

2014 REPORT CARD

Children's Mental Health

IN THE DISTRICT OF COLUMBIA



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CHILDREN'S MENTAL HEALTH

in THE DISTRICT OF COLUMBIA

GOAL	GRADE
Bring Needed Services to the District	8
Improve Access for Children and Families	5
Create a Robust Prevention and Early Identification System	7
Improve Care Coordination	4
Ensure Quality and Timeliness of Services	4
Improve Psychiatric Services	8
Improve Community-Based Services to Reduce Residential Placements	7

ABOUT THE GRADING SCALE:

Grades cover the District government's progress over the past year toward meeting the mental health needs of low-income children. Ten is the highest grade and represents substantial achievement. Zero is the worst grade and represents no progress.



EXECUTIVE SUMMARY

All children with mental health needs deserve services that allow them to learn in school, live with their families and thrive within their communities. Ensuring a full range of quality and accessible mental health interventions is especially critical for the District's poorest children who are more likely to experience violence, homelessness and family instability than other children across the nation. If we do not help vulnerable DC children cope with trauma, we place them at greater risk of dropping out of school, ending up in prison or worse.

While many people impact a child's mental health, the District

government is uniquely responsible for ensuring that services are available to all children who need them—especially low-income children who are receiving services through Medicaid. District agencies also have direct responsibility for children who are in foster care or the juvenile justice system. Historically, mental health services for DC's children have lagged far behind their needs.

In 2013, Children's Law Center released its first report card chronicling the District's efforts to meet children's mental health needs—a follow-up to comprehensive recommendations we issued a year earlier on how to reform

the city's mental health system.¹ These reports sounded a warning bell. We noted that thousands of children were still being locked out of mental health care and that much-needed reforms were not yet being funded or, where funding was available, were not implemented.

The good news is that, over the past year, the District has begun a number of reforms and is poised to get many more children the mental health care they need. While the number of low-income children who are being screened or treated for mental health concerns still remains far too low—research suggests more than 5,000 children are being overlooked—for the first time ever the District is publicly reporting how Medicaid managed care organizations are meeting these children's needs. Medicaid serves the majority of DC children, and the new reports indicate how many mental health services are being offered, how many children are getting treatment and how much is being spent on mental health. In addition, in the FY 2015 budget, important new programs are being funded that will allow pediatricians to better screen, refer and treat children with mental health issues. Finally, the District has made it easier for mental health service providers to become credentialed, meaning children

have more options for care and that hospitalization and residential placements will become more an option of last resort, as it should be. This year's mental health report card gives its highest scores in these areas.

That the District government was able to accomplish these important reforms in the midst of enormous shifts to the mental health landscape deserves praise. First, 2014 was the launch of the federal Affordable Care Act and the District created a successful health care exchange. The District also merged its agencies responsible for providing behavioral health last year, combining the former DC Department of Mental Health and the Addiction Prevention Recovery Administration into the new Department of Behavioral Health. This is a great step forward in treating the thousands of people with co-occurring mental health and substance abuse disorders. The landscape of Medicaid providers also changed significantly. The DC Department of Health Care Finance replaced the three managed care organizations within its Medicaid program. It also had to deal with the unexpected collapse of the District's largest managed care plan, DC Chartered, which covered more than 100,000 beneficiaries and left health care providers with \$65 million in unpaid claims.²



Research suggests the District is still failing to reach more than 5,000 children with mental health needs.

Still, at the end of the day, we must judge the District by the ultimate measure: are kids getting quality mental health services that meet their needs? By that yardstick, the DC government is still failing children. This year's scorecard gives its lowest grades in two areas: ensuring the quality and timeliness of mental health services, and improving children's access

overall. The District's own evaluations show that too many children are still waiting far too long to receive mental health services and that a significant number of these services are of poor quality. And finally, as noted earlier, the District is still failing to reach more than 5,000 children that national research suggests are likely in need of services and not getting them.

GRADING OUR PROGRESS

Bring Needed Services to the District

GRADE 8

Children have a wide range of mental health needs. Depending on their diagnosis, treatment can range from a few sessions of group counseling to emergency hospitalization. Providing a full continuum of quality services that provide effective care at the earliest sign of a mental health issue is the backbone of a strong children's mental health system. Without this continuum of services, children's mental health will deteriorate, leading to unnecessary hospitalizations and placement in residential facilities or foster care. In this section, we focus on the District's progress in expanding the variety of mental health services available to low-income children with serious mental health needs. In addition to adding two additional evidence-based practices, the District has also lowered the barriers for expanding the number of mental health providers by improving reimbursement rates and streamlining the credentialing process. For these reasons, in this area the District has earned a grade of 8.

The District made important strides to remove red tape and increase payments to its mental health providers, which helped create a more attractive business environment for these providers. The Department of Behavioral Health (DBH) primarily provides community-based services through its Mental Health Rehabilitation Services (MHRS) program, a system of private, community-based care.³ On December 30, 2013, MHRS rates were raised an average of 15% as the result of a comprehensive rate

setting review during which DBH worked closely with providers.⁴

Without high-quality, well-trained clinicians, children can't receive the excellent care they need. DBH worked with the Department of Health Care Finance (DHCF) to draft new contracts for managed care organizations (MCOs), which require the MCOs to acknowledge DBH as the "Credentials Verification Organization" for mental health providers already certified by DBH. This means if the provider is already part of the DBH system they can

ABOUT THE GRADES

The children's mental health system is complex and it is not possible to give the District an overall grade for how it is meeting children's needs in this area. Instead, this report card reviews

the District's progress during the past year in each of the seven sections set forth in Children's Law Center's 2012 mental health plan and assigns a grade to each one on a scale of zero to ten.

automatically be part of the MCO's network without being subject to additional credentialing requirements.⁵ Mental health providers have reported to Children's Law Center that they are having an easier time credentialing with the new MCOs as a result of the new process.

The change to credentialing and the increase in MHRS rates address two issues that had been cited as reasons providers would not enter the DC market or expand in DC. While too soon to see results, we are hopeful that these changes will result in an increase of high-quality providers serving DC's Medicaid population.

DC has historically lacked services at every level of need. Over the last several years, the District has made steady progress expanding the variety of mental health services available to low-income children with serious mental health needs. The Department of Behavioral Health added two new evidence-based therapies to its mental health system this year and now

offers nine services that can meet the needs of children with extensive mental health concerns. The new services, which are Multi-Systemic Therapy for Emerging Adults (MST-EA) and the Transition to Independence Process (TIP), target older youth.⁶ Because of the severe lack of mental health services for older youth, both new therapies are important additions and help fill a void.

The District continues to work to ensure its evidence-based practices are billable to Medicaid, which means the District would only pay 30% of the total cost of the service with local funds rather than 100% (federal Medicaid pays the other 70%). This is noteworthy because any savings in local funds could then be reinvested in additional children's mental health services.

The District is also poised to offer better substance abuse services for youth this coming year. Currently there is a significant shortage. The Substance Abuse and Mental Health



Services Administration has awarded DBH a \$3.8 million, five-year State Youth Treatment Grant.⁷ In May 2014, grant funds will be used to train two providers to implement the Adolescent Community Reinforcement Approach (A-CRA), an evidence-based behavioral intervention used to treat alcohol and substance use disorders in adolescents. The intervention also includes a substantial family component.⁸ If A-CRA is fully and properly implemented, the District will have made significant progress in addressing the lack of substance abuse service for adolescents.

The District, led by CFSA, has also adopted Trauma Systems Therapy (TST) as a model for making the District's child welfare system more

trauma-informed.⁹ Ultimately the goal is to make all agencies in the city trauma-informed. Throughout the year, CFSA has trained social workers, foster parents, guardians *ad litem* and other professionals on the model to promote a greater awareness of the impact of trauma in the lives of abused and neglected children and, eventually, to prepare professionals working with children served by the child welfare system to adapt their approach. This summer, DBH plans to train mental health providers on TST to better serve the children identified for treatment as a result of the trauma screen done by CFSA. TST is a promising model, but this process is still in its early stages and its long term impact is too early to judge. It is still unclear

how trauma-informed practices will be incorporated into all child-serving agencies' daily operations.

Despite these significant strides in the last year, there is still much work to be done to provide the full array of services necessary to meet children's needs. For example, we still lack intensive day treatment programs, therapeutic after school programs and therapeutic summer school programs. Within the DBH/Medicaid system it

is hard to locate clinicians with expertise in treating specific populations, such as: youth with co-occurring mental health and substance abuse disorders; children with Pervasive Developmental Disorder (PDD); and children with PDD co-occurring with trauma. Hopefully the changes to the provider environment and DBH's continuing work to bring in evidence-based practice will bear fruit and bring the array of services needed to DC.

Improve Access for Children and Families

GRADE 5

Having a variety of services is only part of the picture. The services also must be accessible, appropriate, timely and of high quality. Streamlined credentialing processes, improved oversight of the MCOs and better coordination of services only matter if they lead to better services and outcomes for the District's children. This year, although the District took steps toward improving access, the number of children utilizing mental health care still remains low. By comparing our treatment rates against national averages, we conclude that the District may be leaving more than 5,000 children without necessary care.¹⁰ Because the District is laying the groundwork to reach more children, but is still serving far too few children with mental health needs, the District has earned a grade of 5 for this area.

An ongoing struggle for the children's mental health system is that the *system* is in fact run by many different agencies that may intersect with the same child at different points in his or her care, with a separate network

of providers and separate funding mechanisms. This means that reforming the system is quite complicated. Approximately 96,000 children and youth under 21 years of age were enrolled in DC Medicaid at some

point during FY13.¹¹ Ninety percent of child Medicaid beneficiaries receive their care through a managed care organization (MCO). Beginning July 2013, the MCOs under the District's Medicaid Managed Care Program are: AmeriHealth DC, MedStarFamily Choice, Trusted Health Plan and Health Services for Children with Special Needs (which serves disabled children up to age 26).¹² In addition to providing care for their enrollees' physical health needs, the MCOs are also responsible for providing office-based mental health services. However, for children diagnosed with severe mental health problems, the responsibility for providing more intensive in-home therapies shifts to DBH's provider network and reimbursements are made directly to providers by DHCF. Unfortunately, even though both the MCOs and DBH have been providing mental health care to the same group of children and families for many years, there has been insufficient coordination between them. This has resulted in many complications for mental health providers and, ultimately, made it difficult for children and families to obtain services. To be reimbursed through Medicaid for providing mental health treatment to children, for example, providers must be credentialed with multiple entities. To treat all children within

DC's Medicaid system, providers previously had to credential separately with each of the four managed care organizations and be licensed by DBH as a Core Service Agency (CSA) or as a specialty provider. To offer these children a full continuum of care required a provider to credential with at least seven and up to eleven payers.¹³

This year, however, DHCF and the MCOs have improved their coordination with DBH. As a result, new MCO contracts are now in place that contain stronger language regarding their obligations to provide mental health services and to make the provider credentialing process easier. It is too early to tell yet whether this will translate into improved services for children enrolled in the MCOs, but the improved contract language is promising.

Contracts, of course, are only as good as their enforcement. In FY14, DHCF initiated a comprehensive review process to assess and evaluate the performance of the MCOs. Each quarter, DHCF plans to publicly release a performance review of the MCOs to address issues including the MCO's financial health, their ability to meet the administrative requirements for plan management, whether each plan has adequate provider networks, each plan's medical spending across various health service categories, whether members are accessing



primary care and to what extent members are using emergency rooms for non-emergency purposes.¹⁴ With the release of its first report in February 2014, DHCF sent a message to the MCOs that it intends to vigorously enforce its contracts. DBH leadership is also meeting regularly with MCO mental health staff to discuss issues related to mental health and improved utilization of mental health services.¹⁵ This level of oversight, transparency and coordination is critical to ensuring MCOs meet children's mental health needs.

Despite these positive steps by both DBH and DCHF, the number of children accessing care still remains too low. Although it has been difficult

for years to assess how many children are receiving mental health services, this year both DBH and DHCF have made progress in reporting more useful and transparent data about the number of children receiving services. Approximately 6.8% of the 96,000 children ever enrolled in the District's Medicaid program during FY13—around 7,000 children—were treated for mental illness through DBH's Mental Health Rehabilitation Services (MHRS) or a Medicaid managed care organization.¹⁶ This is a slight decrease from the 7.6% of children who received a service in FY12.¹⁷ Nationally, however, at least 12.4% of children who are Medicaid beneficiaries have mental health

District agencies are reporting more useful and transparent data about the number of children receiving services.

conditions.¹⁸ This suggests that, conservatively, 5,000 District children who need mental health services may not be receiving them.¹⁹ And, for the children who the District reports as receiving a service, we do not know if they received the correct treatment or the services they need to improve their health and quality of life.

Unfortunately, the evidence-based practices that have been brought to the District are being underutilized.²⁰ For example, in March 2014, DBH noted that just over half of the slots for Trauma-Focused Cognitive Behavioral Therapy were being utilized and only two-thirds of the slots for Transition to Independence Process were filled.²¹ These services should be at capacity. There are so many children, youth and families who could benefit from these treatment options. Unfortunately, accessing these programs is very complicated and cannot be done directly. Families must rely on their MCO, DBH's Access Helpline, a CFSA social worker or their Core Service Agency to refer them to the proper

specialty service and this often does not happen appropriately or efficiently. If the new variety of services in the city is to result in better outcomes, staff must be trained to make proper referrals, mental health access must be simplified and utilization improved.

DCHF's first Managed Care Quarterly Performance Report also illustrated that the MCOs have a long way to go to provide the mental health treatment they are contractually obligated to provide children. Medical spending for behavioral health services is, in DHCF's own words, "negligible."²² AmeriHealth spends an average of \$8.60 per child per month on behavioral health services; MedStar spends only \$1.05; and Trusted only 59 cents.²³ DHCF notes that "the issue of the health management of mental health services clearly warrants more attention."²⁴ We are encouraged that DHCF has recognized this problem and expect improving the provision of mental health care provided by the MCOs will be a priority this year.

Create a Robust Prevention and Early Identification System

GRADE 7

Early identification of mental health problems leads to earlier assessments, diagnoses and treatment—and, at the end of the day, to more positive outcomes for children and families. This year, the District has made significant progress in this area by taking steps to ensure that pediatricians are screening children for mental health problems. For this reason, though there are other improvements necessary to create a robust prevention system, the District has earned a grade of 7 for this area.

Last year, to improve the integration of mental health into pediatric primary care, Children's Law Center joined with Children's National Health System to launch the DC Collaborative for Mental Health in Pediatric Primary Care. This public-private partnership also includes the DC Chapter of the American Academy of Pediatrics, Georgetown University, DBH, DHCF and the Department of Health. One of the Collaborative's main objectives has been to ensure pediatricians are screening children for mental health needs using standardized screening tools during well-child visits. Although Federal Medicaid law requires regular screenings, the screening currently can be as simple as just asking the family if they have concerns about their child's mental health.²⁵ Administering a standardized, validated screening tool

for all children at the annual well-visit is more effective, identifies more children with concerns and identifies them earlier. While many District children were likely being screened informally during their pediatric visits, standardized tools were generally not being used because this can be a difficult process to integrate into a clinic workflow, there was no local requirement for pediatricians to use a specific tool, pediatricians were not being trained or supported, and there was no method to track these screens. This year, the public-private Collaborative recommended appropriate screening tools that have been approved by DBH and DHCF. Over 100 pediatricians, representing clinics and health centers caring for over 80 percent of children insured through DC Medicaid, are now being trained and supported on how to use and implement



the mental health screening tools.

To have more specific data on children's utilization of health services and better track the number of children being screened, DHCF is also working on a larger project to improve the billing procedures for mental health screening and the entire well-child visit.²⁶ Under a new coding and billing structure scheduled to be completed by this spring, the MCOs and DHCF will be able to confirm that the major components of the well-child visit, including a mental health screen, were performed.²⁷ DHCF has also recognized that pediatricians will need additional reimbursement to administer, score and interpret these mental health screens, and they accounted for this new cost in their proposed FY15

budget request.²⁸ Providing compensation for the screen has been shown in other jurisdictions to significantly improve compliance rates.²⁹

In addition to pediatricians' offices, other key places to identify children's mental health needs early on are child care facilities and schools. The District has several strong programs that focus on preventing and identifying mental health problems within child care and school programs, specifically the Primary Project, Early Childhood Mental Health Consultation Project and the School Based Mental Health Program. Unfortunately, these programs are only in a small number of places and have not seen any significant expansions over the past year. To truly make progress in this area the District must scale up these promising initiatives.

The Primary Project, a program to reduce social, emotional and school adjustment issues for children in pre-K through third grade, has expanded from 30 to 35 sites this year (a small percentage of early elementary sites).³⁰ DBH's Early Childhood Mental Health Consultation Project, a project which screens young children for mental health issues at children development centers, has also not expanded in the past year. The project is currently in 26 centers,³¹ which make up less than 5% of the child development centers and home-based child care providers in the District.³²

The School Mental Health Program (SMHP) provides prevention, early intervention and clinical services to children of all ages in the District's schools. In the 2013-2014 school year, the SMHP is in only 53 schools,³³ only one-quarter of the District's public schools and six fewer than two years ago.³⁴ The *South Capitol Street Memorial Amendment Act of 2012* requires SMHP to be in 50% of schools by next school year and in every school by the 2016-2017 school year.³⁵ Although DBH has \$1.9 million in this year's (FY14) budget to expand into 19 additional schools, they are still in the midst of hiring.³⁶ Including those 19 additional schools, a total of 72 schools will have an SMHP (36% of the District's public schools).³⁷ DBH's

budget for next year (FY15) does not include any additional expansion to the program.³⁸

Parents are in the best position to flag concerns about their children's mental health and are critical to early intervention. Home visiting programs that promote positive parent-child relationships and healthy child development are another vehicle for addressing young children's mental health needs. These programs send a trained professional to visit regularly with a new or expecting parent to provide education and support. Home visiting programs educate parents about their children's developmental milestones, teach parents how to build strong parent-child attachments, ensure that parents know how to obtain medical care for their children, and help parents access services they need in order to build their parenting capacity.³⁹ There is a significant need for home visiting services in the District, as roughly 30% of all District children under the age of five live in poverty and 15% of all children born in the District in 2010 were to mothers under the age of 21.⁴⁰

During FY13, there has been some modest expansion in DC's home visiting programs, but expansion has occurred at a much slower pace than expected. The government also has not yet committed to provide sustainable

long-term funding for home visiting at a level that meets the needs of the District's poor children and families.

In October 2012, the District announced it had been awarded \$4.5 million via a competitive federal grant from the U.S. Department of Health and Human Services⁴¹ to allow the District to provide evidence-based home visiting programs to an additional 500 families.⁴² Unfortunately, there were considerable unexplained delays in the contracting and procurement process for this grant (for

over 14 months) and there was no program expansion under this grant for the entirety of FY13.⁴³ Instead, the Department of Health reports that through contracts awarded by DOH in May 2012, home visiting programs served 192 additional families in evidence-based programs over the course of FY13.⁴⁴ The District must do better. Agencies need to do more to expand utilization of existing home visiting programs and to ensure that long-term funding is secured to meet community needs over the long-term.

Improve Care Coordination

GRADE 4

When adults responsible for a child's health do not talk to one another, diagnoses are less accurate and treatment is less effective. To facilitate care coordination, Medicaid MCOs are required to provide case managers. However, recently released data demonstrates that the MCOs are not providing these required services. And, a plan to pay mental health clinicians for the time they spend coordinating care has stalled.⁴⁵ One bright spot is that for the small number of quite vulnerable children in the child welfare system, DBH and CFSA are working more closely together to coordinate services. Because care coordination overall is quite poor, but the District is taking some promising steps toward progress, the District has earned a grade of 4 for this area.

Children and families often need mental health services when they are entering the child welfare system, which is why the improved coordination between DBH and CFSA is a

promising step forward. Choice Providers, a select group of Core Service Agencies, are working with CFSA to ensure that children are more quickly connected to mental health services

when they come into the child welfare system. Choice Providers are now invited to attend CFSA's Review Evaluate and Direct (RED) Team and Family Team Meetings (FTM), team meetings that occur immediately before or after a child is removed from his or her family.⁴⁶ DBH staff is tracking whether having mental health providers engaged earlier in the process will increase children's timely access to care.⁴⁷

DBH is also using CFSA federal funding to hire four mental health specialists who will be located at community locations within the Healthy Family/Thriving Communities Collaboratives sites and will provide mental health services and referrals. This should lead to more families getting services before their situation escalates into a crisis.

In other areas, the District still needs to improve care coordination for children and families. One important part of this coordination is paying mental health clinicians for the time they spend talking to the key adults in a child's life (whether a pediatrician, therapist, teacher or parent) in order to fully understand the clinical needs of the child. In an effort to address this issue, in June 2012, the Council passed legislation that required DHCF to submit a report detailing their efforts to allow behavioral

health providers to bill for collateral contacts.⁴⁸ Collateral contacts are communications between a mental health provider and any party determined by the provider to be necessary to make a diagnosis or to develop and implement a treatment plan. DHCF submitted a work plan to the Council outlining the various tasks they would complete to ensure that all Medicaid clinicians could bill for collateral contacts. The work plan noted that regulations would be drafted in April 2013 and be effective in October 2013, but DHCF missed those deadlines.⁴⁹ Now, DHCF reports it will address the issue of reimbursing clinicians for collateral contacts as part of its larger process of revising the Early Periodic Screening, Diagnosis and Treatment (EPSDT) billing instructions during spring 2014.

The District has also not been successful in expanding case management services through Medicaid Targeted Case Management (TCM), which other states use to provide various groups of children, including those with chronic mental health needs, with intensive case management. For several years, the District attempted to get federal Medicaid reimbursement for TCM for children in foster care, but recently DHCF and CFSA have withdrawn this request. Given this, the District should now explore other



Care coordination must improve so that children can be connected promptly to needed services and their providers can speak to one another.

ways to improve case management for children with mental health needs.

Finally, the MCOs are also supposed to play an important role in care coordination: per their contracts each MCO is required to have “intensive care coordination services for enrollees with multiple, complex or intensive health care problems that require frequent and sustained attention.”⁵⁰ Unfortunately, to date none of the three health plans has established robust care management systems. The MCOs have only contacted and

assessed small percentages of their members to consider admitting them into case management.⁵¹ And of those contacted across all three plans, less than 1% of members are actually in case management.⁵²

Care coordination must improve so that children can be connected promptly to needed services and their providers can speak to one another. Although care coordination has improved for a small group of children, the District has a long way to go in this area.

Ensure Quality and Timeliness of Services

GRADE 4

Children with mental health issues must receive timely, high-quality services in order for them to have the best chance of succeeding at home, in school and the community. While the District is committed to assessing both timeliness and quality, unfortunately not much progress has been made over the last year in either of these areas. Children still wait too long to connect to community-based services and post-hospital care. Too few children entering foster care are screened for mental health problems. One bright spot in this area is the progress made towards implementing a District-wide assessment tool which will be used by many agencies and providers to measure the functional outcomes of children. For these reasons, the District has earned a grade of 4 for this area.

The System of Care Executive Team, an interagency group comprised of all the child-serving District agencies that DBH and the Deputy Mayor for Health and Human Services has convened to improve the children's mental health system, agreed to use the Child and Adolescent Functional Assessment Scale (CAFAS) to assess how children are doing in many areas of their lives including at home, school, work and in the community.⁵³ DBH, CFSA, Department of Human Services (PASS, Teen Parent programs), Department of Youth Rehabilitation Services, DC Public Schools, DC Public Charter Schools and Court Social Services have all agreed to use this same tool to assess children.⁵⁴ DBH began piloting the tool

in April 2014 and will fully implement it in October 2014; other agencies will follow.⁵⁵ Having all these agencies use the same tool will support integrated case planning, treatment decision-making and information sharing across systems. This should improve the quality of case management and, ultimately, improve the outcome for children receiving services.

Unfortunately, children are still waiting too long to receive services. MHRS regulations require that CSAs provide consumers with an appointment within seven business days of referral,⁵⁶ but in FY13 it took an average of 22 days between the time a child was enrolled at a CSA and the date the child was first seen for treatment.⁵⁷ There are also long delays for

District children with mental health concerns are still waiting too long to receive appropriate services.

children who are hospitalized. About one-third⁵⁸ of children discharged from an inpatient hospital did not have a follow-up outpatient appointment within a week.⁵⁹ This delay can be damaging. A child with severe mental health needs can get worse if he or she goes without services. And, follow-up care after hospitalization is critically important to ensure that children are receiving required treatment and medication, and aren't unnecessarily readmitted to the hospital.

In addition to delay in services, the quality of services is still an issue. While there are some excellent providers, children are too often receiving mediocre services according to DBH's own data. In DBH's FY13 Consumer Service Review process, reviewers found that the system performed "in the acceptable range"⁶⁰ in only 70% of cases. DBH's Provider Scorecards also reveal mediocre results for many of the Core Service Agencies.⁶¹ DBH scored ten CSAs that serve children and none of them received the top scores of five (95+) or four stars (90-94); one received three stars (85-89) and three received two stars (80-84).

Another challenge for the system

is screening children entering foster care for mental health issues. According to CFSA, two-thirds of children removed from their homes had mental health needs in FY11.⁶² Due to this large need, DBH has mental health clinicians located onsite at CFSA to conduct mental health screens. However, last year only one-third⁶³ of children were screened for mental health needs within 30 days of entering foster care, in accordance with CFSA's own policy regarding such screens.⁶⁴ This is an improvement over FY12, but still well below the FY11 levels when over half of foster youth were screened.⁶⁵ Failure to screen youth for mental health needs has significant consequences for youth in care: it delays the identification of needed mental health services and leaves professionals working with youth unprepared to handle potential behavioral problems or crises.

Over the past year, the District has not made enough progress in ensuring that children receive timely, high-quality services. But, the selection and roll-out of the new system-wide assessment tool could lead to better outcomes for youth in years to come.

Improve Psychiatric Services

GRADE 8

Child psychiatrists are an important part of the child mental health system. DC, like much of the nation, faces a shortage of child psychiatrists. There has been some progress made this year toward a creative approach to remedy this critical shortage. For this reason, the District has earned a grade of 8 for this area.

The DC Collaborative for Mental Health in Pediatric Primary Care laid the groundwork to launch a DC Mental Health Access in Pediatrics project. Modeled after successful programs in other states, this project will provide consultations to pediatricians who are treating patients with mental health needs within their primary care practice. DBH has committed to funding this project in FY15.⁶⁶

The project has many benefits, including: promoting the integration of mental health and primary care by increasing pediatricians' ability to identify and manage mental health issues; ensuring that children are quickly and appropriately linked to proper services; and promoting the rational utilization of limited psychiatric resources for the most complex and high-risk children. Councilmember Yvette Alexander also introduced legislation at the DC Council, the *Behavioral Health System of Care Act of 2014 (B20-0676)*, to ensure the project becomes a lasting part of DC's children's system.

Another area of concern within psychiatric services is the high risk of children in foster care being over-medicated since they often lack a consistent caregiver to monitor their diagnosis, treatment and medications. Two years ago, representatives from DMH, CFSA and DHCF formed the Psychotropic Monitoring Group to "ensure that psychopharmacologic treatment provided to foster youth in the District meets (or exceeds) the standard of care."⁶⁷ The group's progress, however, has been slow. This year the group completed preliminary steps to prepare to launch its case review process. In April, the group finalized a Memorandum of Agreement which will allow the agencies to share the data necessary to review cases.⁶⁸ Despite its slow pace, this interagency work is an important step in the right direction. Overall, there are promising ideas in the child psychiatry arena but the District needs to take more aggressive approach to implementing these approaches so that children can truly benefit.

Improve Community-Based Services to Reduce Residential Placements

GRADE 7

Community-based mental health services are critically important to ensuring that children are able to remain with their families and in their communities rather than in residential placements far from home. Fewer children were treated in residential facilities this year and the number of programs that provide community-based services has increased. However, there is no information about how children who are being served in the community are faring. Without this data, it is difficult to assess the District, but because of the increase in children being served, the District has earned a grade of a 7 for this area.

DBH and its sister agencies have made impressive strides reducing the number of children entering Psychiatric Residential Treatment Facilities (PRTFs). The number of youth admitted to these facilities decreased 26% from FY12 to FY13.⁶⁹ In FY13, DBH increased by 55 the number of spaces available through its High Fidelity Wraparound Program.⁷⁰ The program is extremely successful at diverting children from residential programs: 100% of the children referred to the program by schools were able to remain in school.⁷¹ Of the youth in the community Wraparound Program, 92% were diverted from residential facilities.⁷² While this reduction of youth admitted to Psychiatric Residential Treatment Facilities is positive, there is no assessment regarding how the

children diverted from these facilities or those discharged and returned to their homes are now doing.

The only data available about children who have been discharged is that 39% received an intensive Community-Based Intervention (CBI) once they returned home.⁷³ This is an increase over previous years. In FY13, some 1,211 children received these services—95 more than in FY12.⁷⁴ CBI services are time-limited, intensive services for youth ages six to 21 intended to prevent youth from an out-of-home placement. It is imperative that these services begin immediately after they are requested because the longer a child has to wait for services the more likely it is his condition will deteriorate. DBH's regulations state that consumers shall



receive CBI within 48 hours after being authorized and referred for the service.⁷⁵ In FY13, the average wait (the number of days from the time the child is referred until the child's first appointment) for CBI was six days,⁷⁶ down from seven days in FY12 and 13 days in FY11.⁷⁷

Although the number of children in the child welfare system who are living in residential placement is decreasing,⁷⁸ too many children are still placed in these facilities because DC does not have an appropriate therapeutic foster care program for children with mental health issues. DC's current therapeutic foster homes are very different from the evidence-based model of treatment foster care⁷⁹ which has been successful in other parts of the

country. CFSA has not implemented a treatment foster care model in the District, but they have indicated they are now exploring some version of a treatment or professional resource parent model to meet this need.

Additionally, many children in the child welfare system have difficulty accessing community-based mental health services because they have DC Medicaid but live with relatives or foster parents in Maryland. There has been no change in the number of Core Services Agencies that are located in Maryland.⁸⁰ However, there is \$750,000 in CFSA's FY14 budget to launch a new mental health initiative primarily for children residing in Maryland.⁸¹ CFSA issued a solicitation for mental health services in Maryland

and selected one provider, JMD Counseling, who is still in the process of becoming fully operational.⁸² This should increase the services available to wards placed in Maryland significantly.

In conclusion, while the District is making great strides in reducing

the number of children being placed in residential facilities, work still remains to be done to ensure that children diverted from these placements are receiving necessary, high-quality services in their community.

ENDNOTES

- 1 Children's Law Center, Improving the Children's Mental Health System in the District of Columbia (2012).
- 2 Wayne Turnage, Director of Department of Health Care Finance, Testimony presented at the Department of Health Care Finance FY13 Oversight Hearing, 5 (March 6, 2014).
- 3 To qualify for MHRS services a child must be diagnosed with a serious emotional disturbance that results in a functional impairment that either (1) substantially interferes with or limits the child's functioning in family, school or community activities; or (2) limits the child from achieving or maintaining one or more developmentally-appropriate social, behavioral, cognitive, communicative or adaptive skills. 22A D.C.M.R. §1201.1.
- 4 DBH FY13 Oversight Responses, Question 64.
- 5 Managed Care Organization Contract C.8.2.8.8, 87-88 (2013).
- 6 There is only one provider who offers MST-EA and they can only serve 12 youth. The new Transition to Independence Process, which several providers began offering in July 2013, helps 14-29 year olds with mental health concerns move into adulthood and face issues such as education, housing and employment. Carol Zahm, Kendra Fitzgordon, System of Care DC Gateway Update, PowerPoint presentation to the DBH, Children's Roundtable (May 3, 2013).
- 7 Substance Abuse and Mental Health Services Administration, FY 2013 SAMSHA Grant Awards, State Adolescent Treatment, DC Department of Health (APRA became part of DBH in FY14). DC was awarded \$950,000 annually for five years.
- 8 DBH FY13 Oversight Responses, Question 81.
- 9 In October 2012, the U.S. Department of Health and Human Services' Administration for Children and Families awarded CFSA a 5-year, \$3.2 million grant to transform the District's child welfare system into a trauma-informed system. TST is the chosen model for carrying out this grant. CFSA FY 13 Responses to the Human Services Committee's Oversight Questions, Question 10.
- 10 Embry Howell, Access to Children's Mental Health Services Under Medicaid and SCHIP, Urban Institute, 5 (2004). 12.4% of children aged six to 17 years old who receive Medicaid have mental health conditions. Approximately 6.8% of the 96,000 enrolled in DC's Medicaid program were treated for mental illness. DHCF, District of Columbia's Managed Care Quarterly Performance Report (July 2013-Sept. 2013) (Feb. 2014). This means that only 6,575 children in DC received mental health services and 5,376 children who may have needed mental health services did not receive them. Other studies suggest the percentage of children with mental health conditions may much higher. *See e.g.*: Substance Abuse and Mental Health Services Administration, Mental Health, United States, 2010, Table 8: Percentage of person aged 4 to 17 with reported emotional and behavioral difficulties, by level of severity and selected characteristics, United States, 2009, 98 (2010). 8.2% of poor children have definite or severe difficulties and 18.1% have minor difficulties (26.6% total); 6.5% near poor children have definite or severe difficulties and 14.6% have minor difficulties (21.1% total).

- 11 Data analysis prepared by Katherine Rogers, Associate Director of Research and Rate-Setting Analysis, DHCF.
- 12 Colleen Sonosky, Division of Children's Health Services, DHCF, Integrating EPSDT/ Primary Care with Developmental, Behavioral and Oral Health Care, Presentation to the HHS Monthly Cluster Meeting (Jan. 30, 2014).
- 13 District of Columbia Behavioral Health Association, Towards a True System of Care: Improving Children's Behavioral Health Services in the District of Columbia, Part 2 of 2 (2009).
- 14 DHCF, District of Columbia's Managed Care Quarterly Performance Report (July 2013-Sept. 2013) (Feb. 2014).
- 15 DC Gateway SOC Expansion Implementation Progress Report (Sept. 2013).
- 16 Data analysis prepared by Katherine Rogers, Associate Director Division of Research and Rate-Setting Analysis DHCF. DBH and DHCF data extracted April 2013. In FY13, 6,575 children age 0-20 received either a MHRS or a MCO mental health service. This is 6.8% of the approximately 96,000 children who were enrolled in Medicaid during any point in FY13.
- 17 Data analysis prepared by Katherine Rogers, Associate Director Division of Research and Rate-Setting Analysis DHCF. DBH data extracted 7/23/13; DHCF encounter data extracted 5/28/13 (July 2013). In FY12 7,349 children age 0-20 received either a MHRS or a MCO service. This is 7.6% of the 97,000 children enrolled in Medicaid during any point in FY12.
- 18 Embry Howell, Access to Children's Mental Health Services Under Medicaid and SCHIP, Urban Institute, 5 (2004). 12.4% of children aged six to 17 years old who receive Medicaid have mental health conditions
- 19 Id. 12.4% of children aged six to 17 years old who receive Medicaid have mental health conditions. Approximately 6.8% of the 96,000 enrolled in DC's Medicaid program were treated for mental illness. DHCF, District of Columbia's Managed Care Quarterly Performance Report (July 2013-Sept 2013) (Feb 2014). This means that only 6,575 children in DC received mental health services and 5,376 children who may have needed mental health services did not receive them. Other studies suggest the percentage of children with mental health conditions may much higher. *See e.g.*: Substance Abuse and Mental Health Services Administration, Mental Health, United States, 2010, Table 8: Percentage of person aged 4 to 17 with reported emotional and behavioral difficulties, by level of severity and selected characteristics, United States, 2009, 98 (2010). 8.2% of poor children have definite or severe difficulties and 18.1% have minor difficulties (26.6% total); 6.5% near poor children have definite or severe difficulties and 14.6% have minor difficulties (21.1% total).
- 20 DBH FY13 Oversight Responses, Question 47. The six services are Functional Family Therapy, Trauma Focused Cognitive Behavioral Therapy, Child Parent Psychotherapy for Family Violence, Multisystemic Therapy (and MST for Problem Sexual Behavioral and MST for Emerging Adults), Parent Child Interaction Therapy and Transition to Independence (which is not listed in Q47). This year, Trauma-Focused Cognitive Behavioral Therapy and Child Parent Psychotherapy for Families Affected by Violence both became Medicaid reimbursable services. DBH FY13 Oversight Responses, Question 56.
- 21 DBH responses to Children's Law Center questions (Apr. 11, 2014)
- 22 DHCF, District of Columbia's Managed Care Quarterly Performance Report (July 2013-Sept. 2013), 17 (Feb. 2014).
- 23 DHCF, District of Columbia's Managed Care Quarterly Performance Report (July 2013-Sept 2013), 43 (Feb 2014). The Report notes that some MCO members are receiving mental health care through the Medicaid fee-for-service system rather than the MCO system.
- 24 Id.
- 25 42 U.S.C. §1369(a)(43): The Early Periodic Screening, Diagnostic and Treatment provision of federal Medicaid law; District of Columbia Medicaid State Plan §3.1(a)(9).
- 26 DHCF FY13 Oversight Responses, Question 54.
- 27 Id.
- 28 DHCF FY15 proposed budget, DHCF proposes an enhancement of \$866,609 (in local funds; the 70% match comes from federal funds) to "better integrate primary care services with developmental, behavioral, and oral health services for children to improve health outcomes," E-176 (Apr. 3, 2014). In response to questions from the Medical Care Advisory Committee, DHCF noted that these funds were based on an assumption of \$10.34 per screen and assumed children under age 2 would receive four screens per year and

- children 2-20 would receive three screens per year.
- 29 After Massachusetts began requiring screening for mental health during Medicaid well-child visits and reimbursing doctors separately for this screen, there was an increase from 16.6% of all visits coded for behavioral health screens in the first quarter of 2008 to 53.6% in the first quarter of 2009. Karen Kuhlthau, Michael Jellinek et al., *Increases in Behavioral Health Screening in Pediatric Care for Massachusetts Medicaid Patients*, JAMA Pediatrics (Mar. 7, 2011).
- 30 DBH FY13 Oversight Responses, Question 9 Attachment 1.
- 31 DBH FY13 Oversight Responses, Question 43. The Early Childhood Mental Health Consultation Project, Healthy Futures Program, is currently serving 26 child development centers. In FY11 the Project was in 24 sites and in FY12 it was in 25.
- 32 There are 342 Child Development Centers and 148 home-based providers in DC. Email correspondence with Barbara Parks, Clinical Program Administrator, Prevention & Early Intervention Programs, DBH (June 2013).
- 33 DBH FY13 Oversight Responses, Question 59.
- 34 In 2011-2012 school year SMHP was in 58 schools, DMH FY11 Oversight Responses, Question 8.
- 35 D.C. PL19-041.
- 36 DBH FY13 Oversight Responses, Question 59.
- 37 There are 103 District of Columbia Public Schools and 96 Public Charter schools, for a total of 199 schools. <https://data.dcpscb.org/dataset/Equity-Reports-DCPS-and-Charter-Schools-Enrollment/sxfs-2j93>
- 38 Fiscal Year 2015 Budget Support Act of 2014 (B20-750)).
- 39 Home Visiting Council, *Home Visiting Questions & Answers*. http://www.dchomevisiting.org/wp-content/uploads/2013/11/DCHVC_br_FNLlo.pdf.
- 40 DC Department of Health, Maternal Infant & Early Childhood Home Visiting Program, 6-7 (2012). <http://www.dcfpi.org/wp-content/uploads/2012/11/ProjNarrative-1.pdf>
- 41 The grant is through HHS' Maternal, Infant and Early Childhood Home Visiting program and is to expand existing home visiting services using the evidence-based Healthy-Families America model.
- 42 DC Department of Health, Maternal Infant & Early Childhood Home Visiting Program, 4-5 (2012). <http://www.dcfpi.org/wp-content/uploads/2012/11/ProjNarrative-1.pdf>
- 43 From October, 2012 when the grant was issued, it took the DC Government 14 months, until January, 2014, to issue a Request for Applications so that providers could be selected. These delays left children and parents who could have benefited from home visiting programs unserved for more than a year and made it difficult for home visiting providers to plan for changes in their activities. Eventually, in January 2014, the District awarded two contracts, one each to Mary's Center and The Healthy Babies Project, to add 60 families each during FY14 and up to 100 each in FY15. Letter from the District of Columbia Home Visiting Council to Councilmembers Alexander and McDuffie (Dec. 4, 2013).
- 44 Department of Health, Community Health Administration FY13 Oversight Responses, Q3.
- 45 DBH notes that as part of its May 2013 MHRS rate setting review "the total cost of provider staff and time necessary to document and coordinate services (collateral) were included in the cost to build the rates." DBH FY13 Oversight Responses, Question 64. However, a separate reimbursement code and rate for collateral contacts would provide a specific incentive for clinicians to engage in this work.
- 46 Department of Behavioral Health, Provider Bulletin 96, CSA Response to CFSA Initial Referrals (Jan. 8, 2013).
- 47 DBH FY13 Oversight Responses, Question 51.
- 48 Title V, Subtitle B of the Fiscal Year 2013 Budget Support Act of 2012.
- 49 DHCF, Response to Title V, Subtitle B of the Fiscal Year 2013 Budget Support Act of 2012, Submitted to the DC Council Committee on Health (Oct. 2012).
- 50 Managed Care Organization Contract C.1.3.31, 6 (2013).
- 51 According to DHCF, District of Columbia's Managed Care Quarterly Performance Report (July 2013-Sept 2013), 32 (Feb 2014), MCOs have only assessed from 1% to 11% of their members about case management.
- 52 The average monthly enrollment of the three MCOs, as of December 31, 2013, is 162,274. And only 1,571 members are in case manage-

- ment. DHCF, District of Columbia's Managed Care Quarterly Performance Report (July 2013–Sept. 2013), 32 (Feb. 2014).
- 53 DBH FY13 Oversight Responses, Question 52.
- 54 *Id.*
- 55 *Id.*
- 56 D.C.M.R. §22A-3411.5(f).
- 57 DBH FY13 Oversight Responses, Question 48.
- 58 DBH FY13 Oversight Responses, Question 9, Attachment 1.
- 59 DMH FY12 Oversight Responses, Question 9, Attachment 1.
- 60 DBH Community Service Review Unit, 2013 DBH Child/Youth CSR Results, 6 (Dec. 6, 2013).
- 61 DMH FY13 Oversight Responses, Question 75. The FY2012 Scorecard is available at <http://dmh.dc.gov/page/provider-scorecard>
- 62 CFSA FY12 Oversight Responses, Question 30. CFSA has not provided the percentage of children who received a positive screen in FY12 or FY13.
- 63 CFSA FY14 Oversight Responses, Question Q9(a) CFSA notes that because only 67% of children entering care were “eligible” for a screen that the rate of screening should actually be calculated at 50%. CFSA FY14 Oversight Responses, Question Q9(a). In FY13, CFSA removed 407 children. Of these, 272 were eligible for mental health screening. Of the 272, 137 received screening within 30 days of entry. CFSA states in its oversight response that “all children do not require a mental health screening. Exclusions include children one-year old or less; and children under six can only receive a mental health screen in the presence of the caretaker and often times there are barriers to completing these within 30 days due to lack of parental involvement, location of parent, incarceration, hospitalization, or mental health condition of the parent.”
- 64 CFSA, Initial Evaluation of Children's Health, Procedure F: Initial Mental Health/Behavioral Health Screening, 1. The initial mental/behavioral health screening shall occur within 30 days of the child or youth coming into care.
- 65 CFSA FY12 Oversight Responses, Question 30.
- 66 DBH's FY15 budget does not include specific funding for the project. However, DBH Director Steve Baron has informed CLC via email correspondence that he has money within the budget he has committed to the project.
- 67 Email correspondence with Cheryl Durden, CFSA (Apr. 22, 2013).
- 68 DBH FY13 Oversight Responses, Question 46.
- 69 DBH FY13 Oversight Response, Question 57. In FY13 there were 128 youth in PRTFs, a 26% decrease compared to the 173 youth who were admitted to PRTFs during FY12.
- 70 DBH FY13 Oversight Response, Question 63.
- 71 *Id.*
- 72 *Id.*
- 73 DBH FY13 Oversight Response, Question 42. 32 youth or 39% received CBI once they returned to the community. In 2009, just 7% of youth discharged from PRTFs received a CBI service.
- 74 Data provided by DBH to Children's Law Center (Apr. 17, 2014).
- 75 D.C.M.R. § 22-A3410.20.
- 76 Data provided by DBH to Children's Law Center (Apr. 17, 2014).
- 77 DBH, Community-Based Intervention Services Data Comparison FY10, FY11 and FY12, Presentation at Children's Roundtable Meeting (Dec. 7, 2012).
- 78 In FY13, 31 CFSA youth were placed in PRTFs compared to 36 in FY12. DBH FY13 Oversight Response, Question 57. DMH FY12 Oversight Responses, Question 51.
- 79 U.S. Department of Health and Human Services, Administration for Children & Families, What is Treatment Foster Care? https://www.childwelfare.gov/outofhome/foster_care/what_treat.cfm. The most widely disseminated model is Multidimensional Treatment Foster Care. *See* www.mtfc.com
- 80 DBH website list of Core Services Agencies (last visited Mar. 26, 2014).
- 81 FY14 proposed budget, CFSA Overview for the Community, 10 (Apr. 8, 2013).
- 82 CFSA responses to questions from Children's Law Center (Apr. 4, 2014).

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