

2015 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	6
Improve Access for Children and Families	8
Create a Robust Prevention and Early Identification System	8
Improve Care Coordination	4
Ensure Quality and Timeliness of Services	5
Improve Psychiatric Services	8
Improve Community-Based Services to Reduce Residential Placements	7

ABOUT THE GRADING SCALE:

Grades cover the District government's progress in FY2014 and the beginning of FY2015 toward meeting the mental health needs of low-income children. Ten is the highest grade and represents substantial achievement over the past year. Zero is the worst grade and represents no progress.



EXECUTIVE SUMMARY

The District of Columbia can be a tough place for vulnerable children to grow up, and no more so than for the roughly 13,000 to 20,000 low-income and poor children who are estimated to have mental health needs.¹ Whether it is a young boy with ADHD or a teenage girl dealing with the trauma of losing her mother to gun violence, these children can have a range of moderate to severe mental health concerns.

Whatever the diagnosis, childhood mental illness that is left untreated can deny children an opportunity to live a happy, healthy, productive life and deny the District of their talent. It also can result in higher financial and social costs to DC if a child's

untreated mental illness results in the need for special education services, causes him to drop out of school, makes her less likely to hold a job, or lands him in the juvenile justice system or in prison.

While many people impact a child's mental health, the District government is uniquely responsible for ensuring that timely, appropriate, high-quality services are provided to all children who need them. The DC Department of Behavioral Health (DBH) leads the charge to develop, manage and oversee our city-wide public mental health system. In addition, the Department of Health Care Finance (DHCF) oversees managed care organizations (MCOs)

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that enroll most of the low-income children on Medicaid, including those with mental health issues. And, several other District agencies also have some responsibility for programs that serve the mental health needs of children, whether it is children in foster care, the juvenile justice system or in our public schools.

The good news is that the District government is beginning to close the gap in unmet need and many more DC children are receiving mental health services from these agencies than ever before. For the first time since we have been issuing our annual Children's Mental Health Report Card, the DC government has reported a significant increase in the number of children they have reached with mental health services.

The Department of Health Care Finance reports that about 13% of children on Medicaid were treated for a mental health issue in FY2014. That's 12,550 children – about 3,000 more than received services the year before.² One reason for this improvement is that DHCF has been putting pressure on the managed care organizations to increase the number of children who get mental health screening, referrals and treatment.

As a result, MCOs have significantly increased their spending in this area.

There is some reason to be cautious about these numbers, given varying data reported by providers and agencies that count different procedures, time periods and age groups in their tally of children getting mental health services. In addition, even with the increase there are still many thousands of children who need help but are not getting mental health treatment when we compare the District's numbers against national estimates. Still, we are optimistic that a significant number of children are now getting treatment who were missed by DC's mental health system in previous years. For this reason, we are giving DC a very high score of 8 in this area.

There is also very good news when it comes to expanding the cadre of skilled professionals who can identify and treat children with mental health needs. Pediatricians across the District are now required to screen children for mental health needs during regular well-child visits, and hundreds of clinicians (who treat 75% of children on Medicaid) were trained this year in standardized screening tools. In addition, pediatricians will soon have a network of psychiatric



professionals on call to help them manage moderate mental health concerns through the DC Mental Health Access in Pediatrics (DC-MAP) program, which has been mandated by the DC Council through the *Behavioral Health System of Care Act of 2014* and funded by the Department of Behavioral Health for FY15. This program will help pediatricians fill the gap created by the shortage of child psychiatrists, which is a problem here in DC and nationwide. Therefore, the District gets a high score of 8 for its progress in creating a robust prevention and early identification system, as well as for improving psychiatric services.

Despite these positive developments, the troubling news is that we still don't know if children are getting the right services or high-quality services. The Department

of Behavioral Health is putting into place new standardized evaluations that are being adopted across all child-serving agencies, which should result in more information about whether mental health interventions had good outcomes for children. For now, however, we have to rely mostly on more limited evaluations and anecdotal evidence to determine if children's needs are being met. Unfortunately, DBH did not publish its FY14 Provider Scorecards nor did it conduct comprehensive Community Service Reviews in FY14, which were two previous measures of service quality. These assessments gave providers poor scores in previous years. What we do know is that children are still not getting connected to services quickly and had to wait an average of 13 days for a needed treatment once enrolled

— about twice as long as regulations require. Concerns about program quality and timeliness led us to give a low grade of 5 in this area.

In addition, the District gets its worst grade in the area of care coordination. Very few children currently have case managers to ensure their families can navigate the complex network of providers, programs and services that comprise our mental health system. These entities often do not share information about progress as a child’s treatment is handed off from one provider to another. And, progress in paying clinicians for time coordinating care has stalled. For these reasons, the District has earned a very low grade of 4 in this area.

Finally, the District still needs to do more to ensure that the children’s mental health system in DC is in fact a *system*. Unfortunately, although the Department of Behavioral

Health states that its mission is to “develop, manage and oversee a public behavioral health system for adults, children and youth and their families,” DBH doesn’t actively oversee service-delivery for all children in the system.³ DBH and the many agencies that oversee pieces of the children’s mental health system need to do more to improve case management for individual children, more to identify and fill gaps in services, ensure that families are connected to unfilled program slots, and standardize how they are tracking how many children are getting services so that the District’s progress can be monitored over time. Fundamentally, Children’s Law Center is concerned that if DC government agencies can’t agree on how many children are getting mental health services, that is a troubling sign that no one agency is keeping their eye on ensuring we are meeting children’s mental health needs.

ABOUT THE GRADES

The children’s mental health system is complex, thus it is not possible to give the District a single, overall grade for how it is meeting children’s needs. Instead, this report card reviews the District’s progress over 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.⁴ Ten is the highest grade and represents substantial fulfillment of the goals; zero is the worst grade and represents no progress.

GRADING OUR PROGRESS IN 2015

Bring Needed Services to the District

GRADE 6

Children with mental health needs can require a wide range of services. Depending on their diagnosis, the appropriate treatment can range from once a week individual therapy to six months of intensive wraparound services to a short-term hospitalization. Providing a full continuum of quality services that provide effective care at the earliest sign of a mental health problem is the backbone of a strong children's mental health system. Without this continuum of services, a child's mental health can deteriorate, leading to unnecessary hospitalizations and placement in residential facilities or foster care. The District continues to slowly expand mental health services, adding two evidence-based practices (EBP) and dropping one this year, bringing the total number to 16 EBP available to children and youth.⁵ However, services are still overwhelmingly focused on severe illness and several important approaches are missing. For these reasons, the District has earned a grade of 6 in this area.

Cities and states who strive to have a high quality children's mental health system regularly work to expand services and determine which mix of services is best for their population.⁶ There is no simple formula for how to develop the perfect array, but an analysis of nine states that have made significant progress found that all of them developed a broad array of home- and community-based services and treatment.⁷ These states have

added services including family and youth peer support, intensive care management, intensive home-based services, respite care, therapeutic behavioral aide services, mobile crisis services, crisis stabilization, therapeutic foster care, and specific evidence-based practices.⁸ In a recent review of DC's childhood mental health system, the Georgetown University Center for Children and Human Development noted that the District has made progress on



DC is expanding its array of mental health services, but is still too heavily focused on severe mental illness.

expanding its array of services, but is still too heavily focused on youth with severe mental illness and has too high a barrier to treatment for youth with moderate mental health problems. They also recommended expanding the array of practices to address specific populations, such as Treatment Foster Care (which provides community-based therapeutic care in specially trained foster families) and treatments for children exposed to family violence.⁹

In the past few years, DBH has placed a particular emphasis on increasing DC's service array through bringing new evidence-based

practices to the District. Evidence-based practices are treatment models that have been proven to be effective through rigorous evaluation. Between DBH and DC Public Schools (DCPS), there are now 16 evidence-based therapies available in the District.

This year, DBH added two new evidence-based practices, Trauma Systems Therapy and Adolescent Community Reinforcement Approach (A-CRA). Trauma Systems Therapy, currently offered by four providers, is designed to treat children and adolescents experiencing traumatic and emotional stress.¹⁰ A-CRA is a behavioral intervention that seeks

to replace environmental influences that have supported alcohol or drug use with prosocial activities and behaviors that support recovery.¹¹ The District's four certified adolescent substance abuse treatment providers have now all been trained and are using the A-CRA model.

Children who attend DCPS have access to six additional evidence-based treatments. All school social workers are trained in at least one of the following evidence-based practices: Cognitive Behavioral Intervention for Trauma in Schools (CBITS); Structured Psychotherapy for Students Responding to Chronic Stress (SPARCS); Cannabis Youth Treatment; Cognitive Behavioral Therapy; Child Centered Play Therapy; and Mental Health Consultation.¹² Unfortunately, there is no comprehensive source of information about mental health services provided by charter schools.

In addition, though not technically evidence-based, child and family peer specialists are recognized as an important way to engage young people and their parents. This year, DBH trained eight peer specialists and five of them are now working at local mental health and social services agencies.

Despite this progress, there are important services that DC's mental health system is lacking for children, including intensive day treatment, therapeutic after school and summer school programs. And, within the

DBH/Medicaid system that serves low-income children, it is hard to locate clinicians with expertise in treating specific populations such as older children with insecure attachments, children with low intellectual function and children with fetal alcohol spectrum disorder. Continuing to expand the array of services will be important to ensure that all children receive appropriate services and treatment that allows them to remain in the community.

There is no centralized tracking of all the mental health services available to children in DC. In addition to the services noted above, there are many additional mental health programs offered by various government agencies and non-profit organizations. The failure of any agency to track and evaluate these services means that their effectiveness is unknown and availability is haphazard.

At the end of the day, more funding will be needed to further expand services. The good news is that the federal government will pay 70% of the cost of mental health services through Medicaid. Thus, one of the best ways to fund additional mental health services is to ensure that they are reimbursable by Medicaid. Currently, nine of the 10 evidence-based practices provided by DBH are Medicaid-reimbursable,¹³ but DCPS does not seek Medicaid reimbursement for any of its EBP.¹⁴

Improve Access for Children & Families

GRADE 8

Having a full array of mental health services is only effective if children in need are using them. This year, District agencies have made significant progress in reaching many more children who have mental health needs; one measure shows that roughly 3,000 more children are getting treatment than received it in previous years. This is due in large part to increased oversight of Medicaid managed care organizations by DHCF in FY14. Yet, the fragmentation of the District's mental health system continues to make it difficult to truly know how many children are getting services; and some estimates show that there could be many thousands more children who are not getting any services. Still, because of DC's very good progress in reaching thousands more children this year, we are giving the District a high grade of 8 for progress in this area.

Citing national research, the Department of Behavioral Health estimates that between 13 to 20% of all children may experience a mental health disorder in a given year.¹⁵ This translates into an estimated 12,000-18,600 of the 98,000 children on DC Medicaid who may have a mental health disorder that requires treatment.¹⁶ Given that the District has a large number of children living in poverty, and that low-income children have an increased likelihood of having mental health problems due to risk factors associated with poverty, it is likely that the number of DC children needing help is at the top of the range.¹⁷

Comparing how many DC children are getting mental health treatment

against these national estimates is one important way to judge whether or not the District is improving access for children and families. Unfortunately, it is impossible to know the exact number of children getting mental health services, given inconsistent data reported by agencies that count different procedures, time periods and age groups in their tally.

One complicating factor is the number of agencies that oversee and deliver children's mental health. Ninety percent of children on DC Medicaid receive their health care through managed care organizations, which are overseen by the Department of Health Care Finance.¹⁸ Children who are in foster care or incarcerated



The District should be applauded for reaching 3,000 more children with mental health needs.

through the juvenile justice system have fee-for-service Medicaid, which bypasses the MCO system. In addition, all DC children who need intensive mental health interventions can access these services through the Mental Health Rehabilitation Services (MHRS) network of providers, overseen by DBH. Schools also provide some mental health services and much of this is not billed to Medicaid. Finally, reports on the numbers of children getting services change over time, as billing data gets corrected and updated.

Despite the limitations of these reports, comparing data from a single agency year over year allows us to judge trends. To do this, Children's Law Center reviewed the Department

of Healthcare Finance's data, which provides the most complete picture of children getting mental health services in DC. According to recently revised DHCF figures, some 12,550 children and youth (up to age 20) had a mental health service billed to Medicaid in FY2014. That is a more than 30% increase from FY13, when only 9,569 children received a mental health service billed to Medicaid.¹⁹ This is a significant increase, and the District should be applauded for this progress.

One reason for this jump is that the MCOs have been increasing their spending on children's mental health. Over the last year, DHCF has released quarterly reports on each of the MCOs, including each plans' medical

and mental health spending across various health service categories, whether members are accessing primary care and care coordination, to what extent members are using emergency rooms for non-emergency purposes, their financial health, and their ability to meet the administrative requirements. DHCF categorized the MCOs' medical spending for behavioral health services as "negligible" in its first quarterly report.²⁰ But, over the course of FY14, with increased pressure from DHCF to increase their spending in this area, the plans have done so.

As a result of this increased oversight, the End of the Year Performance Report (covering July 2013-June 2014) shows that the MCOs are spending an average of \$10.94 per child per month on behavioral health services.²¹ This is a significant increase from the amount being spent when this number was first reported in February 2014, which was only \$6.25.²²

Despite this very positive news, the reality is that many thousands of children who have mental health needs are still likely being overlooked. Given the range that DBH uses to estimate children's mental health needs in DC — which translates into 12,000-18,600 children on Medicaid having a mental health need — potentially 8,000 or more children

may be overlooked by our current system of care. DC will need to make more progress in all areas to connect these children to needed care.

Another troubling fact is that despite the unmet need, the District has underutilized capacity to serve more children. For example, DBH and the Child and Family Services Agency (CFSA) are collaborating on trauma treatment, yet only 50% of the slots for Trauma-Focused Cognitive Behavioral Therapy were utilized last year.²³ And in July 2013, DBH heralded a new service, Transition to Independence Process (TIP), which helps teens and young adults with mental health concerns navigate issues such as education, housing and employment. TIP fills an important service gap for these transition-age youth, yet only 75% of its slots were utilized last year.²⁴

The District has taken one small step forward to reach more children who have been identified as having a high risk of parental neglect. To help these children access mental health services more effectively, DBH has hired behavioral health coordinators and placed them at the five Healthy Family/Thriving Communities Collaboratives sites. These specialists conduct behavioral health screenings and assessment, and help the Collaborative staff make mental health referrals for at-risk children and their families.²⁵

Create a Robust Prevention and Early Identification System

GRADE 8

Early identification of mental health problems is critically important because it leads to earlier assessment, diagnosis and treatment; earlier treatment leads to more positive outcomes for children and families. Last year, the District made significant progress in this area by requiring all pediatricians to screen children for mental health problems and by creating a universal intake form for social service providers. Promising prevention and early intervention programs, however, still serve only a small percentage of DC children and need to be expanded. Still, the District has earned a grade of 8 for its progress in this area.

Pediatricians across the District are now required to screen children for mental health needs using standardized screening tools. Since two-thirds of children in DC regularly visit their pediatricians, this is an excellent way to identify mental health issues early.²⁶ This reform was led by the DC Collaborative for Mental Health in Pediatric Primary Care, a public/private partnership launched by Children's Law Center and Children's National Health System in 2013 to improve the integration of mental health and primary care. Partners include the DC Chapter of the American Academy of Pediatrics, Georgetown University, DBH, DHCF, the Department of Health and DCPS.

Under the leadership of Children's National, 150 pediatricians and

staff (who serve 75% of children on Medicaid) learned how to use the screening tool as part of a nine-month learning collaborative which provided training on a variety of mental health topics.²⁷ A second learning collaborative is currently underway.

In addition, DHCF implemented new rates and billing requirements for FY15, which ensure that pediatricians will get paid for performing and scoring these mental health screenings.²⁸ The MCOs began implementing this new requirement in January 2015. The new billing protocols also allow DHCF to confirm that the mental health screening was performed and track compliance with the screening requirement.

Screening is just a first step; once a child is identified as having a mental health problem, he or she needs to be



connected to appropriate follow-up treatment. DBH has recognized that one of the barriers families have in accessing services is the frequency with which they are asked by different social services and mental health providers to repeat the same information. For a family struggling to help a child with mental illness, this time consuming and emotionally difficult task can prevent them from connecting to needed services. To address this problem, DBH's DC Project Gateway Access Workgroup created a universal intake form which can be shared with other agencies and providers if a parent consents.²⁹ Currently, only staff at five Healthy Family/Thriving Communities Collaboratives have been trained to use this form.³⁰

Children entering foster care often need help recovering from the trauma of abuse and neglect as well as the accompanying trauma of being

removed from their family.³¹ DBH clinicians are located onsite at CFSA to conduct mental health screenings for children that enter or re-enter foster care. This year, DBH has improved its 30-day screen rate and screened 65% of children who they deemed eligible for a screening; this is a marked improvement over last year's rate of 33%.³²

Despite these good steps to identify children in need of services the District has made little progress in expanding early childhood programs to prevent mental health problems or to intervene before mild behavior problems become serious mental health issues.

DC has a few strong programs aimed at young children. However, they serve a small percentage of children and are barely expanding. DBH's Early Childhood Mental Health Consultation project places mental health specialists in child

development centers across the District. These clinicians train staff, provide services to children and parents and make necessary referrals. Young children with behavioral problems can struggle with their parents, disrupting the nurturing parent-child relationship that is necessary for the child's healthy development. Unfortunately, the project has not expanded since its inception in 2010.³³ The project is currently in 26 centers,³⁴ which make up less than 5% of the child development centers and home-based child care providers in the District.³⁵

The Primary Project, which works to reduce social, emotional and school adjustment issues for students in Pre-K through third grade, is now in 45 schools, only four more than last year, although there are plans to further expand the program to five more schools during FY15.³⁶ It is worth noting that the *South Capitol Street Memorial Act of 2012* required the mayor to report in 2014 how it planned to expand early childhood mental health services by the 2016-2017 school year, but no such plan has been released.³⁷

Home visiting programs, which promote positive parent-child relationships and healthy child development, are another prevention and early intervention program aimed at young children who may have social and emotional needs. The need for home visiting programs is especially high in the District where roughly

30% of the more than 38,000 children between the ages of zero and five live in poverty³⁸ and are at risk for a variety of poverty-related challenges, including exposure to trauma and abuse.³⁹ Studies have shown the positive impact of home visiting programs in a variety of areas affecting mental health, including improved parent-child interactions, improved child development measures, and decreased frequency of abuse and neglect.⁴⁰ In FY14 there was a modest expansion of DC's home visiting program, but expansion is still very slow due to episodic and uncertain funding.⁴¹ Currently, the various home visiting service providers have a combined capacity of 935 families.⁴² The need for services is much higher. For example, the DC Home Visiting Council estimates that there are more than 1,800 children born in the District each year who are considered high-risk for developmental delays. This is but one of several groups of children who are at risk of developing mental health problems.⁴³

Finally, the School Mental Health Program (SMHP) provides prevention and early intervention services to children of all ages in the District's schools, in addition to providing clinical services. The *South Capitol Street Act* requires SMHP to be in every school by the 2016-2017 school year,⁴⁴ but it is currently only in 30% of the District's public schools⁴⁵—only four more sites than in the 2011-2012 school year.⁴⁶

Improve Care Coordination

GRADE 4

Many adults play a role in addressing a child's mental health needs: parents, teachers, pediatricians, and any involved social workers or probation officers, among others. A treating mental health clinician may need to talk with all of these key people in order to provide the most effective treatment. Even before a child sees a mental health professional, her family must navigate the complex Medicaid bureaucracy. This is called care coordination or case management. To connect children to services and then to coordinate care, MCOs are required to provide case managers. Data shows, however, that MCOs are not adequately providing these required case management services. In addition, efforts to pay mental health clinicians for the time they spend coordinating care has stalled. Because care coordination overall is quite poor, the District has earned a low grade of 4 for this area.

A key part of care coordination is ensuring that a child's mental health clinician is able to talk to all the key people in the child's life in order to provide the most effective treatment. In the parlance of Medicaid funding, these conversations are called collateral contacts. Despite promises by the Department of Health Care Finance to draft and implement regulations to make collateral contacts reimbursable through Medicaid, this critical component of care coordination remains unfunded.⁴⁷

MCOs are required to provide care coordination and related case management "for enrollees with multiple, complex or intensive health care problems that require frequent and sustained attention."⁴⁸

For parents trying to navigate the complex mental health system, it is often impossible to obtain proper treatment for their children without this assistance. None of the MCOs has enrolled more than five percent of their membership into a program of case management.⁴⁹

Through their Division of Quality and Health Outcomes, DHCF has plans to increase the number of beneficiaries receiving case management services and to improve the quality of these services. The program will include outreach to the community, education and training for case managers and the development of consistent standards of service and performance outcomes.⁵⁰

Ensure Quality and Timeliness of Services

GRADE 5

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 in the community. Though some progress has been made over the last year in both of these areas, children are still waiting too long to connect to community-based services and post-hospital care. The District also has reduced the frequency of its traditional quality assurance testing, so an overall review of progress on quality is unknown. Still, the District is making progress in the implementation of a system-wide assessment tool to be used by agencies and providers to measure whether children are benefiting from treatment in the future. Still, for its lack of progress, the District has earned a grade of 5 for this area.

Children in DC are not receiving timely mental health treatment. Unfortunately, the extent of the delay from initial referral to enrollment to treatment is not fully known. Regulations require core service agencies to treat children within seven business days of a referral.⁵¹ During FY14, it took an average of 18 days from the time a child was enrolled in a core service agency (CSA) to the date the child was first treated (though this number dropped to 13 days in the first quarter of FY15).⁵² While this is a promising trend, the actual length of time between a child's initial referral and their enrollment is not known, and therefore the delay between the time a family seeks help and the time a child eventually receives treatment

could be even longer. The good news is that there continues to be progress since FY13, when the average number of days between enrollment and treatment was 22 days.⁵³

Timely connection to services is particularly important for children in foster care, who have an understandably high level of mental health issues. DBH and CFSA have successfully collaborated to accomplish this goal. Choice Providers, a select group of specifically trained core service agencies, now attend the meeting that is held immediately before or after a child is removed from his or her family.⁵⁴ During the first quarter of FY15, some 87% of these children were properly enrolled with a core service agency within 48 hours of their removal

from their families. There is not yet data on when these children received treatment, but the speed of enrollment is a promising first step.

Another group of children who need timely services are children being discharged from psychiatric hospitalization. Unfortunately, only 61% of children discharged from an acute care hospital connected to community-based treatment within a week.⁵⁵ This is a decrease from 67% in FY13.⁵⁶ This failure to receive timely follow-up care can have serious consequences for a child, including dangerous lapses in medication and repeat hospitalization.

The goal of treatment is to improve a child's health. To do so, it must be the right treatment, offered at the right time and proven to be effective. DBH has two ways to measure quality: the DBH Provider Scorecards and Community Service Reviews (CSRs). In FY13, both measures revealed mediocre results. None of the 11 CSAs that serve children received the top scores of five or four stars.⁵⁷ Similarly, the CSRs showed that they performed "in the acceptable range" in only 70% of cases.⁵⁸

Unfortunately, there is no new information this year about the quality of services provided to children in the District. Anecdotally from Children's Law Center's own work with children we know that service quality remains, at best, uneven. However, DBH has not

released FY14 scorecards. Also, for the first time, they did not conduct full-scale community service reviews, although they did conduct an in-depth review of 12 youth who received wraparound services designed to prevent entry into full-time psychiatric treatment facilities. With the end of the Dixon class action lawsuit,⁵⁹ DBH is no longer required to conduct full-scale, annual CSR reviews and the agency has stated that it will reduce the frequency of these reviews to every other year.⁶⁰

The decision to reduce the frequency of CSR reviews raises concerns. It has been one of the few publicly available measures of the quality of children's mental health services. In its recent review of DC's children's mental health system, the Georgetown University Center for Children and Human Development noted "the yearly CSRs are an effective way to measure the system and improve the quality of service delivery."⁶¹ The report also recommended strengthening the yearly reviews through the "development of quality metrics to evaluate whether quality services are being delivered to children, youth and their families" and supplementing the reviews by collecting standardized consumer surveys.

On the positive side, the District has taken steps to better track treatment outcomes, which could improve quality this coming year. Until now, there has not been a



standard way to assess the impact of mental health treatment. After two years of planning and work, the District's child-serving agencies began the initial phase this year of implementing a new functional assessment tool: the Child and Adolescent Functional Assessment Scale (CAFAS).⁶² The CAFAS is a tool that clinicians are required to use every 90 days to assess the impact of their services on the functioning of the child and family. It will allow individual clinicians, their supervisors and child-serving agencies to track the progress a child and family is making and analyze whether services are improving a child's functioning. The CAFAS should also allow DBH and other agencies to determine whether specific providers and programs are effectively treating children and families.

Currently, DBH, the Department of Youth Rehabilitation Services and several Department of Human Services child-serving programs are using the tool.⁶³ The Child and Family Services Agency plans to use the tool for all children in CFSA care during FY15. DBH is also working with DCPS and the charter schools to pilot the tool in public schools. These agencies are working together to develop a common data warehouse so they can share information from the CAFAS with various providers across agencies.⁶⁴ Given that children often see multiple providers and are involved with many agencies and systems, it will be a huge step forward to have a common tool if it is used to allow the District to measure outcomes and to assess if services and treatments are actually effective.

Improve Psychiatric Services

GRADE 8

Child psychiatrists provide essential care for children with complex mental health problems who require medication. However, like much of the nation, the District faces a shortage of child psychiatrists. There has been significant progress made this year toward a creative approach to remedy this critical shortage in DC by expanding the ability of pediatricians to manage children's mental health concerns. For this reason, the District has earned a grade of 8 for this area.

Children have much better access to pediatricians than to child psychiatrists. Families also frequently turn to their pediatricians with behavioral health concerns. With the right support, many mild behavioral health concerns can be managed by a primary care physician, thus providing better continuity of care for families and decreasing the burden on an already stressed mental health care system.

Following the example of 30 other states, the new DC Mental Health Access in Pediatrics project (DC-MAP) is providing pediatricians with the opportunity to consult a mental health professional whenever a pediatrician has questions about appropriate care.⁶⁵ When patients have mild mental health conditions, DC-MAP will help pediatricians treat children within their own practices. If the child has more intensive needs, the consultative team will help the

pediatrician make the necessary referral. If there is some uncertainty about the patient's need, the consultative team can provide a face-to-face consult to ensure a quick and accurate assessment and referral.

DBH awarded a contract to Children's National Health System to run DC-MAP and the Mayor's FY16 proposed budget includes \$500,000 to fund it.⁶⁶ In addition, the *Behavioral Health System of Care Act of 2014* requires the program to be a permanent part of the children's mental health system.

Another area of concern with 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 DBH, CFSA and DHCF formed the Psychotropic Monitoring Group to "ensure that



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psychopharmacologic treatment provided to foster youth in the District meets (or exceeds) the standard of care.⁶⁷ This year the group worked with the District of Columbia Drug Utilization Review Board to develop a protocol for identifying children under age 5 who were prescribed any psychotropic medication and determined that none had in 2013. They also

developed a protocol to identify any children older than five who were prescribed four or more psychotropic medications but no results have been reported.⁶⁸ As part of their contract, the child and adolescent psychiatrists from DC-MAP will join the Psychotropic Monitoring Group, which plans to look at more extensive data for children and youth ages 5-21 in foster care later this year.

Improve Community-Based Services to Reduce Residential Placements

GRADE 7

Effective community-based mental health services allow children to remain with their families and in their communities rather than in residential placements far from home. The number of children treated in residential facilities this year remained the same as last year. In addition, community-based diversion programs publicly released outcome data, an important step toward determining if the programs are successful. Because of this progress, the District has earned a grade of a 7 for this area.

A well-functioning mental health system should over time reduce the number of children who are hospitalized or in full-time, residential treatment facilities as more and more children are screened and treated earlier in their illness. In the District, the numbers of children admitted to psychiatric residential treatment facilities has gone down over time but stayed the same from FY13 to FY14.⁶⁹ In addition, DBH has increased the capacity of its primary diversion program, the High Fidelity Wraparound Program, by almost 10%.⁷⁰

The wraparound program was extremely successful at diverting children from residential programs in FY14: only 10 of 355 children who were seen in the wraparound program were eventually placed in a residential program.⁷¹ Diversion from residential treatment is just

one measure of this program's success, however. Setting children on a path to success and keeping them from truancy, delinquency and other detrimental outcomes is the true test of a program's worth. DBH's Community Service Review in FY14 focused on the wraparound program; the CSR team did an in-depth look at twelve youth who were receiving these services and rated 75% of the cases as "acceptable."⁷² The two programs that provide wraparound services, DC Choices and the Healthy Families/Thriving Communities Collaboratives Council publicly reported their own outcomes, a step forward from last year when there were no outcomes available. Unfortunately, the data is self-reported and the time period being measured is not specified: DC Choices, for example, reports that 84% of youth were not *currently*



involved in the juvenile justice system, 88% had not “run away, engaged in delinquent behavior or in behavior that threatened the community” and over 80% of youth were maintaining or improving their school attendance and behavior.⁷³ In its evaluation, Healthy Families/Thriving Communities Collaboratives Council reported that 80% of youth it served were not in abscondence, 70% were not in a detention center and 86% were not hospitalized.⁷⁴

Keeping children from re-entering residential treatment is critical as well and is best accomplished by providing intensive services immediately upon a child’s return to the community. In FY 2014, only 38% of the youth discharged

from residential treatment received intensive community-based intervention services, a slight decrease from 39% in FY13. DBH’s regulations state that consumers should receive community-based intervention within 48 hours after being authorized and referred for the service. But in FY14, the average time between referral and service was slightly longer than in FY13 (seven compared to six days).

In other states the Treatment Foster Care program is used as an alternative to residential treatment for many children in the child welfare system.⁷⁵ DC does not currently employ an evidence-based model of Treatment Foster Care, nor does it currently have plans to do so.

ENDNOTES

- 1 DHCF reports that in January 2015, there were 98,000 DC children on Medicaid, the health program for low-income and poor children and families. National estimates show that between 13-20% of children experience a mental health disorder in any given year – which would translate into anywhere from 12,740-19,600 children on Medicaid who have mental health needs in DC. James R. Wotring et. al. National Technical Assistance Center for Children's Mental Health, Georgetown University Center for Children and Human Development, *Behavioral Health for Children, Youth and Families in the District of Columbia: A Review of Prevalence, Service Utilization, Barriers, and Recommendations*, 2 (2014), available at <http://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/webpage.%20Children%20Youth%20and%20Families.%20Behavioral%20Health%20Report.pdf>.
- 2 Last year, DHCF reported to Children's Law Center that only 6,575 low-income children on Medicaid were treated for mental health issues in FY13. This year, that number has been revised upward by DHCF because of two factors: updated billing information, and a new methodology that includes additional treatment codes in their analysis of mental health services. Those data tables are on file with Children's Law Center.
- 3 See Department of Behavioral Health, *About DBH*, <http://dbh.dc.gov/page/about-dbh>.
- 4 Children's Law Center, *Improving the Children's Mental Health System in the District of Columbia* (2012), available at <http://www.childrenslawcenter.org/sites/default/files/clc/MHplanExecSummary.pdf>.
- 5 The 16 practices are counted across both DBH and DCPS. In addition, this year DBH dropped Multi-Systemic Therapy for Emerging Adults, an evidence-based practice which they began offering in FY14. According to information provided to Children's Law Center by DBH, the agency recruited a provider (North American Family Institute) to deliver this service but dropped it in January 2015. DBH is actively recruiting another provider for this service and currently offers Transition to Independence Program (TIP) that provides similar supports to youth transitioning to adulthood.
- 6 Beth A. Stroul & Robert M. Friedman, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Administration, *Issue Brief: Strategies for Expanding the System of Care Approach*, 7 (2011), available at <http://gucchdtacenter.georgetown.edu/publications/SOC%20ExpansionStrategies%20Issue%20Brief%20FINAL.pdf>. This report looks at nine states that have made significant progress in statewide system of care expansion. All of them have developed and expanded a broad array of home- and community based services and supports that are "individualized, coordinated, family driven, youth guided and cultural and linguistically competent."
- 7 *Id.* At 9.
- 8 *Id.*
- 9 Wotring, *supra* note 1, at 42; see also U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, *Mental Health Surveillance Among Children-United States, 2005-2011* (2013), available at <http://www.cdc.gov/mmwr/pdf/other/su6202.pdf>.
- 10 DBH FY14 Oversight Responses, Question 83.
- 11 *Id.*
- 12 DCPS, *DC Public Schools: Building an Infrastructure for School Mental Health*, 5 (2015); see also Email from Nathaniel Beers, March 27, 2015 on file with Children's Law Center.
- 13 Seven EBPs are reimbursable under a General Counseling or Community Based Intervention code. In November 2014, DBH and DHCF received approval from the federal government for two of the services, Trauma-Focused Cognitive Behavioral Therapy and Child Parent Psychotherapy for Family-Violence to become Medicaid reimbursable with unique codes and rates. DHCF is now working on the amended regulations to implement this change. The advantage of billing a unique code is that providers can receive higher rates of pay and the District can track utilization. DBH FY14 Oversight Responses, Question 63.
- 14 Conversation with Nathaniel Beers, Chief of the Office of Special Education, DCPS (March 27, 2015).
- 15 DBH notes on its website that it is estimated that as many as 20% of children and adolescents may have a mental health disorder that can be identified and require treatment. Department of Behavioral Health, *Children, Youth and Family Services*, <http://dbh.dc.gov/service/children-youth-and-family-services>. In a report issued by DBH it is noted that "13 to 20% of all children experience a mental disorder in a given year." Wotring, *supra* note 1, at v; see also *Mental Health Surveillance Among Children-United States, 2005-2011*, note 9, at 2.
- 16 DHCF FY14 Oversight Responses, Question 54.
- 17 Individual and environmental risk factors that increase the likelihood of mental health problems include receiving public assistance, having unemployed or teenage parents, or being in the foster care system. Shannon Stagman & Janice L. Cooper, National Center for Children in Poverty, *Children's Mental Health: What Every Policy Maker Should Know*, (2010), available at http://www.nccp.org/publications/pdf/text_929.pdf. Living in urban poverty greatly increases children's chances of being traumatized.

- Children living in poor urban neighborhoods are more likely to experience potentially overwhelming stressors such as family chaos, conflict, violence and dissolution, victimization/incarceration and/or death of a family member, and neglect and/or maltreatment than children raised in more affluent communities. Laurel J. Kiser, Clinical Psychology Review, *Protecting Children from the Dangers of Urban Poverty*, 27, 211-225 (2007).
- 18 Approximately 90% of children on Medicaid were automatically enrolled in an MCO as of FY12. Wotring, *supra* note 1, at 17. 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).
 - 19 Private analysis prepared by DHCF (April 3, 2015). These numbers are significantly higher than numbers that were reported to the DC Council during FY15 oversight testimony and also higher than the numbers that were provided to Children's Law Center for our preparation of last year's *Children's Mental Health Report Card*. DHCF reports to us that they have revised their numbers upward after determining that they were undercounting various treatment codes in previous years.
 - 20 DHCF, *District of Columbia's Managed Care Quarterly Performance Report (July 2013-Sept 2013)*, 17 (2014), available at http://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/Managed%20Care%201st%20Quarter%20Report%20FY2014_1.pdf.
 - 21 DHCF, *District of Columbia's Managed Care Quarterly Performance Report (July 2013-June 2014)*, 51 (2015), available at <http://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/Managed%20Care%20End%20of%20Year%20Report%20FY2014.pdf>.
 - 22 *District of Columbia's Managed Care Quarterly Performance Report (July 2013-Sept 2013)*, *supra* note 20, at 43.
 - 23 In FY14 the annual capacity for Trauma-Focused Cognitive Behavioral Therapy was 249 slots and 127 were utilized, which is 51%. DBH FY14 Performance Oversight Questions, Question 83.
 - 24 *Id.* In FY14, the annual capacity for Transition to Independence was 527 slots and 393 were utilized, which is 74.5%.
 - 25 Information provided by DBH to CLC (March 2015). There are four DBH behavioral health coordinators serving the five Collaborative sites; one person is assigned half time to the Georgia Avenue and the Collaborative Solutions for Communities sites.
 - 26 In FY13, 63% of children enrolled in Medicaid received their appropriate well child visits. Centers for Medicare & Medicaid Services, *Annual EPSDT Participation Report, Form CMS-416* (2013), available at <https://dhcfp.nv.gov/pdf%20forms/EPSTD/CMS%20416%20FFY%202011%20FINAL%20120727%20CORRECTED.pdf>.
 - 27 DBH FY14 Performance Oversight Questions, Question 45.
 - 28 DHCF FY14 Oversight Responses, Question 50, Attachment 1.
 - 29 DBH FY13 Oversight Responses, Question 47.
 - 30 DBH FY14 Oversight Responses, Question 8.
 - 31 The American Academy of Child and Adolescent Psychiatry and the Child Welfare League of America report that 85% of children in foster care are estimated to have an emotional disorder and/or substance use problem. American Academy of Child and Adolescent Psychiatry and the Child Welfare League of America, *Foster Care Mental Health Values Subcommittee Policy Statement*, (2002), http://www.aacap.org/AACAP/Policy_Statements/2002/AACAP_CWLA_Foster_Care_Mental_Health_Values_Subcommittee.aspx.
 - 32 DBH FY14 Performance Oversight Questions, Question 55.
 - 33 In FY11 the Project was in 24 sites and in FY12 it was in 25. Although the DBH FY2015 Proposed Budget and Financial Plan, Table RM0-4, Line item 4865 shows an increase of \$606,000 for Early Childhood and School Mental Health, Director Baron noted at a FY15 Budget Briefing on April 10 that these funds are to replace expiring federal funds that supported the consultation program. The program will remain the same size.
 - 34 DBH FY14 Oversight Responses, Question 48.
 - 35 There are 342 Child Development Centers and 145 home-based providers in DC. Email correspondence with Barbara Parks, Clinical Program Administration, Prevention & Early Intervention Programs, DBH (June 2013).
 - 36 Information provided by DBH to CLC (March 2015).
 - 37 D.C. PL 19-041. DBH provided the following information to the DC Council's Committee on Health in March 2013 in response to the law's requirement to submit a comprehensive plan to expand early childhood and school-based mental health services: "DMH is working through the Deputy Mayor for Health and Human Services to collaborate with other child serving agencies and DCPS to develop the comprehensive plan. As a first step in developing a strategy to expand services in the public schools, the DMH Child and Youth Division is evaluating the current school based mental health program. In particular, the evaluation is examining the effectiveness of prevention activities in reducing aggressive behavior and promoting a positive learning environment, identifying any

- patterns in treatment, challenges in securing parental consent and participation. In addition, DMH has received an independent evaluation of the second year of Healthy Futures program.” State of Implementation for South Capitol Act Requirements, DMH Submission to DC Council Committee on Health, March 2013.
- 38 Department of Health, *Maternal Infant & Early Childhood Home Visiting Program* (2012), 1, 6, available at <http://www.dcfpi.org/wp-content/uploads/2012/11/ProjNarrative-1.pdf>.
- 39 *Id.* at 6.
- 40 American Academy of Pediatrics, *The Role of Home-Visitation Programs in Improving Health Outcomes for Children and Families* (1998), available at <http://pediatrics.aappublications.org/content/101/3/486.full.pdf>.
- 41 In 2014, the District received \$3 million from the federal government to set up and evaluate a comprehensive home visiting program. In FY15, the DC budget includes \$2.5 million in local funds to replace those federal funds. The funding will allow ongoing services to the families currently served. DC Fiscal Policy Institute, *Expanding Maternal and Child Health Home Visiting To Ensure Kids Enter School Ready to Succeed, Recommendations to the New Mayor and DC Council*, (2015), available at http://www.dcfpi.org/wp-content/uploads/2015/01/1.5.15-8-of-11_Expanding-Maternal-and-Child-Health-Home-Visiting.pdf
- 42 *Id.*
- 43 *Id.*
- 44 D.C. PL19-041.
- 45 See list of 206 DCPS and charter schools. My School DC, available at <http://www.myschooldc.org/schools/>.
- 46 In 2011-2012 school year SMHP was in 58 schools. DMH FY11 Oversight Responses, Question 8.
- 47 DBH FY14 Performance Oversight Questions, Question 48.
- 48 Managed Care Organization Contract C.1.3.31, 6 (2013).
- 49 *District of Columbia's Managed Care Quarterly Performance Report (July 2013-June 2014)*, *supra* note 21, at 20.
- 50 DHCF FY14 Oversight Responses, Question 24. Health Care Delivery Management Administration, Objective 2, Initiative 2.2.
- 51 D.C.M.R. §22A-3411.5(f).
- 52 DBH FY14 Performance Oversight Questions, Question 52. Note that the data provided in response to Question 52 only covers the services provided to children that were billed to MHRS and not those billed to the MCOs.
- 53 DBH FY13 Oversight Responses, Question 48.
- 54 DBH, *Provider Bulletin 96, CSA Response to CFSA Initial Referrals*, (2013).
- 55 DBH FY14 Performance Oversight Questions, Question 53.
- 56 DBH FY13 Performance Oversight Questions, Question 9.
- 57 The FY14 Provider Scorecard will not be available until June. Department of Behavioral Health, FY14 Performance Oversight Questions, Question 95. The FY13 Scorecard is available on DBH's website at: <http://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/FY%202013%20Provider%20Scorecard.pdf>.
- 58 Human Systems and Outcomes, Inc., *2013 Report on Children and Youth Served by the District of Columbia Department of Mental Health*, 6 (2013), available at <http://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/Dixon%20Settlement%20Agreement%202013%20Report%20on%20Children%20and%20Youth.pdf>.
- 59 *Id.* at 7. *Dixon v. Gray*, the 1974 class action lawsuit, established court oversight of the District of Columbia's mental health services. As a result, DC agreed to a set of conditions to improve the District's mental health system. DC reached a settlement agreement to end court oversight of the mental health system in 2012.
- 60 DBH FY14 Oversight Response, Question 96.
- 61 Wotring, *supra* note 1, at 6.
- 62 DBH FY14 Performance Oversight Questions, Question 59. Agencies are also using a companion assessment tool, the Preschool and Early Childhood Functional Assessment Scale (PECFAS), for younger children when appropriate.
- 63 *Id.* The DHS programs which are currently implementing the CAFAS are Parent and Adolescent Support Services (PASS) and Alternative to the Court Experience (ACE).
- 64 *Id.*
- 65 National Network of Child Psychiatry Access Programs, *Existing Programs, Member Organizations by State*, <http://nncpap.org/existing-programs.html>.
- 66 Email correspondence with DBH (April 2, 2015).
- 67 Email correspondence with Cheryl Durden, CFSA (Apr. 22, 2013).
- 68 DBH FY14 Oversight Response, Question 49.
- 69 In FY13 there were 128 youth in PRTFs. DBH FY13 Oversight Response Questions, Question 57. In FY14 there were 125 youth in PRTFs. DBH FY14 Oversight Response Questions, Question 46.
- 70 DBH FY14 Oversight Response, Question 70.
- 71 *Id.*
- 72 DBH FY14 Oversight Response, Question 96.
- 73 DBH FY14 Oversight Response, Question 70 Attachment 2.
- 74 *Id.*
- 75 Child Welfare Information Gateway, *What is Treatment Foster Care?*, <https://www.childwelfare.gov/topics/outofhome/foster-care/treat-foster/what-treat/>.

LIST OF ACRONYMS

A-CRA	Adolescent Community Reinforcement Approach
CAFAS	Child and Adolescent Functional Assessment Scale
CBITS	Cognitive Behavioral Intervention for Trauma in Schools
CFSA	DC Child and Family Services Agency
CSA	Core Service Agency
CSR	Community Service Review
DBH	DC Department of Behavioral Health
DC-MAP	District of Columbia Mental Health Access in Pediatrics program
DCPS	District of Columbia Public Schools
DHCF	DC Department of Healthcare Finance
EBP	Evidence-Based Practice
MCO	Managed Care Organization
MHRS	Mental Health Rehabilitation Services
PRTF	Psychiatric Residential Treatment Facility
SMHP	School Mental Health Program
SPARCS	Structured Psychotherapy for Students Responding to Chronic Stress
TIP	Transition to Independence Process

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