

2013 REPORT CARD

Children's Mental Health

IN THE DISTRICT OF COLUMBIA



2013 CHILDREN'S MENTAL HEALTH REPORT CARD for THE DISTRICT OF COLUMBIA

GOAL	GRADE
Bring Needed Services to the District	Making Progress
Improve Access for Children and Families	Incomplete
Create a Robust Prevention and Early Identification System	Needs Improvement
Improve Care Coordination	Making Progress
Ensure Quality and Timeliness of Services	Needs Improvement
Improve Psychiatric Services	Making Progress
Improve Community-Based Services to Reduce Residential Placements	Incomplete

GRADING SCALE:

Achieved *There has been substantial fulfillment of the goals.*

Making Progress *The District is making progress toward the goals.*

Incomplete *The District is taking steps to achieve the goals, but it is too soon to determine if these steps will result in significant progress.*

Needs Improvement *There has been no significant progress toward the goals.*

No Change *There has been no progress at all toward the goals.*



INTRODUCTION

In May 2012, Children's Law Center released *Improving the Children's Mental Health System*. This plan, which included seven sections with detailed recommendations, set forth a vision of what a truly functioning children's mental health system would look like in the District of Columbia.

Good mental health is essential to a child's overall health and development, as well as ability to learn in school, live with his or her family and thrive in the community. Too many children — especially those who live in poverty and witness violence in their neighborhoods on a daily basis — face mental health problems that impair how they function. The good news is that we have better tools than ever before to screen children for mental

health issues, to identify problems early and to treat children and families with the best evidence-based services available.

Improving our children's mental health system is critically important — not only for the children and families whose lives will be personally improved by quality treatment, but for our city as a whole. A properly functioning mental health system is vital to our education, child welfare and juvenile justice systems — it provides services to ensure children reach developmental milestones, aid their academic achievements, reduce their stays in foster care and cope with the trauma in their lives effectively rather than repeating the cycle of violence.



One of the most significant challenges facing the District's children's mental health system is that no single agency is fully in charge of running the system or reforming it.

ASSESSING OUR PROGRESS A YEAR LATER

Now, a year later, we return to that plan to assess the progress the District has made.

There has been significant progress in several areas. The District received two competitive, multi-year federal grants for mental health planning, training and service delivery. The Department of Health Care Finance (DHCF) put out a Request for Proposals for new managed care organizations (MCOs) that included strong language describing the responsibilities of the MCOs regarding mental health credentialing, network adequacy and data collection. A new multidisciplinary group has been formed to work on issues of pediatric and mental health integration, such as screening and psychiatric access. All of this planning and discussion is encouraging, but it is too early to know if they will lead to the concrete improvements that children and families desperately need.

However, challenges remain. One of the most significant challenges facing the District's children's mental health system is that no single agency is fully in charge of running the system or reforming it. Children receive services from managed care organizations or Department of Mental

Health (DMH) service providers as well as through the Child and Family Services Agency (CFSA), the Department of Youth Rehabilitation Services (DYRS), school-based clinicians, pediatricians and others. No one entity is responsible. For example, DHCF monitors the managed care contracts which serve the overwhelming majority of the District's children, but DMH oversees community-based services for children with the most serious mental health needs. This bureaucratic fragmentation prevents the District from developing a working children's mental health system.

The District is not currently collecting or analyzing the necessary data to make informed decisions for improving the children's mental health system. Currently, it remains too difficult to get accurate, timely information about the number and percentage of children receiving various services from the Medicaid and DMH systems and data points are often not consistent from year to year, making comparisons inaccurate. A well-functioning system must hold itself accountable — and be accountable to the children and families it serves; transparent, reliable data is a necessary part of this.

GRADING OUR PROGRESS

The children's mental health system is complex and it is not possible to give the District a simple "A" or "F" grade for the progress it has made in the last year. Instead, this report card reviews District's progress 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. The grades are as follows:

- ▶ **Achieved:** There has been substantial fulfillment of the goals.
- ▶ **Making Progress:** The District is making progress toward the goals.
- ▶ **Incomplete:** The District is taking steps to achieve the goals, but it is too soon to determine if these steps will result in significant progress.
- ▶ **Needs Improvement:** There has been no significant progress toward the goals.
- ▶ **No change:** There has been no progress at all toward the goals.

1 BRING NEEDED SERVICES TO THE DISTRICT: Making Progress

The District has made some progress in expanding the variety of mental health services available to children, particularly evidence-based services

for children with more serious mental health needs. They have also increased the number of children receiving two specific services intended to prevent children from needing psychiatric residential treatment (see Section 6 below). In addition, the District took an important step toward improving the business environment for mental health providers, which should lead to an increase in the number of children served. At this time, however, there is no available data to indicate whether or not more children, overall, received mental health services this year.

Over the past several years, DMH has implemented a creative strategy to strengthen the array of available services by training community-based providers in specific treatment modalities and then creating a payment structure (first using local dollars if necessary) to support a roll-out of these treatments. The District currently offers six evidence-based services. During this past year, DMH added two new evidence-based services and expanded the number of providers capable of providing two

other evidence-based services. The new services are Child Parent Psychotherapy for Family Violence and Multi-Systemic Therapy for Problem Sexual Behavior. Functional Family Therapy and Trauma-Focused Cognitive Behavioral Therapy are now available from additional providers. Parent Child Interaction Therapy and Multi-Systemic Therapy remain available from the same number of providers as in 2011.¹ DMH reports that it has plans to add additional evidence-based therapies this coming year.²

The District is working to ensure these evidence-based services can be billed to Medicaid. Multi-Systemic Therapy and Functional Family Therapy are Medicaid-billable already and DMH reports they are currently working with DHCF and the federal Centers for Medicare and Medicaid Services (CMS) to get Trauma-Focused Cognitive Behavioral Therapy and Child Parent Psychotherapy for Family Violence covered by Medicaid.³

The District has also launched an initiative to bring trauma-informed care to children in the foster care system. In October 2012, the U.S. Department of Health and Human Services' Administration for Children and Families awarded CFSA a \$3.2 million competitive grant to transform the

District's child welfare system into a trauma-informed system.⁴ CFSA plans to implement Trauma Systems Therapy, a clinical and organizational model that includes retraining child-serving staff in various District agencies, as well as others who interact with foster children such as foster parents and attorneys, as well as implementing new evidence-based screening, assessment and case planning practices.

Despite the addition of these important programs, the District does not have the full array of services necessary to meet children's needs. We still lack key services such as intensive day treatment programs, therapeutic after school and summer school and integrated mental health and substance services for youth with co-occurring disorders.

In addition to expanding the types of treatment available, the District must also ensure that there are enough providers to serve all children in need. A primary reason why the District lacks a full array of services and the capacity to meet the demand for services is the unnecessarily complex and redundant bureaucracy that deters providers and the clinicians they employ from working in the District.

The Request for Proposals that was issued by the Department of

Health Care Finance this year to solicit bids for three new MCOs included language intended to reduce the bureaucracy by simplify the credentialing process for providers and clinicians. DMH worked collaboratively with DHCF on this language, which is intended to make it easier for mental health providers who are already credentialed with DMH to become part of the MCO networks.⁵ It is too soon to determine if this change will accomplish the intended goal.

2 IMPROVE ACCESS FOR CHILDREN AND FAMILIES: **Incomplete**

In the past year, access for children has not improved overall. The system remains difficult for families to navigate, although some progress has been made for children with significant mental health needs who receive mental health treatment through DMH's Mental Health Rehabilitation Services (MHRS) system. The District reports serving 18% more children through MHRS in 2012 than they did in 2009.⁶ However, the overwhelming majority of children are served through Medicaid MCOs, which are responsible for having a mental health provider network in place for traditional mental health outpatient services. Sixteen percent (16%) fewer children were served

solely through an MCO provider in 2010 than in 2009, which is the last year the MCOs reported their utilization data.⁷ The signing of new MCO contracts creates an ideal moment for DHCF to strengthen its oversight of the MCOs and ensure they fulfill their obligations to provide mental health services. To be successful, DHCF will need to ensure that the contracts incorporate the language from the Request for Proposals that requires the MCOs to report on mental health utilization. DHCF will also need to strengthen their contract monitoring and hold MCOs accountable for creating accessible services. In order for stakeholders to hold the MCOs and DHCF accountable, this information must be shared with the public in a timely manner.

Increasing the number of children who access service through MHRS and MCOs is important, but there are also larger, overarching issues to be addressed as the District seeks to improve the children's mental health system. In September 2012, DMH received a System of Care Expansion Grant from the U.S. Department of Health & Human Services' Substance Abuse and Mental Health Services Administration which is designed to guide the District in taking this comprehensive view.⁸ The overarching goal of this four-year grant is to



improve and expand the capacity and coordination of services for children and families with mental health needs. The goals of the grant are quite broad, but increasing access to services is a key component. The grant is coordinated by an Executive Team and Management and Implementation Team. In January 2013, the Management and Implementation team developed an action plan for achieving the goals identified in the strategic plan.⁹ The action plan covers a four-year period and so far the District has taken some promising first steps. While it is too soon to make an assessment now, in the months and years to come, these changes may improve the manner and ease by which children and families access services.

3 CREATE A ROBUST PREVENTION AND EARLY IDENTIFICATION SYSTEM: **Needs Improvement**

The District has several strong programs that prevent mental health problems or identify these issues early. Unfortunately, only one program has expanded over the past year, and the District is at risk of losing federal funds for another program because of its failure to distribute funds timely.

The Primary Project, a prevention and early intervention program that provides services to pre-K through 1st grade students to reduce social, emotional and school adjustment issues has expanded this past year. The project has grown from 16 sites in FY11 to 30 sites in FY12.



The School Mental Health Program (SMHP) provides prevention, early intervention and clinical services to children of all ages in the District's schools. Because the overwhelming majority of children attend them, schools are an ideal location to identify children with mental health needs and provide them with appropriate services. In the 2012-2013 school year, the SMHP is only in 53 schools, five fewer than last year.¹⁰ Although the law requires the program to be in 50% of schools by the 2014-2015 school year, SMHP is currently only in 30% of the District's total schools.¹¹ The Mayor's proposed

FY14 budget does not include funding for any expansion.

The District has not increased its ability to screen young children for mental health issues either. In FY12, DMH's Early Childhood Mental Health Consultation project, an excellent early identification program, placed mental health specialists in 25 child development centers across the District.¹² This promising program did not expand in the past year and is also level funded for FY14.

Another opportunity to address young children's mental health needs is through home visiting programs that promote positive parent-child

relationships and healthy child development. The capacity of home visiting programs has remained essentially static over the past year. The District was awarded a \$4.5 million competitive federal grant to expand evidence-based home visiting programs over two years.¹³ The grant is intended to provide for the expansion of the Healthy Families America model to serve approximately 400 additional families, as well as the creation of a universal intake system, enhanced professional development opportunities, and a program evaluation that will include mental health metrics.¹⁴ Children and families have yet to benefit from this grant, however; delays in the DC Department of Health's (DOH) contracting and procurement process have prevented the awarding of grants to contractors to carry out the home visiting.¹⁵ The delay in issuing contracts to community organizations may result in some of the federal funding being permanently lost.

To sustain home visiting programs after the federal funding ends, DC must find local dollars or other funding sources. Various changes and plans are currently being proposed. The FY14 budget for DOH includes a cut of approximately \$1 million in federal dollars for the Healthy Start home visiting program which, while not an evidence-based program, serves

many families.¹⁶ At the same time, the CFSA budget includes \$300,000 to expand two home visiting models that serve families at risk of child welfare involvement, bringing the total CFSA budget for home visiting to \$590,000.¹⁷ CFSA is also exploring providing increased funding for home visiting if the agency is awarded a Title IV-E waiver.¹⁸ Additionally, the Home Visiting Council is exploring the possibility of working with DHCF on a Medicaid State Plan Amendment that would allow home visiting providers to bill Medicaid under Targeted Case Management, an approach used successfully in other states.

Another opportune time to identify mental health issues early is during pediatric visits. Federal Medicaid law requires these screenings¹⁹ and leading medical organizations such as the American Academy of Pediatrics endorse them. Currently, many pediatricians do not know how to screen, which tools to use, or how to connect to the mental health system when a child needs more intensive services than a pediatrician can provide. In response to Children Law Center's May 2012 plan, a DC Primary Care and Mental Health Integration Project comprised of representatives from Children's Law Center, Children's National Medical Center, Georgetown University Hospital, the

DC Chapter of the American Academy of Pediatrics, DMH and DHCF has been convened to address pediatric mental health screenings (among other issues). The group is developing a plan to select standardized behavioral health screening tools, encourage doctors to consistently use these tools and ensure clinicians are properly reimbursed.

4 IMPROVE CARE COORDINATION: **Making Progress**

To effectively address a child's mental health issues, all of the adults in a child's life (such as the pediatrician, therapist, psychiatrist, community support worker, teacher and parent) must work together. Failing to do so can lead to the child's condition failing to improve or getting worse. Because clinicians are currently not paid for the time spent coordinating care, too often mental health treatment is ineffective. In the past year, the District has taken some important steps toward improving care coordination. DHCF has committed to reimbursing mental health clinicians for the time they spend communicating with those individuals who are necessary to diagnosis and treat a child. These communications are often referred to as "collateral contacts." In June 2012, the Council passed legislation (FY13

Budget Support Act) which included a requirement that DHCF submit a report to the Council by October 1, 2012 detailing their efforts to allow behavioral health providers to bill for "communications between a provider and any party determined by that provider to be necessary to make a diagnosis or to develop and implement a treatment plan." DHCF submitted a work plan to the Council which noted that while collateral contacts are readily acknowledged as an integral part of assessment and treatment, the way they are reimbursed in fee-for-service Medicaid and under DC MCOs needs to be clarified. DHCF's work plan set forth various tasks they would complete to ensure that all Medicaid clinicians can bill for collateral contacts. Draft regulations for the fee-for-service program were scheduled to be released at the end of April 2013, however DHCF is still working on finalizing the proposed rule for an effective date of October 2013. Changes for the MCO program should be in place by 2014.

The District has not been successful, however, in expanding case management services by utilizing Medicaid Targeted Case Management (TCM) to cover additional groups of children. Other states use this Medicaid service to cover various groups of children, including those with chronic

mental illness. Currently, the District is still attempting to get Medicaid reimbursement for a very limited group of children — those in foster care. The State Plan Amendment that would allow this billing to occur (just for CFSA) is still under review by CMS.²⁰ This State Plan Amendment was submitted in May 2010²¹ and is pending CMS approval.²²

5 ENSURE QUALITY AND TIMELINESS OF SERVICES: **Needs Improvement**

Children who do not receive timely or quality mental health services are at risk of developing more serious conditions. Though the District is working hard at this goal, not much progress has been made over the last year in improving the timeliness or quality of service delivery.

MHRS regulations require that children are seen for an appointment within seven business days of referral.²³ However, in FY11 and the beginning of FY12, only 26% of children were seen by a mental health provider within seven days of their enrollment in MHRS and only 50% were seen within a month.²⁴

For children whose mental health problems are so severe that they are hospitalized, it is particularly critical that they receive appropriate mental health services immediately after

they are discharged from a psychiatric hospital. Unfortunately, in FY12 only 61%²⁵ of children discharged from an inpatient hospital had an outpatient appointment within a week (an improvement over the rate of 47% from 2011).²⁶

DMH and CFSA are working more closely together on ensuring children entering foster care are screened properly for mental health issues and receive appropriate mental health services. In FY11, 66% of children that CFSA removed from their homes had mental health needs.²⁷ For this reason, DMH has mental health clinicians on site at CFSA to conduct mental health screens. In FY12, however, only 49% of children entering foster care received a mental health screen within 30 days,²⁸ down from 56% in FY11.²⁹ DC law³⁰ and CFSA's own policy³¹ require these screenings within 30 days of a child coming into care. A lack of timely screening is a substantial impediment to children receiving necessary and appropriate mental health services.

CFSA's goal is to screen all children age 1 and older entering or re-entering foster care who are not screened by the Safe Shores DC Child Advocacy Center.³² CFSA has set an aggressive target of screening 90% of children this next year. In FY14, there will be an additional DMH

clinician located at CFSA on evenings and weekends to try and reach more children removed from their homes outside of normal business hours.³³

In addition to enhancing its screening and assessment of foster children's mental health, the District has taken some first steps toward developing a city-wide assessment tool which would be used by all agencies to measure the functional outcomes of children they serve. The directors of the child-serving agencies, under the auspices of the System of Care/DC Gateway Project Executive Team, have discussed the need for their agencies to jointly select a functional assessment instrument, such as the Child and Adolescent Functioning Assessment Scale. Currently, DMH, CFSA and Court Social Services are developing a budget for implementing such a tool in their agencies. DYRS as well as the Office of the State Superintendent for Education, DC Public Schools and the DC Public Charter School Board are still considering how they would use this tool in their agencies.³⁴

The District has also made some small improvements in the manner in which certain youth involved in the juvenile justice system receive mental health services. Mental health service delivery and coordination has improved for the small number of youth involved in the Juvenile Behavioral

Diversion Program at the DC Superior Court. Youth in this program are given the option to participate in mental health services instead of facing traditional prosecution. In 2012, 64 youth were enrolled in the program, an increase of 10 youth from 2011.³⁵

6 IMPROVE PSYCHIATRIC SERVICES: **Making Progress**

Nationwide and in the District there is a dearth of child psychiatrists. Children who do visit a psychiatrist are at risk of overmedication or improper medication, especially youth in foster care. In order to address the child psychiatrist shortage, plans are being made to launch a DC Child Psychiatry Access. Modeled after successful programs in other states, this program provides mental health consultation teams to assist primary care providers in meeting the needs of children with psychiatric problems. The consultation team — consisting of a child psychiatrist, social worker or psychologist and care coordinator — respond to primary care clinicians who need assistance with a patient's mental health needs, including diagnosis, medication management and referrals. As mentioned in Section Three, in response to Children Law Center's May 2012 plan the DC Primary Care and Mental Health



Integration Project, with representatives from Children's Law Center, Children's National Medical Center, Georgetown University Hospital, the DC Chapter of the American Academic of Pediatrics, DMH and DHCF has been convened. The group is researching successful programs in other states and has already talked with national experts and applied for national and state funding to begin a local program.

The District has also taken some important first steps towards ensuring that children in foster care are not being improperly medicated. Representatives from DMH, CFSA and DHCF attended a federal Department of Health and Human Services sponsored summit on the topic in August 2012 and then formed a workgroup,

the Psychotropic Monitoring Group. The group's goal is "to ensure that psychopharmacologic treatment provided to foster youth in the District meets (or exceeds) the standard of care."³⁶ The group is establishing an operational framework and finalizing a memorandum of agreement to allow the sharing of information to identify foster youth prescribed psychotropic medications.³⁷

7 IMPROVE COMMUNITY-BASED SERVICES TO REDUCE RESIDENTIAL PLACEMENTS: **Incomplete**

In order for children to remain with their families rather than receive services far from home in residential placements, there must be sufficient high-quality community-based

services in the areas where children live. There have been some small improvements in this area, but many are not yet implemented so it is not possible to assess whether they will lead to improved services being available for children and families.

The District has expanded the High Fidelity Wraparound program. In FY12 a total of 282 children and their families were served,³⁸ an increase of 71 children from FY11.³⁹ In FY13, DMH's goal is to serve 338 children. Over half of the children served were those attending full services schools through DCPS; and 98% of these children remained in public schools.⁴⁰ Of the youth receiving wraparound services in the community, 73% were successfully diverted from residential treatment and continued to receive services within the community.

The number of children receiving Community-Based Intervention (CBI) services has increased from 581 children in FY10 to 1,116 children in FY12.⁴¹ CBI services are time-limited, intensive services for youth age 6 through 21 intended to prevent the youth from an out-of-home placement. The longer a child has to wait for CBI to start, the more likely his or her condition will deteriorate, leading to a hospital or residential stay. DMH's goal is for a child to wait no

more than 72 hours from referral until he receives his first CBI service. In FY12, the average wait for all levels of CBI (Level I: Multisystemic Therapy; Level II & III: Intensive Home and Community Based Services; and Level IV: Functional Family Therapy) was 7 days, down from 13 days in FY11.⁴²

The District's human services agencies are working on a plan for how money saved by reducing the number of children in residential placements and other high-end, costly placements such as hospitals and full-time, non-public special education schools can be reinvested into community-based mental health services. Under the System of Care/DC Gateway Project, there is now a Reinvestment Plan Development Work Group subcommittee drafting a compact with the goal that all child-serving agency directors will sign, committing their agencies to a yet-to-be-released reinvestment strategy.

Many foster children cannot access mental health treatment because they live with relatives or foster parents in Maryland. There has been no change this year in the number of Core Service Agencies — only two — that are located in Maryland.⁴³ But CFSA has budgeted \$750,000 in its FY14 budget to launch a new mental health initiative primarily for children residing in Maryland.⁴⁴

ENDNOTES

- 1 Child Parent Psychotherapy for Family Violence is currently provided by five agencies; Multi-Systemic Therapy for Problem Sexual Behavior is currently provided by one agency; Functional Family Therapy has expanded from two to four providers; Trauma-Focused Cognitive Behavioral Therapy has expanded from four to five providers. For Parent Child Interaction Therapy and Multi-Systemic Therapy, the number of providers has remained constant.
- 2 In April 2013, DMH began pre-training providers in the Transition to Independence Process (TIP) practice and initial clinical training is scheduled to begin in July. TIP is an evidence-supported practice that is demonstrated to improve progress and outcomes of youth and young adults (14-29) with emotional/behavioral as they work to transition to adulthood. In addition, in partnership with CFSA, DMH is adding Trauma System Therapy as an additional practice for the all child and youth direct care staff in the DMH provider network.
- 3 DMH FY12 Oversight Question 50.
- 4 CFSA FY 13 Oversight Responses, Q10.
- 5 The RFP states that the MCOs must “accept and acknowledge DMH as the Credentials Verification Organization for mental health providers already credentialed by DMH. The providers shall be considered by participation in the Contractor’s network and shall not be subject to additional credentialing requirements.” Department of Health Care Finance, Request for Proposal for Managed Care Organizations, C.8.2.8, 89 (2012).
- 6 DMH Director Steve Baron, Presentation to Children’s Law Center (February 15, 2013).
- 7 In FY2009 1,384 children received an outpatient mental health services solely through the MCO (an additional 824 received services from their MCO and MHRS); in FY2010, 1,161 children received an outpatient mental health services solely through the MCO (an additional 1,155 received services from their MCO and MHRS). Medical Care Advisory Committee, Behavioral Health Subcommittee, FY2011 Year-End Report and Recommendations, 3.4 (April 18, 2012).
- 8 DMH FY12 Oversight Question 47. The grant is officially called the “DC Children’s System of Care Expansion Implementation Project: the DC Gateway Project” and was awarded on September 30, 2012. It is for \$999,640 per year, for four years (although DMH has to apply for continuation of funding each year, so funding is not guaranteed). Email correspondence with Carol Zahm, Project Director, DC Gateway Project, (April 22, 2012).
- 9 DC Children’s System of Care, DC Gateway Project, January 2013 Action Plan.
- 10 In the 2012-2013 school year, the SMHP is in 53 schools, DMH Oversight Responses, FY12, Question 53, Attachment; In the 2011-2012 school year SMHP was in 58 schools, DMH Oversight Responses, FY11, Attachment 4, Program and Activity Detail Worksheet.
- 11 There are 57 charter schools and 125 DCPS schools for a total of 182 schools.
- 12 A study completed in fall 2012 found statistically significant improvements in the emotional climate of the classrooms participating in the program. CDC directors also had a significantly more positive view of their teachers’ ability to respond to children and parents. Unfortunately, the evaluators weren’t able to properly assess whether the individual consultations for children with identified behavioral problems led to positive outcomes for those children and families. Deborah F. Perry, Sarah Deardorff, Georgetown University, Center for Child and Human Development, Healthy Futures: Year Two Evolution Report (Sept. 30, 2012).

- 13 The funding comes from the U.S. Department of Health and Human Services' Maternal, Infant and Early Childhood Home Visiting program (MIECHV). DC Fiscal Policy Institute, DC Receives \$2.25 Million to Help Boost Early Childhood Resources, Oct. 3, 2012, available at www.dcfpi.org/dc-receives-2-25-million-to-help-boost-early-childhood-resources.
- 14 DC's Home Visitation grant application, p. 5, available at www.dcfpi.org/wp-content/uploads/2012/11/ProjNarrative-1.pdf.
- 15 Representations from DOH staff at Home Visiting Council meetings.
- 16 FY 2014 Proposed Budget and Financial Plan for the Department of Health, p. E-69.
- 17 CFSA's Responses to Questions for the FY14 Community Budget Briefing, p. 3-4.
- 18 The U.S. Department of Health and Human Services has authority to approve child welfare waivers to titles IV-E and IV-B of the Social Security Act.
- 19 42 U.S.C. §1369(a)(43): The Early Periodic Screening, Diagnosis and Treatment provision of federal Medicaid law; District of Columbia Medicaid State Plan §3.1(a)(9).
- 20 DHCF's responses to the Health Committee's FY12 Oversight Questions, Q73. The State Plan Amendment is still under review by CMS. CMS recently sent DHCF a new set of questions, which DHCF and CFSA are working to respond to.
- 21 DHCF's responses to the Health Committee's FY11 Oversight Questions, Q40. The State Plan Amendment (SPA) was submitted in May 2010. In November 2010, CMS transitioned the SPA to a formal Request for Additional Information (RAI) status and asked the DC government for more information. DHCF worked with CFSA to resubmit the SPA.
- 22 CFSA explains that the primary barrier to approval "involves CMS' misinterpretation of Medicaid coverage responsibility for out-of-state IV-E eligible TCM participants."
- CFSA notes that DHCF has submitted additional responses to CMS on February 6, 2013 and is continuing to work with CMS. CFSA's Responses to Questions for the FY14 Community Budget Briefing, Question 30 (April 8, 2013).
- 23 D.C.M.R. §22A-3411.5(f).
- 24 DMH FY11 Oversight Question 48.
- 25 DMH FY12 Oversight Question 9, Attachment.
- 26 Dennis R. Jones, Court Monitor, Report to the Court: Dixon v. Gray, Exit Criteria No. 17, 8 (July 26, 2011).
- 27 CFSAFY12 Oversight Question Attachment Q30..FY11CFSA Programs Utilization Update Quarter 4, Mental Health Screenings Conducted by DMH Clinical Staff at CFSA.
- 28 Department of Mental Health, FY12 Oversight Questions, Question 43. 49% represents the rate of children deemed eligible by DMH/CFSA for a mental health screen who are, in fact, screened. Information provided by Denise Dunbar, DMH (May 2013). To date in FY13, the rate has improved to 71%. Some children who entered or re-enter foster care are not deemed eligible for a screen because they are under one year old or because they have already received a screening from Safe Shores DC Child Advocacy Center which included a trauma screening, making a DMH screening unnecessary.
- 29 CFSA FY12 Oversight Question 30(c).
- 30 "All children in the custody of the Agency shall, to the extent that it is not inconsistent with a court order, receive a behavioral health screening and, if necessary, a behavioral health assessment within 30 days of initial contact with the Agency or a placement disruption." DC Code § 4-1303.03e.
- 31 CFSA, Policy: Initial Evaluation of Children's Health, Section F.1, 8 (May 17, 2011). Additional clarifying information provided by Sandra Gasca-Gonzalez, CFSA.

- 32 CFSA's Responses to Questions for the FY14 Community Budget Briefing, Question 12 (April 8, 2013).
- 33 According to CFSA, the clinician working these extended hours will also be able to engage caregivers for children under age 8 for whom caregiver participation is necessary for a mental health screening. These caregivers are often not available to assist in the screening process during normal business hours and CFSA believes this approach will assist in increasing the screening rates. Email correspondence with Cheryl Durden, CFSA (April 22, 2013).
- 34 Meeting minutes, DC Gateway Project, System of Care Expansion Implementation Updates (April 8, 2013).
- 35 DMH FY12 Oversight Question 42.
- 36 Email correspondence with Cheryl Durden, CFSA (April 22, 2013). There are no available reports from the workgroup.
- 37 Email correspondence with Cheryl Durden, CFSA (April 22, 2013).
- 38 DMH FY12 Oversight Question 57
- 39 In FY11 a total of 211 youth were served. DMH FY11 Oversight Question 61.
- 40 DMH FY12 Oversight Question 57
- 41 DMH, Community-Based Intervention Services Data Comparison FY10, FY11 and FY12, Presentation at Children's Roundtable Meeting (December 7, 2012).
- 42 DMH, Community-Based Intervention Services Data Comparison FY10, FY11 and FY12, Presentation at Children's Roundtable Meeting (December 7, 2012).
- 43 DMH website list of CSAs (visited April 23, 2013).
- 44 FY14 Proposed Budget, CFSA Overview for the Community, 10 (April 8, 2013). \$750,000 additional will be spent to expand community-based mental health services. During the presentation, CFSA staff noted this new money will be concentrated on expanding services in Maryland to reach the children placed there. Some of this money may also be used to provide otherwise non-covered services to foster children living in DC as well. The category of services that will be offered include: diagnostic assessments, individual therapy, evidence-based practices, medication evaluation, medication management, grief and loss counseling, dialectical behavior therapy, behavior assessment, applied behavior analysis, one-to-one behavior intervention, and family/group services.

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