department of Mental Health created the District's first-ever comprehensive "Children's Plan," which was last updated over a decade ago in May 2012.[25] Since then, the District has successfully collaborated and executed other plans to tackle pressing, complex issues which serve as models, such as the Interagency Council on Homelessness' *Homeward D.C.* and *Homeward D.C. 2.0* strategic plans.[26] We need this kind of detailed, actionable, measurable plan to make meaningful change.

The expeditious production of a coordinated vision across agencies and sectors should be initiated in the Fiscal Year 2025 budget.[27] Based on other plans, we expect it would cost about $300,000 per year. If a subtitle was included in the Budget Support Act in the spring, the government could begin the process of contracting an entity to lead and coordinate the work to develop the plan, and the Council could expect a plan to review at the beginning of the 2026 fiscal year. This would also, of course, require oversight to ensure the deadlines are met and that the process is inclusive of all relevant stakeholders (including government agencies, community-based organizations, clinicians and professionals, community members, hospital, primary care and other service providers, public and private insurers, school leaders and educators, and, of course, District families and youth). Ongoing Council engagement is required to ensure the final plan is effectively implemented.

*Maintain Investments in Prevention and Early Intervention Programs*

The District should maintain – and expand – programming that promotes well-being through skilled support available from caring professionals in accessible settings. For example, HealthySteps is a national, evidence-based model that provides families with infants and toddlers social-emotional and development support by integrating child development specialists into pediatric primary care, increasing their access to appropriate health screenings, system navigation support, and connection to resources in one central place.[28] Prevention is embedded in the School-Based Behavioral Health program (SBBH); Tier 1 services include social-emotional lessons for all students, and Tier 2 are more targeted, such as group sessions to build skills and navigate difficult moments. Topics for Tiers 1 and 2 include conflict resolution, emotional intelligence, healthy relationships, bullying, suicide prevention, positive coping strategies, boundaries around social media, self-care, etc. Sufficient funding for the professionals in these programs is crucial to their longevity and success. Specifically, in Fiscal Year 2025, we will be looking for adequate funding for HealthySteps ($1.35 million), Healthy Futures ($3.64 million local dollars), and SBBH clinician compensation (about $25 million).

*Build Services and Facilities Specifically for Youth*

An effective and complete behavioral health system should include both prevention *and* treatment of mental illnesses and substance use disorders, early identification, therapy, recovery and rehabilitation services, and long-term supports.

Many categories of treatment are either partially or entirely lacking in our current system. In addition to increased number of providers, there must be more kinds of services and facilities added to the system. Intermediate levels of care services refer to acute or intensive services provided in the community or outpatient settings. Examples include Intensive Outpatient Programs (an alternative to or transition from residential or inpatient care), Partial Hospitalization Programs (short term, full-day treatment programs for adolescents experiencing acute psychiatric symptoms but not in need of 24-hour care),[29] as well as Youth Crisis Stabilization Units (often co-located in a hospital emergency department).[30] These services provide a safe, secure, and less-restrictive environment for short-term evaluation and intervention, with the goal of working toward stabilization with the individual and their family. The lack of intermediate levels of care options means that youth may be served at a level of care that is insufficient for their needs, which leads to costly, avoidable inpatient psychiatric admissions, excessive numbers of patients boarding in the emergency department, patient/family dissatisfaction, and poor patient outcomes.

There are likewise very few options for the most acute services. There are currently no residential substance use treatment facilities for young people in DC. There are only a few psychiatric beds for youth in the District, no therapeutic group homes or community residences, no psychiatric residential treatment facilities (PRTFs), and no "bridge" services for youth who are being discharged from hospitalization. With no psychiatric

residential services in our borders, families (or CFSA) must send young people out of state to Maryland, Florida, or often further distances for much-needed residential services. This separation can cause trauma in and of itself, and caregivers are not functionally incorporated into treatment during or after discharge.

One impactful service the District could pursue is a "bridge clinic" or Children's Comprehensive Psychiatric Emergency Program (CCPEP) model. A CCPEP bridge clinic could address two key needs: crisis stabilization unit with extended observation, and "step down" services for youth who are being discharged from emergency rooms or inpatient psychiatric units. Another approach would be to expand DC Mental Health Access in Pediatrics (DC MAP) – a consultation service for pediatric primary care providers – to include psychiatry access services for patients discharging from hospitals or in need of substance use disorder expertise.

***Share Program Evaluations, Data, and Processes***

For effective oversight and functioning, the DC Council and other stakeholders need access to important data collected by agencies. Unfortunately, there are several reports the public is still waiting to see. Results from the DC Council-mandated cost study of the SBBH program from DBH were due December 2022, but the study has not been shared a year later. Additionally, it is our understanding that program evaluations for SBBH conducted by ChildTrends are completed for school year 2020-21 and school year 2021-22 but have likewise not been released.

In addition to DBH's internal evaluations, several governmental and external reports have made recommendations for data sharing that could be picked up, in addition to *A Path Forward*. The DC School Behavior Health Stakeholder Learning Community (SLC) Report offers a robust source of recommendations and best practices for school-based behavioral health.[31] The DC Auditor worked with Georgetown University Center for Global Health Science and Security on the 2023 report *COVID-19 & Behavioral Health in the District of Columbia* which emphasizes how the COVID-19 pandemic exacerbated ongoing concerns about public data collection, coordination and availability for behavioral health.[32] It concluded that "DBH should coordinate with care providers across the District to define data sources and metrics to track needs for behavioral health services, especially among youth." Further, it recommended that D.C. government develop reporting requirements for District providers in both public and private behavioral health systems, including counts of individuals served, grouped by age and type of service, capacity of each service provider across each domain, length of wait time to receive care/services (beyond DBH and Medicaid), and attrition from waiting lists (e.g., enrolled but never seen).[33]

Lastly, *A Path Forward* notes that there is no standard of measures or metrics for assessing and reporting on quality of care and services. This is true across the different agencies and providers of behavioral health services. There is also a need to develop

meaningful qualitative data collection methods to track and assess consumers' perceptions of quality of the services they are receiving.

***Invest in Deliberate Workforce Development, Retention, and More Inclusive Staffing Models***

As the District is seeing for health and social services professionals across programs, DC must fund competitive salaries – with increases for inflation – to attract and retain a robust, consistent workforce. The Mayor's Healthcare Workforce Task Force recently called for many concrete actions, including "adoption of healthcare reimbursement policies that support workforce retention for experienced members of the healthcare workforce [...] and adjusting provider payment rates based on beneficiary social risk stratification."[34] It also recommends setting "a payment floor for District healthcare workforce wages at 120% of the District's Living Wage or minimum wage, whichever is greater, to ensure competitive wages and access to apprenticeship training funding" through federal programs, and enhancing healthcare worksite wellness and safety.[35] The full document of recommendations should be actively pursued.

The District should also think more creatively and inclusively about the kinds of professionals equipped to serve children and families across the behavioral health service continuum. Namely, Community Health Workers (CHWs) are trusted and trained individuals who serve as the bridge between health care systems and their communities.[36] There is strong evidence supporting the integration of CHWs into health care teams to provide services such as care coordination and system navigation, leading to improved

health care outcomes and reduced costs.[37] Many other states have more fully embraced the use of Community Health Workers (CHWs) in healthcare service delivery. As another example, the Strengthening Families Coalition is encouraging SBBH to pilot integrating non-clinical staff into SBBH teams, to deliver the Tier 1 and 2 services described above. In every case, sufficient and sustainable funding mechanisms must accompany these staffing strategies.

***Increase Reimbursement Rates from CFSA, DBH and Medicaid***

We have reiterated the imperative for an adequate and diverse network of child-serving providers to deliver behavioral health care in the District. This cannot be done without sufficient pay for providers. Programs need adequate grant funds (see HealthySteps and SBBH above), and providers must be sufficiently reimbursed for their services in hospitals, health centers, primary care, and private practice offices, if they are to participate in public services like Medicaid.

Contracts with community-based organizations for delivery of essential services must support skilled professionals to stay in jobs and provide services on call. However, this requires the District to supplement or correct current grant amounts. For example, the funding for the Child and Adolescent Mobile Psychiatric Service (ChAMPS) responds to behavioral health crisis calls for young people; this used to be available 24/7. Unfortunately, the contract was reduced this year to exclude important night and weekend services. In previous years, the District was able to use large federal infusions

like the American Rescue Plan ACT (ARPA) to supplement program funds, including the CBO grants for SBBH. With ARPA funds expiring this year, the base salary of clinicians must be adjusted to compensate for the loss of these and other one-time funds.

Public health insurance programs in the District, like Medicaid Managed Care Organizations (MCOs), must offer competitive provider reimbursements to encourage behavioral health providers to participate in public insurance plans. Providers have many options for work in the service landscape outside of Medicaid, but it is in our best interest to compel them to participate. A recent report from the National Bureau of Economic Research demonstrates that more competitive Medicaid reimbursement rates are tied to better access to care and outcomes for children.[38] Provider reimbursements rates should be updated regularly to remain competitive in evolving markets. Additionally, billing processes should be easy to navigate, and reimbursements should be timely enough to avoid disruptions to providers' businesses.

It is critical for DHCF to not only routinely monitor but also enforce "network adequacy" within MCOs. Meaningful measures of behavioral health network adequacy standards should go beyond the federally mandated standards (which include travel time and distance standards)[39] and should have strong correlations with access to and quality of care.[40] All network adequacy standards should be tied to accountability mechanisms that are regularly and transparently enforced. More details on these recommendations – and others – are laid out in detail in *A Path Forward*.

## Conclusion

If we hope to deliver effective, comprehensive, and sustainable behavioral health care to District children and families – including those in CFSA's care – we need to accelerate the momentum. Today's conversation is an important mile marker on the journey.

Children's Law Center believes that when a child – or family – needs any kind of therapy, it should be available. We strongly support efforts to create access to expressive therapies for children in care. It is unsustainable and undesirable, however, for CFSA to create every needed service in-house. We are concerned about approaches that reinforce siloed stopgaps rather than address the underlying systemic challenges. The existing model is too limited to truly meet a child's long term mental health needs. DC's children and families need more support, including ART and beyond. To begin to deliver these important therapies, we must have hard conversations about why they are missing in the first place. We must think more broadly about creating access in the public behavioral health system, so that all kids get the services they need when they need them.

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[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. DC Children's Law Center, Who We Are, available at: https://childrenslawcenter.org/who-we-are/. The term "protective supervision" means a legal status created by Division order in neglect cases whereby a minor is permitted to remain in his home under supervision, subject to return to the Division during the period of protective supervision. D.C. Code § 16-2301(19).

[2] Reports, news and policy testimonies by Children's Law Center staff dating back to 2013 are available at: https://childrenslawcenter.org/search/behavioral+health/.

[3] Children's Law Center is the chair of the Strengthening Families Through Behavioral Health Coalition. Our vision is to ensure DC has a fully integrated behavioral health care system in which all students, children, youth, and families have timely access to high-quality, consistent, affordable, and culturally responsive care that meets their needs and

enables them to thrive. Our coalition is composed of advocates, parents, educators, community-based organizations, and behavioral health providers. Learn more at: https://www.strengtheningfamiliesdc.org/.

[4] B25-0500, *Alternative Restorative Therapy Options for Youth Amendment Act of 2023, available at:* https://lims.dccouncil.gov/downloads/LIMS/53951/Introduction/B25-0500-Introduction.pdf?Id=177068.

[5] The Department of Behavioral Health (DBH) oversees the city's public mental health and substance use services. Department of Healthcare Finance (DHCF) administers the District's Medicaid plan, under federal oversight from the U.S. Centers for Medicare and Medicaid Services (CMS). The Department of Health (DC Health), specifically the Health Regulation & Licensing Administration, performs a regulatory role through the licensure of behavioral health practitioners and health care facilities. Other agencies are also involved in the governance of the behavioral health system through their mandate to serve children who are negatively impacted by certain social determinants of behavioral health. For example, the Department of Human Services (DHS) is responsible for addressing youth homelessness, while the Child and Family Services Agency (CFSA) investigates child abuse or neglect and aims to ensure safe homes for children.

[6] "Children exposed to traumatic events experience long-lasting negative effects including brain impairments, variations to gene expressions, issues with physical growth and development, complications forming attachments, serious health problems, and significant mental health conditions (Bartlett & Rushovich, 2018). Similarly, children and youth in foster care have increased mental health issues; it is estimated that half (50 percent) of children and youth in the child welfare systems are at a 2.5 times heightened risk in developing mental health disorders compared to children not involved in the child welfare system. (Jankowski, Schifferdecker, Butcher, Foster- Johnson, & Barnett, 2019). Children in foster care are diagnosed with behavioral health issues five times as often versus children not in care." *See* Papovich, Caitlin, *Trauma & Children in Foster Care: A Comprehensive Overview*, Forensic Scholars Today, Concordia University, St. Paul, July 10, 2019, *available at:* https://www.csp.edu/publication/trauma-children-in-foster-care-a-comprehensive-overview/. "Children in out-of-home care (OOHC) are found to have experienced significant trauma, and as a result have behavioral health needs that must be addressed (Casanueva et al., 2011). Griffin et al. (2011) found that the proportion of youth in OOHC reporting at least one type of trauma was more than 95%, compared to approximately 68% in the general population (Copeland et al., 2007)." See Akin, Becci A., et. al., *Screening for trauma and behavioral health needs in child welfare: Practice implications for promoting placement stability*, Child Abuse & Neglect, Volume 122, 2021, 105323, ISSN 0145-2134, https://doi.org/10.1016/j.chiabu.2021.105323. (https://www.sciencedirect.com/science/article/pii/S0145213421003926). *See also* Trivedi, Shanta, *The Harm of Child Removal*, 43 New York University Review of Law & Social Change 523 (2019), *available at:* https://scholarworks.law.ubalt.edu/all_fac/1085; *Behavioral Health Consequences of Child Abuse and Neglect*, Child Welfare Information Gate, *available at:* https://www.childwelfare.gov/topics/can/impact/consequences-can/health/; American Bar Association, *Trauma Caused by Separation of Children from Parents* (July 2020), *available at:* https://www.americanbar.org/content/dam/aba/publications/litigation_committees/childrights/child-separation-memo/parent-child-separation-trauma-memo.pdf; and Engler, A. D., Sarpong, K. O., Van Horne, B. S., Greeley, C. S., & Keefe, R. J. (2022). *A Systematic Review of Mental Health Disorders of Children in Foster Care.* Trauma, Violence, & Abuse, 23(1), 255-264. https://doi.org/10.1177/1524838020941197

[7] Hambrick, Erin P., et. al., *Mental Health Interventions for Children in Foster Care: A Systematic Review,* Child Youth Serv Rev. 2016 Nov; 70: 65–77 (September 2018), *available at:* https://pubmed.ncbi.nlm.nih.gov/28496286/; American Academy for Pediatrics, *Mental and Behavioral Health Needs of Children in Foster Care*, *available at:* https://www.aap.org/en/patient-care/foster-care/mental-and-behavioral-health-needs-of-children-in-foster-care/; Abrams, Zara, *Psychologists work to support children and parents in the child welfare system, but more is needed*, American Psychological Association, Vol. 54 No. 2 (March 1, 2023), *available at:* https://www.apa.org/monitor/2023/03/hope-for-foster-kids; Michaela Guthrie and Jennifer Lee, *This National Foster Care Month, be the Champion; Support Youth Mental Health*, Administration of Children and Families for Department of Health and Human Services (April 28, 2023), *available at:* https://www.acf.hhs.gov/blog/2023/04/national-foster-care-month-be-champion-support-youth-mental-health; *Supporting Successful Reunifications*, Bulletins for Professionals, Child Welfare Information Gateway, 2017, *available at:* https://www.childwelfare.gov/pubPDFs/supporting_reunification.pdf.

[8] Internal Children's Law Center Data Collection, "GAL Deep Dive," June 2021 through May 2022.

[9] *Id.*

[10] *Id.*

[11] Harvard University Center on the Development Child, *Deep Dives: Early Childhood Mental Health, available at:* https://developingchild.harvard.edu/science/deep-dives/mental-health/.
[12] National Institutes of Mental Health, *Technology and the Future of Mental Health Treatment, available at:* https://www.nimh.nih.gov/health/topics/technology-and-the-future-of-mental-health-treatment.
[13] Substance Abuse and Mental Health Services Administration, *Evidence-Based and Culturally Relevant Behavioral Health Interventions in Practice: Strategies and Lessons Learned from NNEDLearn (2011-2020),* (June 2021), *available at:* https://store.samhsa.gov/sites/default/files/pep21-05-02-001.pdf.
[14] Substance Abuse and Mental Health Services Administration, *National Guidelines for Child and Youth Behavioral Health Crisis Care* (November 2022), *available at:* https://store.samhsa.gov/sites/default/files/pep-22-01-02-001.pdf.
[15] B25-0500, *Alternative Restorative Therapy Options for Youth Amendment Act of 2023, available at:* https://lims.dccouncil.gov/downloads/LIMS/53951/Introduction/B25-0500-Introduction.pdf?Id=177068.
[16] District of Columbia Child and Family Services Agency, *Annual Needs Assessment 2022*, p. 93, *available at:* https://cfsa.dc.gov/sites/default/files/dc/sites/cfsa/publication/attachments/FY22_Needs_Assessment_FY24_Resource_Development_Plan_FINAL.pdf.
[17] *Id*. at 95.
[18] *Id*. at 93.
[19] *Id.* at 94.
[20] *Id.* at 95.
[21] *Id.* at 95.
[22] *Id.* at 94-95.
[23] *A Path Forward – Transforming the Public Behavioral Health System for Children and their Families in the District* (December 2021), *available at*: https://childrenslawcenter.org/wp-content/uploads/2021/12/BHSystemTransformation_Final_121321.pdf. This report is released by Children's Law Center, Children's National Hospital, the District of Columbia Behavioral Health Association, Health Alliance Network, Early Childhood Innovation Network, MedStar Georgetown University Hospital Division of Child and Adolescent Psychiatry, Parent Watch, and Total Family Care Coalition.
[24] *Report and Recommendations of the Mayor's Healthcare Workforce Task Force,* (September 2023), *available at:* https://dchealth.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/2023-09-Healthcare-Workforce-Report-web.pdf;
Georgetown University Center for Global Health Science and Security for the Office of the D.C. Auditor, *COVID-19 & Behavioral Health in the District of Columbia*, (April 20, 2023), *available at:* https://dcauditor.org/report/covid-19-behavioral-health-in-the-district-of-columbia/.
[25] DC Department of Mental Health, *The Children's Plan*, (Updated 2012), *available at:* https://dbh.dc.gov/page/childrens-plan.
[26] DC Interagency Council on Homelessness, *Homeward DC 2.0: ICH Strategic Plan FY2021 - FY2025*, *available at*: https://ich.dc.gov/page/homeward-dc-20-ich-strategic-plan-fy2021-fy2025.
[27] This number is an estimate based on the cost of prior rate studies the District has commissioned. Ultimately, our request is for adequate funding to conduct a comprehensive and informative cost study of the program.
[28] HealthySteps DC ensures access to behavioral health services in a setting child frequent, their pediatric primary care practice. Children are more likely to go to their primary care provider due to scheduled well-child visits, thus a primary care provider is well positioned to detect the early onset of behavioral problems. However, a primary care provider may not have the knowledge or skill set to address developmental, behavioral, social, and emotional needs of a child. *See* HealthySteps, *Our Model*, *available at:* https://www.healthysteps.org/what-we-do/our-model/. HealthySteps in the District embeds Family Services Coordinators (FSCs) and HealthySteps Specialists (HSSs) within the primary care setting to engage with families at each routine pediatric visit from birth to three years of age. Family Service Coordinators provide dedicated case management and care coordination for families through the support of DC residents with lived experience navigating systems. *See* Early Childhood Innovation Network, *Innovation Spotlight: HealthySteps DC*, (May 2019), ECIN Newsletter, *available at:* https://www.ecin.org/newsletter-may-2019. HealthySteps Specialists can deliver clinic-based mental health visits with families to address critical needs in areas such as maternal depression, grief and loss, and child behavior management. Specialists can also answer questions

about behavioral health as well as facilitate the development of attachment, self-regulation skills, and family resiliency.

[29] Partial Hospital Programs may offer group therapy, family therapy, individual counseling, and/or psychoeducational sessions. Research on PHPs has shown they have been proven to prevent future hospitalizations and decrease the length of stay in the hospital. A 2014 study with 35 adolescents demonstrated that the PHP was effective in improving psychological symptoms and resulted in positive self-perceptions of getting better. *See A Path Forward – Transforming the Public Behavioral Health System for Children and their Families in the District* (December 2021), p. 76, *available at*: https://childrenslawcenter.org/wp-content/uploads/2021/12/BHSystemTransformation_Final_121321.pdf.

[30] In Youth Crisis Stabilization Units, children and youth who are experiencing acute concerns but do not rise to the level of needing residential treatment are admitted on average for three to five days and receive brief intensive mental health therapy (e.g., one-on-one therapy, family therapy, crisis intervention, psychiatric evaluation, and, if necessary, medication management). *See A Path Forward – Transforming the Public Behavioral Health System for Children and their Families in the District* (December 2021), p. 77, *available at*: https://childrenslawcenter.org/wp-content/uploads/2021/12/BHSystemTransformation_Final_121321.pdf.

[31] The DC School Behavioral Health Stakeholder Learning Community (SLC), *Strengthening the DC School Behavioral Health System and Enhancing Equity, (*2022), The Center for Health and Health Care in Schools, *available at*: https://healthinschools.org/wp-content/uploads/2022/03/SLC-Report-2022.pdf.

[32] Georgetown University Center for Global Health Science and Security for the Office of the D.C. Auditor, *COVID-19 & Behavioral Health in the District of Columbia*, (April 20, 2023), *available at:* https://dcauditor.org/report/covid-19-behavioral-health-in-the-district-of-columbia/.

[33] *Id.* at 8.

[34] *Report and Recommendations of the Mayor's Healthcare Workforce Task Force,* (September 2023), available at https://dchealth.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/2023-09-Healthcare-Workforce-Report-web.pdf;

[35] *Id.* at 16.

[36] American Public Health Association, *Community Health Workers*, accessed August 12, 2021, *available at:* https://www.apha.org/apha-communities/member-sections/community-health-workers.

[37] Association of State and Territorial Health Officials, *Clinical to Community Connection – Making the Case for Community Health Workers*, accessed August 12, 2021, *available at:* https://www.astho.org/Community-Health-Workers/.

[38] McKnight, R. *Increased Medicaid Reimbursement Rates Expand Access to Care,* National Bureau of Economic Research, (October 2019), *available at:* https://www.nber.org/bh/increased-medicaid-reimbursement-rates-expand-access-care.

[39] Canady, V.A. *NABH access to care resolution to address unfair managed care practices*, Ment Health Wkly. 2019;29(14):1-7. doi:10.1002/ mhw.31847.

[40] Network Adequacy Standards, 42 Code of Federal Regulations § 438.68 (2020).

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

Additional Testimonies 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

Multiple Guardians *ad Litem*
Children's Law Center

**Introduction**

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.

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

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. Each year, our attorneys serve as guardians *ad litem* for several hundred children in foster care and protective supervision – more than half of all children in the care and custody of the Child and Family Services Agency (CFSA).[i]

I am here to testify about the unmet mental health needs of the children and families within the District's child welfare system. As a guardian *ad litem* representing youth in child abuse and neglect cases, extreme stress and trauma are inherent to my clients' circumstances—whether it is based on the events that led to CFSA involvement in the first place, the trauma inflicted by separating a child from their family, or the trauma of bouncing between multiple strangers' foster homes while coping with feelings of confusion, abandonment, and unworthiness.

A necessary aspect of our role is to advocate for clients to receive the services and interventions necessary to reduce the effects of severe stress and trauma and develop the skills they need to navigate the difficult circumstances they face. But no legal advocate or court order can ensure clients receive these critical supports if they don't exist. Yet that is the landscape we are operating in. DC's public behavioral health

system lacks the resources necessary to properly serve our clients—and it is leading to devastating outcomes.

In particular, I am here today to share how the lack of adequate mental health resources has impacted one of our clients. We will call them Leslie. Leslie has spent their preteen and early teenage years in foster care. Following their removal, they wanted nothing more than to return home to their mother and siblings. Their confusion and anger at why CFSA would not allow them to go back to their mother affected their relationships and behaviors in all contexts of their life. Simultaneously, Leslie's feelings of rejection, abandonment, and unworthiness from having been separated from their family and forced to remain in the homes of strangers strained their parent-child relationship.

Without a healthy outlet, Leslie's emotions went unprocessed and began to build up. Over time, this began contributing to a self-defeating and tumultuous cycle. Leslie spent day after day in their foster home waiting for the reprieve of their next parent-child visit. But when the time actually came for Leslie to visit with their mother again, Leslie didn't know how to interact with her or express their emotions around being involved in this system. This led to increasingly adversarial dynamics between Leslie and their mother and contributed to even greater strife for Leslie.

Soon, those emotions began bleeding over into Leslie's school days. Leslie began losing academic interest and exhibited avoidance behaviors, such as getting into fights

or absconding from school grounds. As the number of incidents grew, so too did Leslie's receipt of suspensions, police calls, and even trips to the emergency room for psychiatric assessment.

These incidents alarmed Leslie's foster parents who, overwhelmed and feeling unequipped to manage their behaviors, would ask CFSA to remove Leslie from their home—which only reinforced the feelings of confusion, abandonment, and worthlessness that started this cycle for Leslie in the first place.

This was a cycle that could have easily been interrupted. Leslie's social workers submitted countless referrals for mental health services. But it can take weeks or even months to just get off the wait list to schedule an intake appointment. It can then take *another* several weeks or months for the given core service agency to identify and assign an available provider to a client. And, even after a provider is found and assigned, it can sometimes take *yet another* several weeks or months before they actually schedule their first session with a client.

Even if you make it past all of these hurdles, it still doesn't guarantee that a client's mental health needs will be met. I'll use Leslie's CBI (Community-Based Intervention) services as an example. Leslie was recommended for in-person CBI services because virtual therapy was not working for them. As a reminder, Leslie was a preteen who could think of a million other ways they'd rather be spending their time. And, facing increasingly serious outcomes flowing from their unmet needs, they

needed a clinician who could meet them anytime, anywhere to help them manage triggering situations and prevent them from escalating into crises. Leslie waited months before they were finally assigned a CBI worker. They then waited another two months before the CBI worker scheduled their first appointment together. The CBI worker then conducted fewer than five sessions over the course of a month—not even close to the three sessions per week Leslie had been recommended and authorized to receive—before suddenly disappearing from Leslie's life.

After the CBI worker suddenly stopped communicating with Leslie, the core service agency didn't replace them with another CBI worker to fulfill the same role. Instead, they gave Leslie a new therapist who had been trained in CBI, who only met with Leslie virtually once a week.

This is only one of Leslie's experiences, but Leslie has faced similar barriers to working with other providers as well. Leslie now has no community-based crisis intervention services to interrupt their self-defeating and tumultuous cycle. Leslie's lack of mental health supports has left them to fend for themselves while living out some of the worst-case scenarios one can imagine for any teenager.

As a consequence, Leslie has repeatedly missed out on accessing their education. They face an extremely high risk of becoming involved in the juvenile system. They now associate mental health professionals with trauma because so many of their encounters with them have been the result of being taken involuntarily for psychiatric

assessment. And now, Leslie faces a future where their mother's inability to meet their mental health needs is causing the government to contemplate changing Leslie's case goal from reunification to adoption or guardianship.

Leslie's is just one story, though. I can tell similar stories for almost every client I work with—and their families. So many of our cases are delayed because of the barriers parents face similar to obtaining the mental health services they need to reunify with their children. In one case, a parent who entered the system with a domestic violence (DV) protection order against her children's father experienced several additional DV incidents while waiting to begin working with a DV counselor. Her delay in receiving services not only resulted in her multiple additional hospitalizations, but also caused the government to recommend changing her children's permanency goal to adoption because she was not making sufficient progress to ameliorate the risk of exposing her children to DV.

Moreover, waitlists aside, the barriers parents face in finding providers who can accommodate parents' disability needs, work schedules, or transportation limitations can prove insurmountable. Foster parents face these challenges as well. While the consequences may not be as dire as for biological parents, whose parental rights and family integrity are on the line, a foster parent's inability to connect with appropriate services to meet our clients' needs often results in our clients being shuffled from one home to another in the hopes they might manage to land with someone capable of

meeting their needs. As each placement disruption risks re-traumatization for our clients, it is also necessary to ensure foster parents receive the services they need to create stable, supportive, and healthy environments for our clients.

In summary, the consequences of DC's inadequate public mental health system are devastating to its youth and families. I implore you to take the actions necessary to interrupt these cycles. Please increase the capacity of DC's public mental health system. Thank you.

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[i] 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. DC Children's Law Center, Who We Are, available at: https://childrenslawcenter.org/who-we-are/. The term "protective supervision" means a legal status created by Division order in neglect cases whereby a minor is permitted to remain in his home under supervision, subject to return to the Division during the period of protective supervision. D.C. Code § 16-2301(19).

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. Each year, our attorneys serve as guardians *ad litem* for several hundred children in foster care and protective supervision – more than half of all children in the care and custody of the Child and Family Services Agency (CFSA).[i] I am one of those attorneys – representing children as guardian *ad litem* for over three years.

Thank you for the opportunity to testify about the unmet behavioral health needs of the District's foster children and their families. Today I'm here to share a story that unfortunately has become all too common for the foster youth of DC.

This story is about one of the children our organization has worked with, who I will refer to as Alex to maintain confidentiality. Alex is a middle school student whose life was turned upside down when they were removed from their mother and placed in foster care more than one year ago. While removal of a child from their home is always an unfortunate and traumatic experience, the government and I were initially optimistic that Alex could be reunified with their mother relatively quickly as the primary issue was escalating conflict between Alex and their mother. It was clear to all involved that the most important intervention needed to heal this family was therapy, especially family therapy. To their credit, within the first 30 days of Alex's removal, the agency made

referrals for individual therapy, family therapy, and Community Based Intervention (CBI). However, Alex was initially connected to a core service agency that didn't offer family therapy or Community Based Intervention services. It took over five months to connect them to an individual therapist. Less than a month later after finally having a therapist, Alex was abruptly switched to a new core service agency, requiring a new intake appointment, and another waitlist for individual therapy. To make matters worse, this new agency – once again - didn't offer any family therapy or Community Based Intervention services.

There were also significant barriers getting Alex's mother connected to mental health services. While getting the child services should always be a priority, it is often just as important, if not more so, to get the parent connected to mental health services and provide the coping skills needed to keep the family together. Unfortunately, in a pattern I have seen time and time again, even when there aren't months-long waitlists, the majority of therapy providers are only available Monday to Friday from 9am-5pm. While that may be feasible for some, there are countless parents, including Alex's, who are single parents with multiple children, working a minimum wage job as the only source of income for their entire family. While one-two hours of therapy per week may not seem like much, there are few employers willing to tolerate that much time off weekly. Like many parents, Alex's mother can't afford to risk the only income she has to feed her family.

Today, Alex's case has been open for over year, and they still haven't been provided with either family therapy or CBI. As a result, Alex has had to go through crisis after crisis without any mental health services and bounced between more than five foster homes in the first few months after removal.

What is even more tragic is that this failure to get Alex the mental health services they and their mother desperately needed has now caused irreparable harm to the family and the possibility of reunification. Despite our best efforts in the absence of family therapy, Alex has had multiple emergency psychiatric holds, they've gone through an unsuccessful attempt at protective supervision with their mother that ended with another removal from their home by the agency, and now the relationship between Alex and their mother has deteriorated to the point that the agency is now contemplating a request to pursue adoption.

There is almost no doubt that if this family had been connected to family therapy from the very beginning, Alex could have safely returned home within the first six months. Instead, it is now more likely that this family will be permanently ripped apart.

Not knowing how to help a family in crisis is frustrating. But what is absolutely infuriating is knowing exactly what is needed, yet not being able to provide it. The mental health resources available to DC foster youth and their families are grossly inadequate. We can and we must do better.

[i] 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. DC Children's Law Center, Who We Are, available at: https://childrenslawcenter.org/who-we-are/. The term "protective supervision" means a legal status created by Division order in neglect cases whereby a minor is permitted to remain in his home under supervision, subject to return to the Division during the period of protective supervision. D.C. Code § 16-2301(19).