



Testimony before the District of Columbia Council
Committee on Health
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Performance Oversight Hearing
Department of Mental Health

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Good morning Chairman Catania and members of the Health Committee. My name is Judith Sandalow. I am the Executive Director of Children's Law Center¹ (CLC) and a resident of the District. I am testifying today on behalf of CLC, the largest non-profit legal services organization in the District and the only such organization devoted to a full spectrum of children's legal services. Every year, we represent 1,200 low-income children and families, focusing on children who have been abused and neglected and children with special health and educational needs. The children we serve have some of the most significant and complex mental health needs in the District, and my colleagues routinely cite the lack of appropriate mental health services as the greatest barrier to success our children face. I appreciate this opportunity to testify regarding the performance of the Department of Mental Health (DMH) over this past year.

DC children struggling to address a myriad of problems in their families, schools and community have a paucity of quality mental health services to assist them. Sixty one percent of DC children – or approximately 70,000 children - are enrolled in Medicaid.² An Urban Institute study found that, nationally, 12.4 percent of children aged 6 to 17 year old who receive Medicaid have mental health conditions.³ Yet, DMH is serving, by its most recent count, 4.33% of children in the District through its MHRS and Medicaid Managed Care Organization (MCO) system.⁴ And these are children who are simply receiving at least one mental health service, not necessarily the correct

¹ Children's Law Center works to give every child in the District of Columbia a safe home, meaningful education and healthy life. As the largest nonprofit legal services provider in the District, our 70-person staff partners with hundreds of pro bono attorneys to serve 1,200 at-risk children each year. Applying the knowledge gained from this direct representation, we advocate for changes in the city's laws, policies and programs. For more information, visit www.childrenslawcenter.org.

² Department of Health Care Finance, *Working Together for Health: Medicaid Annual Report FY 2008*, at 2 (2008).

³ Embry Howell, *Access to Children's Mental Health Services Under Medicaid and SCHIP*, Urban Institute, at 5 (2004).

⁴ Stephen Baron, DMH Director, Letter to Dennis R. Jones, Court Monitor in *Dixon et al v. Fenty, et al.* (February 24, 2010). In the letter the Department requests that the Court Monitor find that DMH has substantially complied with the required performance Exit Criterion #5 regarding the penetration rate for children aged 0-17. DMH asserts the penetration rate is 4.33%; this number is revised from earlier figures to take into account services provided to children not only through DMH's MHRS program, but also through the Medicaid MCOs. In the Department's responses to the Health Committee's FY09 Oversight Questions, Program/Services Questions (Round 2), Question 1, the Department reported this penetration rates as 3.07% (for the time period of 10/1/08-9/30/09). It is our understanding this 3.07% only included services provided by the Department through MHRS.

treatment or all the services to which they are entitled or need to truly improve their health and quality of life.

The District's failure to provide adequate mental health services to our children has a long history, but during the past year we have seen the seeds of positive change. This optimism begins with the Director of Child and Youth Services, Ms. Marie Morilus-Black, who clearly articulates an understanding of the problems to be overcome and some of the key steps to success. In particular, Ms. Morilus-Black embraces outcome-driven change and has begun gathering data and evaluating programs' effectiveness. She also understands the critical importance of teaming – with other providers, agencies and families – and has begun the process of training providers and other agency staff on how to engage in effective teaming. Perhaps most importantly, Ms. Morilus-Black and DMH are in the process of creating a three to five year Children's Plan. We are not only very pleased to be participating in this process, but we are impressed that critical issues such as funding streams, interagency collaboration and workforce development are being addressed.

Over the past year, DMH has expanded or launched several pilot programs that are intended to expand the array of services available to children. As one strategy to build the District's capacity to provide specialized mental health services to children in the child welfare system, DMH in collaboration with CFSA launched the Choice Provider Network in October 2008. Although training efforts have been slower than we would have liked, DMH, according to its own report, has this year trained 18 clinicians to provide Trauma Focused Cognitive Behavioral Therapy, a clinical service which has been much needed in the District for many years. DMH will begin training providers in Functional Family Therapy, Child Parent Interaction Therapy and Child Parent Psychotherapy for Family Violence in upcoming months.⁵

⁵ DMH's responses to the Health Committee's FY09 Oversight Questions, Program/Services Questions (Round 2), Question 49.

In 2008, DMH launched its Children and Adolescent Mobile Psychiatric Service (ChAMPS). ChAMPS has not had a straight line path to success, but DMH and ChAMPS have been responsive to community feedback and we have seen improvements. This year, it has had, both in terms of data⁶ and anecdotal reports, a positive impact in de-escalating situations and reducing the number of children who end up in emergency rooms due to mental health crises.

We also commend DMH for expanding school-based mental health clinics to 10 additional schools during the 2008-2009 school year, serving a total of 47 DCPS schools and 11 public charter schools.⁷ DMH has taken some encouraging initial steps towards launching its Early Childhood Consultation Project and we look forward to seeing this project fully implemented during 2010.

Finally, DMH has taken steps this year to improve its Wraparound Pilot project, which has kept some children out of residential placements. As many agencies are involved in placing children in residential facilities, we also applaud DMH for its leadership in convening an interagency committee on residential placements and look forward to learning more about how this oversight body will monitor psychiatric residential treatment facility placements.

Despite the progress DMH has made there is still much work to be done before it can be said that we have a functioning children's mental health system. These new or expanded pilots will remain simply pilots or, worse, will ultimately fail unless the District addresses the underlying structural problems that make DC an untenable environment for high quality service providers. No Children's Plan will be successful if the system continues to be fragmented and if money continues to be invested in incarceration, foster care and in-patient hospitalization rather than in front-end services.

⁶ Id.

⁷ DMH's responses to the Health Committee's FY09 Oversight Questions, Program/Services Questions (Round 2), Question 40.

Despite the progress mentioned earlier, the District is still lacking many important mental health services for children, such as: intensive day treatment programs; therapeutic after-school programs; therapeutic summer programs; integrated mental health and substance abuse services for youth with co-occurring disorders; and services for children birth to five years old. DMH must come up with a clear plan on how to recruit and retain providers in these areas.

For many years, a major gap in our service array has been specialty mental health services. It is a promising sign that DMH is focusing on training providers in several evidence-based therapies. However, training providers is just the first step. To ensure that trained providers translates into improved outcomes for children, DMH must address the system's current difficulty in timely identifying and timely referring children to the right service providers. DMH must also ensure that the services offered by the Choice Providers are available not only to children in foster care (who have fee-for-service Medicaid), but to other children in the District involved with the child welfare system but living at home. This means ensuring that the Choice Providers accept children enrolled in each MCO, that the MCOs are aware of the services and that they refer children to them when appropriate.⁸ Additionally, many of the services provided by the Choice Providers, including the new evidenced-based services, are funded through local dollars. We understand DMH and the Department of Health Care Finance are exploring whether these services may be billable to Medicaid and we urge them to make this a high priority.

DMH must also ensure services are high-quality. Each year DMH goes through a Consumer Service Review process required by the Dixon lawsuit through which sample cases are selected for review and scored in a variety of categories. In 2009, only in 48% of these cases did reviewers find

⁸ D.C. Citizens Review Panel, *Meeting the Mental Health Needs for Abused & Neglected Children: Findings and Recommendations regarding the District of Columbia Government's Implementation of the 2007 Department of Mental Health and Child & Family Services Agency Mental Health Needs Assessment* at 7 (February 2010)

that the system performed “in the acceptable range.”⁹ This poor performance did not surprise me, since my colleagues frequently complain of the poor quality services provided to our child clients. Performance problems include assessments that do not happen in a timely or complete manner and major mental health conditions left undiagnosed for months or years. Children leave hospitals without proper discharge plans or supports in place and end up back in the hospital soon thereafter. Clinicians are pressed for time and do not talk to each other or to the child’s caregivers, teachers and other key adults and therefore often review complex situations superficially and fail to identify core issues. Effective teamwork is critically important in developing a robust community-based mental health system; we know DMH is committed to improving teaming and we hope to see the tangible effects of this commitment demonstrated through improved outcomes for children.

Successfully increasing the array and quality of community-based mental health services is critically important to achieving another major goal: reducing the number of children in residential placements. In FY10, the Wraparound Pilot will serve 144 children, an increase of just 10 children from FY09. With over 500 youth in out-of-home placements, there is great need and this pilot must expand by significantly more than 10 children each year.¹⁰ In FY09, of the 86 youth served by the school wrap pilot, 98% were diverted from psychiatric residential treatment facilities (PRTFs). Of the 37 youth in the community wrap pilot, 71% were diverted from PRTFs.¹¹ While these numbers are encouraging, my colleagues with clients in the wrap program have reported mixed results with this new program. Some of the children have received robust services through the wrap program and are doing extremely well. Other children have not received any new or additional services and

⁹ Court Monitor Dennis R. Jones, *Report to the Court*, January 22, 2010 at 12 (Exit Criterion 17b).

¹⁰ DMH’s responses to the Health Committee’s FY09 Oversight Questions, Program/Services Questions (Round 2), Question 51. See also Jennifer Lav. *Out of State, Out of Mind: The Hidden Lives of D.C. Youth in Residential Treatment Centers*, University Legal Services, Inc. at 3 (June 22, 2009).

¹¹ DMH’s responses to the Health Committee’s FY09 Oversight Questions, Program/Services Questions (Round 2), Question 49.

while they may have avoided a PRTF they have faced other negative outcomes such as multiple foster home placements or incarceration through the delinquency or criminal systems.

None of these problems will be fully addressed until DMH and the District address the fragmentation and complexity that makes our Medicaid-funded mental health system unattractive to high quality mental health providers. Because the solution requires the active participation of many agencies, I discussed the issue at last week's oversight hearing for the Department of Health Care Finance. There are four MCOs, fee-for-service Medicaid and a separate MHRS system. MCOs are responsible for providing office-based mental health services, such as counseling or family therapy. However, for children diagnosed with severe mental illness and who need more intensive in-home therapies, the responsibility for providing services shifts to DMH and the payments shift directly to Medicaid. DMH uses a network of core service agencies to provide their mental health services. Providers must credential separately with each MCO and subcontract separately with each CSA which is a time-consuming process and is often mentioned by providers as the reason they will not accept DC Medicaid. To complicate matters, children who are enrolled in an MCO switch to fee-for-service Medicaid if they enter the foster care system. In order for that child to maintain continuity of services, their mental health provider must also be properly credentialed as an MHRS provider. This complicated set-up has led many providers to refuse to contract with Medicaid at all. Lawyers in our office have come across many providers who accept Maryland and Virginia Medicaid, but refuse to accept DC Medicaid because it's too burdensome. This leads to a shortage of providers, resulting in many children failing to get important mental health treatment or facing long delays that impair their health. Too often children go without services or treatment until a crisis arises. Crisis care is extremely disruptive to children and families and also costs the system significantly more than less-intrusive mental health care.

Last year, the District agencies that are collectively responsible for the children’s mental health system, DMH, the Department of Health Care Finance, and the Child and Family Services Agency met to discuss options to address this critical problem. One option considered was for the District to carve-out mental health services from the MCOs and have either DMH or another entity, such as one specialty managed behavior health care organization, run the mental health services for all Medicaid beneficiaries. Last Spring, the Department of Health Care Finance contracted with Department of Health Policy at the George Washington University to conduct an assessment of the children’s behavioral health services in the DC Medicaid system and examine whether a carve-out would be a good way to improve services. The report has not yet been released, but our understanding is that it does not provide a clear solution. Whether through a carve-out or other mechanism a solution must be found. We cannot wait another year. No one agency is responsible for fixing this problem. For too long this shared responsibility has prevented the District from tackling and solving this problem. The Mayor needs to make this a priority and the agencies must coordinate to find a solution.

If the solution to fix our children’s mental health system includes the continued use of MCOs to provide mental health services, DMH must be involved in oversight and accountability. A recent study by RAND Corporation found that many MCOs authorize only a limited number of mental health visits which often doesn’t adequately meet a child’s mental health needs;¹² this is particularly troubling given the expansive right to services children have under federal Medicaid law.¹³ In addition to the general charge DMH has to oversee the mental health services of *all* children in the District, DMH should pay special attention to the services received by children in

¹² Rand Corporation, Rand Health, *Technical Report: Health and Health Care Among District of Columbia Youth*, 112 (2009)

¹³ Early Periodic Screening, Diagnosis and Treatment (EPSDT) requires a comprehensive health care benefits package for all Medicaid-eligible children under age 21. 42 USC § 1396 (a)(43).

MCOs: If these children are not receiving appropriate office-based care and their mental health conditions worsen, DMH will then become responsible for providing for and paying for their care.

In conclusion, we applaud DMH for the positive steps they have taken this year to improve the children's mental health system. In the coming year, we hope to see the array of services continue to expand, the quantity of services increase and the quality of services continue to improve. Most importantly, however, we hope that DMH, the Mayor and the Council will treat the situation facing children using mental health services as the crisis that it is – and make solving the problem a priority. This will require working together to address and dismantle the underlying systemic barriers presented by our fragmented, complex mental health system. We look forward to working with all of you to achieve these goals.

Thank you again for the opportunity to testify. I am happy to answer any questions.