

Improving the Children's Mental Health System

IN THE DISTRICT OF COLUMBIA



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a plan by

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Endorsements

The following organizations have endorsed this plan and its recommendations:

- ▶ American Academy of Pediatrics, DC Chapter
- ▶ The Capital Region Children’s Center
- ▶ Children’s National Medical Center
- ▶ DC Behavioral Health Association
- ▶ DC Coalition Against Domestic Violence
- ▶ DC Fiscal Policy Institute
- ▶ DC Lawyers for Youth
- ▶ DC Primary Care Association
- ▶ Family Voices of the District of Columbia Inc.
- ▶ Foster and Adoptive Parent Advocacy Center
- ▶ Healthy Families/Thriving Communities Collaborative Council
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EXECUTIVE SUMMARY

The District of Columbia’s public mental health system, despite many recent improvements, is still not fully meeting the needs of our children and families. Improving our children’s mental health system is critically important—not only for the children and families whose lives are personally impacted by mental health issues, but for the larger community as well. The cost to society of unmet mental health needs is substantial. If a child’s mental health needs are addressed early and treated properly, he is much less likely to require costly special education programs for social or emotional reasons. If a child’s mental health needs are addressed when she is young, she is less likely to commit a crime and end up in the juvenile justice system. If a child’s mental health problems are mitigated when he is young, he is much less likely to drop out of school and grow up to be an adult who is unable to keep a job and relies on housing and other public assistance.

The District has never been more ready to make good on its promise to our children. It will take the concerted efforts of the government and the community—including the mayor, child-serving government agencies, the DC Council, private providers, advocates and families—to build on the progress made to provide appropriate and accessible mental health services to our children, youth and their families. The mayor has successfully brought to an end 37 years of federal court oversight of the mental health system and secured an important federal planning grant to support this work. The Department of Mental Health has brought several important evidence-based practices to the District, piloted an impressive early child mental health program and creatively

addressed the shortage of child psychiatrists. The child-serving government agencies, working together, have reduced the District’s long-standing overreliance on psychiatric residential treatment facilities. And the DC Council has recently turned its attention to screening and early detection.

Too many children, however, still do not have access to the care they need. The number of children in our juvenile justice, foster care and special education systems demonstrate this unfortunate truth. Now is the time for the mayor and the DC Council to address the structural problems that prevent these separate reform efforts from becoming a comprehensive mental health system that successfully reaches all the children in need.

The goal of this plan is to provide a blueprint for change, drawing from prior research and reports—as well as from Children’s Law Center’s extensive experience working with the mental health system as advocates and as attorneys representing more than 1,200 low income children and families a year. It also reflects the suggestions and feedback of many allied organizations who also serve the District’s families.

The plan sets forth a clear vision of what a truly functioning system would look like. It includes seven sections with detailed recommendations for making that vision a reality. Each section includes specific recommendations to improve various elements of the District’s complex children’s mental health system.

Some of these changes can and should happen immediately, while others will take time to plan and implement. Some of these changes can be acted on by the District’s Department of Mental Health and its provider network, but others will require the mayor to coordinate the work of several agencies, such as

the Department of Health Care Finance (which runs DC’s Medicaid program) and the Child and Family Services Agency (which is responsible for DC’s child welfare system). Many of the recommendations build on the recent successes that are already occurring and focus on taking pilot programs and bringing them to scale.

Throughout the plan are stories that summarize the experiences of real DC children and families with whom Children’s Law Center has worked. Each of these children has met one obstacle after another on the path to mental health. Together we can remove these obstacles and give their stories happy endings.



SUMMARY OF RECOMMENDATIONS

1. Bring Needed Services to the District

- ▶ Offer and expand necessary mental health services, particularly evidence-based practices.
- ▶ Streamline the credentialing process for mental health providers.
- ▶ Conduct a comparability study to compare provider rates in the District to those in surrounding jurisdictions and adjust rates if necessary.
- ▶ Maximize the District’s use of Medicaid dollars.
- ▶ Use local dollars for necessary services that Medicaid does not cover.

2. Improve Access for Children and Families

- ▶ Ensure children can access a wide range of mental health services at one clinical home.
- ▶ Strengthen oversight and enforcement of managed care organizations operating in the District.
- ▶ Institute 12-month continuous eligibility in the District’s Medicaid/Children’s Health Insurance Program to allow children to maintain coverage for up to one full year.
- ▶ Create and maintain a website for providers and the public with current information on all available mental health services in the District.

3. Create a Robust Prevention and Early Identification System

- ▶ Ensure children are screened for mental health needs in primary care settings.
- ▶ Ensure that all pediatric practices regularly screen for maternal depression.
- ▶ Expand home visiting programs and ensure they promote early childhood mental health.

- ▶ Fully support and fund mental health consultation and intervention services in child care and preschool programs.
- ▶ Expand the school-based mental health program.

4. Improve Care Coordination

- ▶ Implement a system-wide child and family team practice model and train all relevant staff in this model.
- ▶ Reimburse clinicians for time spent coordinating care (i.e., pay for collateral contacts).
- ▶ Provide targeted case management services to additional groups of children.

5. Ensure Quality and Timeliness of Services

- ▶ Continue annual community service reviews.
- ▶ Ensure that all child mental health providers are using appropriate, standardized tools to measure the functional outcomes of children they serve.
- ▶ Improve the percentage of children getting services in a timely manner from core service agencies.
- ▶ Ensure all children receive appropriate mental health services within seven days of discharge from a psychiatric hospital.
- ▶ Ensure that all children entering foster care are screened and receive appropriate mental health services.
- ▶ Ensure that all children entering the juvenile justice system are screened and receive appropriate mental health services.

6. Improve Psychiatric Services

- ▶ Assess the gap between need and availability of child psychiatric services and develop a plan to close the gap.
- ▶ Create a DC Child Psychiatry Access Project with mental health consultation teams available to assist primary care providers treat children with psychiatric needs.
- ▶ Develop oversight mechanisms to ensure children in foster care are not being improperly medicated.

7. Improve Community-Based Services to Reduce Residential Placements

- ▶ Ensure there are appropriate community-based programs to support youth in the community.
- ▶ Ensure that there are providers available to serve DC wards living in Maryland.
- ▶ Improve oversight and monitoring of children in residential treatment centers.
- ▶ Expand the High Fidelity Wraparound Pilot program to serve more children.
- ▶ Ensure that children receive community-based intervention services in a timely manner.
- ▶ Develop consistent standards, training and quality implementation of therapeutic foster care.

BACKGROUND

Children’s mental health is essential to their overall health, development and ability to learn. Nationally, 1 in 5 children has a diagnosable mental disorder and 1 in 10 has a serious mental health problem¹ that is severe enough to impair how they function at home, school or in the community.² Many mental disorders begin by the time a person is 14 and a large majority of them begin by the time a person is 24.³ Some children may need long-term treatment from a team of providers, with medication as part of their clinical intervention, while other children and families may need only short-term therapy.

According to the President’s New Freedom Commission on Mental Health, “no other illnesses damage so many children so seriously.”⁴ If children are not screened and treated, these childhood conditions may persist and lead to a cycle of school failure, poor employment opportunities and poverty. Children and youth with untreated mental health problems have more difficulties in school, more involvement with the criminal justice system, and fewer stable and long-term placements in the child welfare system than their peers.⁵

Although mental health problems impact children from all types of families and at all economic levels, there are certain conditions which can increase the prevalence of mental health needs. Many of DC’s children are subject to the most significant of these conditions: living in poverty, witnessing violence or having a parent who has depression.⁶ There is a well-researched association between socioeconomic status and indices of both physical and mental health.⁷

Often because of the trauma and turmoil in their lives, children and youth in the child welfare and

juvenile justice systems have a higher percentage of mental health problems than children in the general population. Being the victim of abuse and neglect, being removed from one’s family or living in multiple foster homes can each separately lead to trauma-induced mental health problems; when experienced together, these traumas can greatly compound problems. Nationally, 50% of children in the child welfare system have mental health problems.⁸ In the juvenile justice system, 67% of youth have a diagnosable mental health disorder.⁹

Nationally, 12.4% of children aged 6 to 17 who receive Medicaid have mental health conditions.¹⁰ Yet the District’s public mental health system is only serving—by DMH’s most recent count—5.48% of children in the District.¹¹ This count includes all children receiving at least one mental health service, without taking into account whether children are receiving the correct treatment or all the services they need to truly improve their health and quality of life.¹² Given that such a large percentage of the District’s children receive Medicaid—61%¹³—the fact that there is such a large gap between the children who need services and those receiving them is particularly worrisome.

Children on Medicaid are legally entitled to a comprehensive range of support including emergency services, inpatient hospital care, outpatient physician visits, prescription medications and rehabilitation services.¹⁴ In addition to all of the services individually listed in the District’s Medicaid State Plan, children have a right to any services that are medically necessary based on the Early Periodic Screening, Diagnosis and Treatment (EPSDT)



provision of federal Medicaid law¹⁵ (which is also referenced in DC’s Medicaid State Plan¹⁶). However, this legal entitlement can only be fully realized by the District’s children when there is a complete array of services available. To be effective, these services must be high quality and well-coordinated. Providers

must be willing to work in the District, and it must be easy for them to accept all forms of DC Medicaid. Recognizing that children live in families and communities, our treatment models must move beyond a child-only focus to more inclusive approaches that involve parents and other caregivers.

According to the President’s New Freedom Commission on Mental Health, “no other illnesses damage so many children so seriously.”

VISION

Over the past 15 years, the concept and philosophy of “systems of care” (SOC) has provided a guide and framework for system reform in children’s mental health.¹⁷ The SOC philosophy states that services should be community based, child centered, family focused and culturally competent. The SOC guiding principles specify that services should be:

- ▶ Comprehensive, with a broad array of services;
- ▶ Individualized to each child and family;
- ▶ Provided in the least restrictive, appropriate setting;
- ▶ Coordinated both at the system and service delivery level;
- ▶ Involve families and youth as full partners;
- ▶ Emphasize early identification and intervention.¹⁸

With these principles in mind, we envision a District where all children and youth achieve appropriate developmental, cognitive, social and emotional milestones. DC’s children and youth should have secure attachments, strong families, satisfying social relationships and effective coping skills. They should function well at home, in school and in their communities. When a child struggles in any of these areas, parents, teachers, social workers, mental health clinicians and others in her community should be readily available to provide her with appropriate supports, including mental health treatment.

DC’s children and families deserve a mental health system that provides a seamless array of comprehensive services which are individualized and easily accessible. Parents and child-serving professionals should know how to access services; there should be many doors through which children enter the system and receive the same high-quality services.

The system should focus on early identification so that children receive screening and assessments and are quickly linked to appropriate services before their condition deteriorates; a child should not have to be in crisis before he comes to someone’s attention. The system should be informed by an outlook that is strengths-based and focuses on the child and the entire family. Services should be culturally and linguistically competent and, as much as possible, based in the community so a family can stay together while taking advantage of services. Children should only be in out-of-home placements as a last resort when other treatment models have failed or no other intervention will prevent harm to the child or others.

Mental health should be viewed as part of good overall health and integrated not only into primary medical care but also into child care and school settings. Everyone who works with children should be aware of the signs of mental health problems and be trained to make proper referrals. Case management and care coordination must ensure that each child is receiving the most appropriate services and that all of the various providers, teachers and caregivers involved in a child’s life are working together.

We must have a robust provider network that meets the needs of the community. Providers must be well-trained and well-paid so that turnover is minimized and clinicians and families can develop the strong relationships which are at the core of quality care. All children, regardless of their insurance type, should be able to access the same system of high-quality services. Children should not have to change providers due to changing insurers; services should not be discontinued due to billing problems.

CHALLENGES AND SOLUTIONS

1. BRING NEEDED SERVICES TO THE DISTRICT

Lack of Services

Despite some recent progress in improving services, the District still lacks many key mental health services for children.¹⁹ Providing a full continuum of services is the backbone of the children’s mental health system; without these services, children will continue to be unnecessarily hospitalized and placed in residential facilities. The Department of Mental Health (DMH) should place particular emphasis on strengthening the number of evidence-based practices available to children in the District. Evidence-based practices are models which have been proven to be effective when delivered in a particular manner to children with specific characteristics. There have been many studies and reports about the services needed and this plan does not seek to generate yet another list; rather, it draws from those prior reports and presents a synthesized list of key needed services.

A Complicated and Fragmented System

A primary reason why the District lacks a full array of services is that the children’s mental health system is complicated and fragmented which makes the District a difficult environment for high-quality service providers and the clinicians they employ.²⁰ In the last year and a half, six providers have closed mental health programs which served people on Medicaid or gone out of business completely.²¹ Several other providers laid off 60–75% of their mental health staff.²² High-quality providers are the key to a children’s mental health system that meets the needs of the District’s families. The District needs enough

16-YEAR-OLD GREG came into care due to neglect linked to his mother’s severe mental health problems. For several years, Greg’s mother kept him home from school and mostly inside the house due to her extreme fear of others. Now, Greg is in foster care but he is still not getting appropriate mental health treatment. He has been linked to a core service agency, but they have no clinicians who have the training or skills to deal with his specific diagnosis. The Child and Family Services Agency has found a psychiatrist who has the expertise to treat Greg, but he is not a Medicaid provider and arranging the necessary paperwork and finances to secure the doctor’s services has taken months. Meanwhile, Greg’s condition deteriorates while he waits for appropriate treatment.

properly trained, high-quality providers to meet the demand for services. The District must be able to recruit, train and retain new providers and clinicians to a well-functioning system that streamlines bureaucracy and therefore allows clinicians to have the maximum time to focus on delivering services.

Providers must be able to rely on a properly and consistently funded system. For too long the District has relied on pilot projects or local dollars to fund services rather than maximizing federal Medicaid funds. While pilots frequently show promise, by their nature they serve only a small number of children. Pilots and new projects also create challenges for providers who cannot plan or rely on stable funding streams. Pilot projects must be launched with a plan for long-term sustainability, including details about

what is needed financially and logistically to expand successful projects to serve a larger population. With an available federal match of 70 cents on the dollar,²³ the way to build a sustainable system is by billing all allowable services to Medicaid. While some important services are not eligible for Medicaid reimbursement and thus need local funding sources, these local dollars should only be used when the District has first ensured that Medicaid (or other federal funding streams/grants) will not fund a service.

To be reimbursed through Medicaid for providing mental health treatment to children, providers must be credentialed with multiple entities. To treat all children within DC's Medicaid system, providers must credential separately with each of the three managed care organizations and be licensed by DMH as a free-standing mental health clinic and as specialty provider. To offer these children a full continuum of care requires a provider to credential with at least seven and up to eleven payers.²⁴ On top of this, the credentials must be renewed annually.²⁵ Meeting these requirements is a time-consuming process and is often cited by providers as the reason they will not accept DC Medicaid. 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. The credentialing process must be improved so that it is easier for providers to work with this host of entities and serve all children on Medicaid—who encompass the majority of DC's children.

Low-income children with mental health problems receive services through a convoluted process which is difficult to understand and not easy to explain simply. Here is a list of the key agencies, organizations and providers:

- ▶ Medicaid managed care organizations: three managed care organizations (MCOs) serve 90% of the

children on Medicaid in the District. Chartered Health Plan and United HealthCare Community Plan receive a flat rate from the Department of Health Care Finance (DHCF) to provide services. Health Services for Children with Special Needs, an MCO specifically for children with special needs, has a contract through which the District reimburses them for the cost of services they actually provide. Complicating the structure, children in Chartered and United HealthCare Community Plan receive behavioral health benefits from Beacon Health Strategies and Optimum, respectively.

- ▶ Medicaid fee-for-service: The District's fee-for-service program serves children in its custody through the foster care or juvenile justice system.
- ▶ The child's school: There are a variety of different pilots and projects in the District's public and charter schools that are paid for with a combination of local and Medicaid funds. In addition, some children receive mental health services mandated by their special education plans.
- ▶ Core service agencies: Approximately 30 community mental health care organizations contract with DMH to provide a specific array of services to children and adults.
- ▶ A network of community-based organizations, private agencies and individual clinicians who provide services through contracts with the following agencies:
 - DMH;
 - Child and Family Services Agency (CFSA);
 - Department of Youth Rehabilitation Services (DYRS); and
 - Addiction Prevention and Recovery Administration (within the Department of Health).

MCOs are responsible for providing office-based mental health services, such as individual or family

therapy. However, for children diagnosed with severe mental illnesses and who need more intensive in-home treatment, the responsibility for providing those intensive services shifts to DMH and the payments come from DHCF. The MCO, however, still retains responsibility for providing those children their office-based services.

DMH primarily provides community-based services through its Mental Health Rehabilitation Services (MHRS) program, a system of private, community-based care. To qualify for MHRS services, a child must be diagnosed with a serious emotional disturbance that results in a functional impairment that either (1) substantially interferes with or limits the child's functioning in family, school or community activities; or (2) limits the child from achieving or maintaining one or more developmentally-appropriate social, behavioral, cognitive, communicative or adaptive skills.²⁶ MHRS services are mostly provided through a network of core service agencies (CSAs). To become a CSA, a provider must offer four core MHRS services (medication/somatic treatment; counseling; community support; diagnostic/assessment services).²⁷ Providers who only offer some subset of MHRS services are certified as sub-providers or specialty providers.²⁸

The Carve-Out Option

One method the District is considering to simplify the current system is to completely carve out mental health services from the MCOs. A carve-out is an arrangement in which mental health services are financed and administered separately from physical health services.²⁹

Over the last decade, specialty managed behavior health care (MBHC) carve-out companies have emerged as a dominant approach to managed mental health care in the private sector. More state Medicaid

ELI AND DAMIAN are 10- and 11-year-old brothers who have severe behavioral issues. Their mother has four children under the age of 11 and has serious health issues herself. She is unable to get the boys to weekly therapy appointments. No provider within the DC Medicaid system can provide the appropriate in-home therapy. A qualified and experienced provider has been identified, but the only way for families on Medicaid to access their services are to negotiate single-case agreements through the family's MCO. This is a timely and complicated process a family can rarely navigate without the assistance of a lawyer.

programs are following suit.³⁰ The argument for MBHCs is that they can use their expertise to establish networks of mental health specialty providers, negotiate volume discounts, identify evidence-based treatment protocols and develop other incentive programs to manage utilization and quality of care.³¹ Unfortunately, although carving out mental health services in Medicaid managed care programs is increasingly popular, there is little research on its impact on children's well-being. Much of the research focuses instead on whether a mental health carve-out can reduce costs, not whether a carve-out improves care or increases access.³²

Two of the District's MCOs already carve out mental health services—Beacon Health Strategies is the MBHC for Chartered Health Plan and Optimum is the MBHC for United HealthCare Community Plan. The District's current system of several carve-outs, plus the separate DMH/MHRS system, would benefit from consolidation. The District could remove responsibility for mental health care from the



MCO contracts completely and place all responsibility for mental health services either with DMH or with one specialty MBHC organization.³³ Given the long history of uncoordinated care and the paucity of providers, the District should choose a model which will streamline services and centralize responsibility.

Should the District decide to maintain the current MCO structure, the system needs to be simplified and oversight of the MCOs increased so that care can improve (some of the suggestions that follow are relevant only for this alternative). The financial structure of how MCOs are compensated also needs to be examined more closely and aligned with incentives to provide patient care. Currently, MCOs receive capitation payment; that is, they are paid prospectively based on the number of consumers enrolled in their plan and not based on the actual care they deliver. According to a report from the U.S. Government Accountability Office, this payment system can create an incentive for MCOs to under serve or deny access to needed care.³⁴

RECOMMENDATIONS

1-1. The District should offer and expand necessary services, particularly evidence-based practices (EBPs). As a first step, the District should create a clear written plan within the next six months which answers the following questions:

- ▶ What additional EBPs are needed in DC? Are there EBPs being used successfully in other jurisdictions from which DC's children could benefit as well?
- ▶ How many children are estimated as likely to need each service?
- ▶ What is the current capacity to provide this service?
- ▶ To what extent do special populations (e.g., youth who identify as lesbian, gay, bisexual, transgender or questioning; non-English speakers; youth with physical disabilities; District wards residing outside of DC) need the service and to what extent are current providers trained to provide the service to these youth? If necessary, how will the capacity to reach these special populations be expanded?
- ▶ If a service doesn't exist currently in DC, how will DMH overcome barriers to bring it into existence? Barriers to consider include:
 - Is there a lack of qualified providers?
 - Could current providers deliver the service with additional training? If so, how can the District ensure that providers it trains will remain in practice here? One option is to require providers who receive training to reimburse the District for the training if they fail to provide a certain number of hours of service to DC Medicaid-eligible youth.

- How many hours of additional training would they need and from whom?
- How can an appropriate workforce be recruited and retained? Are there clinicians in private practice who offer the service and may consider doing this work through a pro bono program?
- ▶ Does the service exist in the DC Metro area?
- ▶ Are there agencies other than DMH involved in offering the services? If so, is there a breakdown in communication or lack of coordination?
- ▶ Is there a lack of funding or inadequate funding for the service?
 - Is the DC rate comparable to the surrounding areas?
 - Is the service funded with solely local dollars?
 - Do other states cover this service with Medicaid dollars?
 - Is there a way to fit this service into DC's existing Medicaid plan? If not, should a State Plan Amendment be drafted?
- ▶ Are there other barriers (e.g., licensing requirements) keeping qualified providers from offering the service?
- ▶ What is the specific timeline for getting the service established and scaled to the needed size?

Services that need to be offered or expanded include:³⁵

- ▶ Psychotherapy³⁶
- ▶ An increased array of therapeutic foster care models, including evidenced-based models
- ▶ Intensive day treatment programs³⁷
- ▶ Therapeutic after school and summer school programs

- ▶ Integrated mental health and substance abuse services for youth with co-occurring disorders
- ▶ Partial hospitalization³⁸
- ▶ Treatment for children who are the victims or perpetrators of sexual abuse
- ▶ Attachment therapies
- ▶ EBPs³⁹, specifically:
 - trauma-focused cognitive behavior therapy⁴⁰
 - functional family therapy⁴¹
 - parent-child interaction therapy⁴²
 - child-parent psychotherapy for family violence⁴³
- ▶ Services for young children (birth to age 6)⁴⁴
- ▶ High-quality parenting programs that do not require the child to have a formal mental health diagnosis in order for the family to qualify for services,⁴⁵ and
- ▶ Services for children in crisis that can be accessed quickly without the children going through lengthy evaluations to receive a diagnosis (often children without a DSM-IV Axis I diagnosis cannot receive needed services).⁴⁶

1-2. The District should streamline the credentialing process for mental health providers. All of the existing processes seek similar, and sometimes identical, information. The District could save providers valuable time—and itself valuable resources—by streamlining these processes. DHCF should institute voluntary deemed status accreditation for outpatient mental health clinics. Deemed status accreditation is when a licensing body recognizes a provider's national accreditation and allows the accredited organization to provide proof of accreditation in lieu of undergoing certain parts of the licensing process.⁴⁷ This

would reduce the administrative cost for the District as well as providers, and 25 states already use it for a wide range of health and human services.⁴⁸ In fact, the District already uses this accreditation process for DC residential treatment facilities and inpatient hospitals.⁴⁹ There are 41 DC providers who are nationally accredited for behavioral health services, including at least 25% of MHRS CSAs. For providers who are not nationally accredited, the District should develop a single process that is accepted by all insurers.

1-3. Within the next year, the District should conduct and make publicly available a comparability study to assess MHRS, fee-for-service and MCO reimbursement rates for all child mental health services and compare these rates to surrounding jurisdictions to ascertain if low rates are part of the reason providers are not accepting DC Medicaid. If the study demonstrates that the District's rates for any service are below the rates in surrounding jurisdictions, within one year the District should raise rates to be at least on par with neighboring communities.

1-4. The District should maximize its use of Medicaid dollars. Within the next three months, the District should create a list of all the current children's services that are being funded with local dollars. For each service, the District should report if this service could be covered by Medicaid, and if so, develop a plan for promptly securing Medicaid coverage.

1-5. The District should use local dollars for necessary services that Medicaid does not cover. Some services that children and families need do not fit into Medicaid's medical model of care, but these more holistic family supports are a critical part of the system of care, and DMH must dedicate local dollars to fund them. Once the District maximizes its use of Medicaid dollars, currently dedicated local dollars will be available to help expand services that are not covered by Medicaid.

2. IMPROVE ACCESS FOR CHILDREN AND FAMILIES

Lack of a Comprehensive System

A family-friendly system that is easy to navigate and treats parents as partners in their child's care is an essential feature of a well-functioning children's mental health system. Unfortunately, there is no clear gateway into the children's mental health system. Instead, families enter through various doors, each of which leads to a different service or provider. Having multiple doors into the system is a strength, but each door must lead to the full array of services. In the current system, families rarely see the whole map of services before they begin the complicated process of seeking treatment.

In addition, there are many payment structures and providers, and often parents are unable to find anyone who has an accurate and comprehensive understanding of all the service and treatment options available for their child. Because even providers and case managers do not understand our system, parents are frequently referred to providers who do not accept their specific type of Medicaid or any Medicaid at all. A child's condition deteriorates during the time the family waits to find appropriate, consistent treatment.

Too Few Children Are Receiving Care, Especially from MCOs

MCOs have an obligation to manage and provide patient care, including mental health services. Because comprehensive data is not gathered by the government and reported to the public, it is impossible to get a full understanding of how many children with mental health needs each MCO serves, what services the children receive, the size of the MCO networks and the credentials of the providers. The available statistics paint a troubling picture.



A recent study also supports the disturbing experience of parents and advocates: among children enrolled in the District's MCO for children with special health care needs, a substantial number with mental health diagnoses appear to have had no mental health treatment at all, including 74% of those with an emotional disturbance, 66% of those with pervasive developmental or adjustment disorders, 50% of those with depressive disorder, and 33% of those with an episodic mood disorder.⁵⁰

In fiscal year 2010, the number of children receiving mental health treatment solely through the MCOs (and not also through MHRS) shrank by 16% compared to the number served in fiscal year 2009.⁵¹ During the same period, the number of children receiving treatment solely through DMH rose by 31%.⁵² Given the growth in DMH utilization numbers, the decline in MCO utilization numbers raises serious questions.

Children with fee-for-service Medicaid often fare no better. A recent study found that among District children in fee-for-service Medicaid, 14% of emergency department visits for children ages 7 to 12 were related to mental illness,⁵³ suggesting that less intensive services were not provided. Crisis care is

extremely disruptive to children and families and also costs the system significantly more than more routine services such as therapy and home-based services.

Not All Providers Accept All Types of Medicaid

Continuity of care is an essential component of good mental health treatment. Unfortunately, since many providers do not accept all types of Medicaid insurance, children are frequently required to change providers mid-treatment. Providers and parents cite problems with re-enrollment and switching among MCOs as one of the biggest barriers to health care in the District.⁵⁴ A 2009 Memorandum of Understanding between DHCF and DMH places the responsibility with DHCF to ensure that MCOs include CSAs in their mental health provider network.⁵⁵ Yet, DHCF is not taking the necessary steps to actually enforce this MOU. Following this MOU would require DHCF, among other things, to have clear and enforceable expectations about the MCO credentialing process. The type of credentialing standards an MCO imposes on providers has a great deal of impact on whether or not providers will want to work with that MCO.⁵⁶ Further, DHCF also doesn't seem to measure or monitor the MCO's mental health provider capacity. DHCF does not appear to perform any oversight of capacity needs, growth or the number of closed providers. A review by the DC Behavioral Health Association of the MCOs' online provider directories found that more than 50% of the identified mental health practitioners listed in each directory were no longer employed or in business.⁵⁷

Lack of Continuity of Medicaid Coverage

When children maintain insurance coverage they are more likely to receive appropriate care. Even brief gaps in health coverage cause people to skip or delay care.⁵⁸ For children with mental health needs,

this loss of coverage can be particularly problematic if they are in the midst of treatment. Bureaucratic details often contribute to coverage gaps.⁵⁹ Currently, families must update their financial information with the District of Columbia Economic Security Administration whenever they experience a change in income or family status. This can lead to temporary coverage gaps because low income families often have frequent fluctuations in family income—national studies show that many children lose coverage and then reenroll again within a few months.⁶⁰

RECOMMENDATIONS

2-1. Children should be able to access a wide range of mental health services at one clinical home to increase access to services and enhance coordination. Currently, most CSAs can only provide the nine mental health services covered by the District's MHRS system, many of which are home- or community-based rather than office-based services.⁶¹ If these same children are enrolled in an MCO, they must get their office-based services through the MCO network but if they are in the fee-for-service system, they must get office services through a limited number of individual providers who accept fee-for-service Medicaid. One way to make the system less fragmented is for all CSAs to become certified as free-standing mental health clinics (FSMHCs). There are more than 20 such clinics in the District, some of which are CSAs. As an FSMHC, a provider can offer a broader range of clinical services and different Medicaid rates than CSAs. There are currently barriers to CSAs becoming FSMHCs. The District must lower or remove these barriers before this model can be a successful way to ensure children can access appropriate and better coordinated services. Challenges include:

- ▶ FSMHCs require staff to have higher level professional credentials than the current MHRS requirements.

- ▶ FSMHC rates may not be high enough to encourage CSAs to expand.
- ▶ CSAs who seek to become licensed as an FSMHC face start-up costs such as hiring properly credentialed staff and creating the proper billing mechanisms. Rather than just billing MHRS/DMH, they have to bill Medicaid and each MCO separately.

2-2. In order to increase continuity of care across Medicaid insurers and to ensure a robust provider network, DHCF must strengthen its oversight and enforcement of the MCOs in the following ways:⁶²

- ▶ Require MCOs to credential behavioral health providers as an organization, rather than by individual clinician.
- ▶ Enforce the timely processing of credentialing requests.
- ▶ Hold MCOs accountable to provide legally required mental health services. The District should analyze how each MCO complies with legal and contractual mandates to provide mental health services. Without detailed information about the MCOs it is difficult to assess whether the MCOs are an effective service delivery model. DHCF should conduct quarterly mental health utilization and network adequacy reports of all MCOs and make these publicly available. Data should be broken down by diagnosis and include:
 - How many children were diagnosed;
 - How many children with mental health diagnoses were treated by each type of provider (i.e., pediatrician, social worker, psychologist, psychiatrist);
 - How many children with mental health diagnoses were treated in an emergency room or hospital;
 - The wards the children live in;
 - The time it took from the initial referral until services were successfully received;

- How many licensed professionals in each provider type are credentialed to provide mental health services by each MCO; and
- How many licensed professionals in each provider type are accepting new patients at a given time.

2-3. The District should institute 12-month continuous eligibility in its Medicaid and Children’s Health Insurance Program (CHIP) programs within the next two years. By implementing this change, the District would allow children 18 and younger to maintain insurance coverage for up to one full year. Continuous eligibility is achieved by eliminating mid-year reports of changes in family status or income. As of January 2011, 32 states have 12-month continuous eligibility for one or both of their Medicaid or CHIP programs.⁶³ Federal law allows states to implement continuous eligibility, lifting the otherwise mandatory requirement that a family report on changes in circumstances during that year (unless the child reaches age 19 or the family moves out of state).⁶⁴ In addition to improving insurance coverage and health outcomes for children on Medicaid, this policy change is also cost effective. When children have ongoing health insurance they receive better health care, have better health outcomes and require less costly emergency and hospital care.⁶⁵ The District’s administrative costs would also be reduced due to the smaller number of children whose taken disenrollments and re-enrollments that have to be processed.⁶⁶

2-4. The District should develop and maintain a website for providers and the public with current information on all mental health services which are available in the DMH/publicly funded system. Currently, there is very little on DMH’s website about the services available for children. There is a list of community-based providers but no information about what services each provides. There is also a link to a resources guide which again lists providers with no information about

their services. The website should be a useful portal for parents and others seeking information. It should explain the Medicaid (fee-for-service and MCO) and DMH (MHRS) systems and how to access care. Explanations of various types of services should be provided so that individuals can understand the difference, for example, between a diagnostic assessment, office-based therapy, functional family therapy and medication man-

agement and how to access each of these. It would also be helpful to have information about providers and their specialties, education, training and licensure. DMH projects should be highlighted as well as new EBPs. The website should be a first stop for anyone in the city seeking more information about how to connect a child and family to mental health resources.⁶⁷



Having multiple doors into the system is a strength, but each door must lead to the full array of services.

3. CREATE A ROBUST PREVENTION & EARLY IDENTIFICATION SYSTEM

Why Early Identification Matters

Early identification of mental health problems leads to earlier assessments, diagnoses and treatments. National data show that early detection and treatment of mental health problems can result in a substantially shorter and less disabling course of illness.⁶⁸ Early identification and treatment also decreases stress and negative outcomes for the child's whole family; decreases the child's penetration further into the mental health, child welfare and juvenile justice systems; and significantly decreases the long-term costs of mental health care. Ideally, children's mental health needs should be identified in natural settings such as pediatrician's offices, child care facilities and schools.

Expanding the Role of Pediatricians

Children in the District of Columbia have better access to primary care than to specialty mental health care. Primary care offices are fairly well distributed across the District.⁶⁹ In 2007, 70% of children in Medicaid MCOs had at least one office visit.⁷⁰ All children should be seen for well-child visits and these visits are an ideal time for parents to discuss any mental health concerns they may have with their pediatrician—someone with whom they already have a relationship and who already knows their child. In June 2010, the American Academy of Pediatrics Task Force on Mental Health recommended that pediatricians screen for possible mental health issues at every visit.⁷¹

Nationally, about half of the care for common mental disorders is delivered in general medical settings (such as a pediatrician's office), and primary care providers prescribe the majority of psychotropic



drugs for both children and adults.⁷² Especially when there is a known shortage of child psychiatrists and other mental health professionals, pediatricians have a large role to play in addressing mental illnesses; however, there are many challenges in assuring that pediatricians have the skills, knowledge and time to properly identify and treat mental health concerns and make appropriate referrals. Too often, mental health problems go undiagnosed and untreated in primary care settings.⁷³ Studies show that children and adolescents are particularly unlikely to receive care for mental disorders.⁷⁴ It is important that the District ensure pediatricians are a key part of our children's mental health system.

Pediatricians and Maternal Depression

Pediatricians also have a critical role to play in the identification of mothers who may be depressed or have other mental health problems. Children whose mothers are depressed have a higher prevalence of mental health problems.⁷⁵ Low-income mothers with young children have shown rates of depression ranging as high as 40–60%,⁷⁶ and a large percentage

13-YEAR-OLD AMY used to excel academically. Before this year, she received all As in school, even though she was living with a drug-addicted mother in terrible housing conditions. Now Amy is in foster care and getting individual therapy outside of school. But she is suffering at school; without mental health clinicians in her school, no one is equipped with the knowledge and skills to help her succeed. She is having behavior problems and instead of offering her services and support, the school is constantly suspending Amy. Her grades are dropping and this girl—who once felt like school was a safe haven—now feels like everyone there is against her.

of these mothers do not speak to any medical professional about their depressive symptoms.⁷⁷ Maternal depression threatens attachment and bonding, psychological processes critical to an infant's development. Living with a mother who has depression can also have negative effects on a child's cognitive and social-emotional development, behavior and language acquisition.⁷⁸ These problems do not just impact infants but can also impact older children as well—behavior disorders, attachment disorders, depression and other mood disorders in childhood and adolescence can occur more often in children of mothers with major depression.⁷⁹

Because of the importance of maternal health to a child's development, the American Academy of Pediatrics (AAP) has called for pediatricians to do routine screenings of mothers for depression during prenatal and postpartum visits to health care providers.⁸⁰ As the AAP notes, treating a child includes optimizing that child's healthy development and healthy family functioning.⁸¹

Home Visiting Programs and Mental Health

Another opportunity to address maternal depression and young children's mental health needs is through home visiting programs that promote positive parent-child relationships and healthy child development. Many of these programs have been shown to lead to improved outcomes for children in a variety of areas, including improved social-emotional health and reduced behavior problems.⁸² The recent federal health reform law, the Affordable Care Act, includes funding for home visiting programs.⁸³ The District submitted an application for funding which included an assessment of the District's current home visiting programs and their capacity to serve our community's need. According to the DC Department of Health's report, DC currently has seven home visiting programs which serve a total of approximately 900 families.⁸⁴ The community need has been defined less clearly. The District has identified Wards 7 and 8 as the most at-risk communities and has identified various subgroups within these wards that could be defined as eligible for home visiting—the largest of which is the almost 13,000 children in those wards who younger than 5.⁸⁵

Early Childhood Mental Health Programs

Early childhood is a critical period for the onset of emotional and behavioral impairments.⁸⁶ National research indicates that 9–14% of children under age 6 experience emotional and behavioral problems.⁸⁷ Young children with behavior problems can struggle with their parents, disrupting the nurturing parent-child relationship which is necessary for the child's healthy development. It is particularly important to detect problems in young children quickly because their mental health provides “an essential foundation for early learning and development.”⁸⁸

When young children have mental health problems, they miss out on developmental experiences important for early learning. Some children's problems are so severe they are expelled from early care and education settings—leading them to miss out on important early socialization and learning. Too often this sets them up for a troubling trajectory of school failure. Some children with mental health problems exhibit challenging behaviors which lead to difficult relationships with teachers and classmates; this can limit the child's ability to learn. Children who are sad or anxious may not be able to fully participate in activities which promote growth and learning.⁸⁹ Without intervention, conditions that begin in a child's early years tend to persist and interfere with healthy development and learning.

Given the importance of early childhood mental health, child care and preschool facilities are also key places where children with mental health issues should be identified early and receive appropriate interventions. The District should properly train those who work with young children to recognize signs of distress and provide proper treatment for children and families who need it.

School-Based Mental Health Programs

Nationally, schools (partnering with health and mental health organizations) are the largest provider of mental health services to children; among children who receive mental health services, up to 80% get their care at school.⁹⁰ Because the overwhelming majority of children attend school, schools are an ideal location to identify children with mental health needs and provide them with appropriate services. Students and parents are also familiar with school facilities and staff which helps lessen the stigma of seeking help for mental health issues. In the course of a school year, children with mental health prob-

lems may miss as many as 18 to 22 days of school. These children are also more likely to drop out or fail out of school: up to 14% of students with mental health problems receive mostly Ds and Fs and up to 44% drop out of high school.⁹¹ DC's current school based mental health program should be expanded to reach all of our students.

RECOMMENDATIONS

3-1. As is required by Medicaid's Early Periodic Screening, Diagnosis and Treatment (EPSDT) provisions, the District should ensure all children receive mental health screenings. Within two years, the District should require all pediatric practices throughout the city to regularly screen for developmental delays, mental and substance abuse disorders using clinically sound, formal screening tools.⁹²

- ▶ DHCF and DMH should convene a working group on the early identification of children's behavioral health problems in pediatric primary care settings.
 - The workgroup should include representatives from the pediatric, mental health, and substance abuse communities, as well as patient and child advocacy organizations.
 - The workgroup should review the current Medicaid regulations on the early and periodic screening, diagnosis and treatment program as they relate to behavioral health and make recommendations about the frequency of screenings, the screening tools used, and the training and education of those conducting the screenings and treatment protocols.
 - DHCF should develop reimbursement rates for use by primary care providers conducting developmental, mental health and substance abuse screenings. The rates should be

reasonably calculated to cover the cost of screening tools and the time to screen, score and interpret the results. Screenings should be reimbursed separately from the standard Medicaid office visit case. DHCF should also require the MCOs to reimburse separately for these screening services.

- ▶ DMH should create a simple, easy-to-read referral guide for pediatricians to give to parents who are seeking mental health services for their child.

3-2. The District should ensure that within two years all pediatric practices throughout the city are regularly screening for maternal depression using clinically sound, formal screening tools.

- ▶ DHCF and DMH should convene a working group on screening for maternal depression in pediatric practices.
 - The working group should include representatives from the pediatric and mental health communities in addition to patient and child advocacy organizations.
 - The workgroup should review other states' practices in this area as well as the screening tools used and the necessary training and education of those conducting the screenings.
 - DHCF should develop one or more reimbursement rates for use by primary care providers conducting these screens. The rates should be reasonably calculated to cover the cost of screening tools and the time to screen, score and interpret the results. Screenings should be reimbursed separately from the standard Medicaid office visit case. DHCF should also require the MCOs to reimburse separately for these screening services.
- ▶ DMH should also create a simple, easy-to-read referral guide for pediatricians to give to parents who are depressed.

3-3. The District should expand its home visiting programs and ensure they promote early childhood mental health.

- ▶ As the District expands its home visiting programs, it should select programs that are evidence-based and have a proven track record of success.⁹³ One of the outcome measures that should be considered when evaluating programs is child and maternal mental health.
- ▶ DMH should partner with the District's various home visiting programs to ensure that home visiting teams are able to properly address maternal and child mental health. For example, a DMH mental health consultant could offer education and training to the home visiting teams and also work with individual home visiting families to address problems and connect them with ongoing mental health services, if necessary.⁹⁴

3-4. The District should fully support and fund mental health consultation and intervention services in child care and preschool programs. These programs place mental health clinicians in child care settings to provide services to individual children and families who are experiencing difficulties in functioning well in the early childhood program. The clinicians also work with child care staff to improve their ability to respond to the behavioral health needs of all the children in the program. In fiscal year 2010 the District launched one such project, Healthy Futures. This program is currently operating in 24 child development centers.⁹⁵ The program places one early childhood mental health specialist in each center one day a week. The program is currently funded through federal grants and local funds, including funds from the Deputy Mayor for Education, and there is uncertainty as to whether full funding will continue to be available.⁹⁶

- ▶ The District should develop a sustainable funding strategy for this program.

- ▶ DMH should evaluate this project to analyze whether its results demonstrate it is the right model to expand or whether other models should be considered.⁹⁷

3-5. The District should expand and improve its school-based mental health program, currently in 59 schools.⁹⁸

- ▶ The District should conduct a comprehensive examination of all viable funding options for school-based mental health, including grants, contracts, insurance and interagency funds. The District should then develop a blended funding strategy to support the expansion of school-based mental health programs.⁹⁹
- ▶ DMH and the Office of the State Superintendent of Education (OSSE) must ensure that all students can access school-based mental health programs. Paradoxically, students who require mental health treatment as part of their special education services are currently ineligible to receive their treatment through these school-based programs, which can delay these children receiving treatment.¹⁰⁰
- ▶ DMH and DHCF have been working to ensure that clinical services provided in the school setting are billed back to insurance companies.¹⁰¹ While it is a laudable goal to have MCOs pick up costs for which they are responsible, the programs should not be limited to Medicaid-reimbursable services.
 - The District must ensure that all students at a school can access the mental health services, not only students with certain types of insurance.



- The District must also ensure that school mental health programs provide more than simply one-on-one therapy which is billable to Medicaid. There are other programs and services that are needed in schools—such as training teachers to identify children with mental health needs, working with teachers to manage children with difficult behaviors, delivering whole-class training programs or providing school-wide prevention services¹⁰² which, though they may not be reimbursable by insurance, are highly necessary services. These non-billable services are critically important to foster positive school climates and ensure that students with mental health needs are not excluded from school.

4. IMPROVE CARE COORDINATION

High-Quality Care Requires Coordination

Too often, mental health treatment is provided in isolation. The child’s parent, pediatrician, therapist, psychiatrist, community support worker and teacher may all be using different approaches with the child and not speaking to one another. High-quality care requires coordination. When clinicians do not talk to each other or to the key adults in a child’s life they often review complex situations superficially and fail to identify core issues—and the child’s condition fails to improve or actually gets worse because of this lack of communication.

While the word “team” is often used informally, there are child and family team practice models which specifically teach clinicians how to properly form, run and coordinate a team in a way that is most beneficial for children and families. Good team formation and functioning ensure that children receive coordinated services that reflect the knowledge and involve the participation of all people involved in the child’s life.¹⁰³

A Strong Core Practice Model

In addition to improved teaming models, the District needs a strong core practice model through which to deliver services. A core practice model is a system-wide model that guides the practice of all mental health professionals regarding how to plan, provide and evaluate treatment. Each year DMH goes through a Community Service Review process required by the Dixon lawsuit¹⁰⁴ through which sample cases are selected for review and scored in a variety of categories. In FY11, reviewers found that the system performed “in the acceptable range” in only 59% of cases.¹⁰⁵ Many of the problems were attributed to lack of effective teaming.

Paying Providers to Coordinate Care

For a mental health clinician to do her job properly, she needs to speak with the key adults (collaterals) in a child’s life such as the child’s parent, pediatrician, teachers or after-school providers. Often a child cannot fully articulate what is happening in all spheres of his life and a clinician needs to hear from adults to fully appreciate the complexity of what the child is feeling and expressing. Providers report that a major barrier to providing effective teaming and case coordination is that this aspect of care is often not reimbursable. Mental health organizations operate on small profit margins and clinicians feel pressure to bill a certain number of hours per week; thus, clinicians cannot afford to do care coordination for free.

RECOMMENDATIONS

4-1. The District should implement a system-wide child and family team practice model and train all relevant staff in this model within the next two years. Currently, only a small number of children in the wraparound pilot project benefit from a specific teaming model. DMH should ensure that all children getting mental health services through its MHRS system are getting the high-quality case management and planning that comes through a teaming process. CSAs, with DMH’s guidance and support, need to institute an evidence-based model, such as the Child and Family Team model, for all their child cases.

- ▶ DMH should work with DHCF and issue a strategic funding plan for this new teaming model. The plan should include:
 - The variety of Medicaid service codes that cover teaming activities and which clinicians can bill under such codes;
 - Medicaid funding options and whether they are a viable option at this time;

- How local dollars can be reallocated to pay for this care coordination.

4-2. Within the next six months, the District needs to create comprehensive policy for how children’s mental health clinicians will be reimbursed for the time they spend communicating with individuals whom they deem to be necessary to make a diagnosis and develop and implement a treatment plan for the child. Currently, reimbursement for collateral contacts is unevenly available. There is a collateral contacts code in the fee-for-service fee schedule, but there is no modifier permitting reimbursement.¹⁰⁶ There are no separate collateral contacts billing codes within the MCOs plans. DMH’s MHRS system offers a limited collateral contacts reimbursement to providers;¹⁰⁷ it is limited to face-to-face contacts (i.e., it doesn’t include telephone consultations) and only specifically applies to one MHRS services, community support.¹⁰⁸ The definition of collateral contact is also not well defined in the MHRS system; without clear standards, providers may be taking an unnecessarily narrow interpretation of this standard.¹⁰⁹ To create a well-used collateral contacts benefit, the District should take the following steps:

- ▶ DHCF should modify its fee-for-service schedule to authorize the payment of collateral contacts. The schedule should clearly state that collateral contacts can be reimbursed if the contact occurs in person or via telephone.
- ▶ DHCF should exercise its authority over the MCOs to ensure their plans offer providers the full range of codes and modifiers necessary to bill for collateral contacts. MCO guidance should clearly state that collateral contacts can be reimbursed if the contact occurs in person or via telephone.
- ▶ DMH should modify existing regulations to provide a clear definition of collateral contacts and ensure it is available as a billable service under all MHRS services. The regulation

JOE IS A 16-YEAR-OLD with complex mental and physical health problems. He has diabetes and an auto-immune disease which has resulted in his becoming deaf and visually impaired. He also has an eating disorder, ADHD and Oppositional Defiant Disorder. After being in a residential placement and several years of unsuccessful treatments, Joe now has some good providers working with him. His progress is limited, however, because there is no meaningful case planning and no short-term or long-term goals for Joe. The clinicians, teachers and Joe’s mother are all busy putting out daily fires, but no one is planning or talking to each other.

should clearly state that collateral contacts can occur in person or via telephone.

- ▶ These services should be paid for with local dollars while Medicaid funding is explored. If DHCF concludes that Medicaid will not fully cover this service, the District should commit to using local dollars to fund this critically important service.
- ▶ DMH and DHCF should issue detailed policy guidance and train providers on the appropriate use of this service.

4-3. The District should consider other methods for expanding case management, such as expanding Medicaid targeted case management (TCM) services to cover additional groups of children. TCM is the provision of case management—a service to assist eligible individuals access needed medical, social, educational and other services—to a targeted beneficiary group. Target groups can be defined by disease or medical condition or any other group identified by a state and approved by Centers for Medicare & Medicaid Services (CMS) (e.g., all individuals with HIV/AIDS, individuals with chronic mental illness, children in foster

care).¹¹⁰ TCM and case management are optional services that states may elect to cover, but the plan must be approved by CMS. Currently, the District has a State Plan Amendment pending approval by CMS which would allow the District to bill Medicaid for providing TCM services to children in foster care through CFSA's Nurse Care

Management program.¹¹¹ Other states use TCM more broadly to cover, for example, all children with serious emotional disturbance.¹¹² Within two years, DCHF and DMH should issue a brief report on TCM, its use in the District and a plan for expanding eligibility to a wider group of children with mental health needs.



When clinicians do not talk to each other or to the key adults in a child's life they often review complex situations superficially and fail to identify core issues.

5. ENSURE ACCESS TO QUALITY AND TIMELY SERVICES

Children Need Timely, High-Quality Services

Too often children in the District of Columbia suffer because services are delayed or low quality. Assessments do not happen in a timely or complete manner, major mental health conditions are left undiagnosed for months or years, and children leave hospitals without proper discharge plans or supports in place and end up back in the hospital soon thereafter.

Often it seems to caregivers and other involved in a child's life that the child is not getting any better despite months or years of mental health treatment. Sometimes the reason is that therapy is inconsistent or interrupted due to provider unavailability. Other times treatment plans are not formally developed or shared with families or other relevant people in the child's life. While a child's behaviors are not likely to change immediately—often treatment takes time and effort—providers should be required to measure the outcomes of their treatment. And treatment plans should be adjusted if the child's symptoms or behavior are not improving.

Children Discharged from Hospitals Wait Too Long for Services

Good discharge planning begins almost as soon as a child enters an inpatient facility, and a comprehensive discharge plan should be developed with the child's guardian, hospital treatment team and community-based service providers in the weeks or days prior to discharge. The hospital team should share treatment information with a child's community-based psychiatrist, therapist and other mental health providers by the time the child is discharged. When a child leaves a hospital after receiving in-patient psychiatric care it

JOSE IS A 16-YEAR-OLD boy who was sexually abused by his father as a child and is diagnosed with PTSD and major depression. He was hospitalized last year when he said that he wanted to kill himself and his father. There was no discharge planning during his hospital stay—there were no meetings to discuss what community-based services might serve the needs of the family and how to keep Jose safely at home. Jose's mother was told to make him an outpatient appointment anywhere she could find; there was no one to help her decide what might be the best service. One day at 2 p.m., Jose's mother was told that he would be released that evening. He left the hospital without appropriate services in place. Since then, Jose's situation has not improved. Currently, he is not in school, is abusing drugs and getting into trouble with the police.

is critical that she is immediately seen in the community. Children who do not have these services are much more likely to end up back in the hospital. In the District, less than 50% of children who are discharged from an inpatient unit are seen within seven days in a non-emergency outpatient setting.¹¹³

Children in the Community Wait Too Long for Services

Children whose conditions do not require hospital-level care also deserve to get timely services. During FY11, only 26% of children received a service from a CSA within seven days of their enrollment¹¹⁴ in MHRS and only 50% were seen within a month.¹¹⁵ MHRS regulations require that CSA provide patients with an appointment within seven business days of referral.¹¹⁶ These numbers are particularly troublesome given that the vast majority of children eligible

TARIK IS A 7-YEAR-OLD boy who, along with his younger siblings, was removed from his mother’s custody due to neglect. Despite a court order for therapy, he received no services for 10 weeks—he didn’t even have an intake appointment for more than 6 weeks. This is Tarik’s second time through the foster care system, his second time suffering the trauma of being separated from his family. Without any services, he is experiencing behavioral problems at school and at home. Even though he’s only in first grade, he was recently suspended for fighting. His foster mother says she may not be able to keep him because of his aggression.

for services from a CSA are those who desperately need prompt services—many have been diagnosed with a serious emotional disturbance that results in a functional impairment. The timeliness of CSA services also varies widely by provider. One provider was able to see 80% of its patients within seven days of enrollment while another was only able to see 8% of its patients within seven days.¹¹⁷

Screening and Connecting Foster Children to Services

Children in foster care have a high level of need for mental health services. In addition, children with mental health issues experience additional hardships in the child welfare system. Compared to those children without a mental health disorder, children with a mental health disorder:

- ▶ have fewer stable placements and more remain in the child welfare system longer due to the difficulty of identifying permanent homes for them;
- ▶ are more likely to be placed out of home in order to access services; and

- ▶ are more likely to receive care in restrictive settings such as juvenile detention, residential treatment, and emergency rooms.¹¹⁸

DMH and CFSA have begun to work more closely together to ensure children get proper mental health care, but much work remains to be done. In FY11, DMH clinicians screened 56% of CFSA children removed from their homes.¹¹⁹ Of those children screened, 66% were found to have mental health needs.¹²⁰

It takes an average of 34 days for CFSA involved children to receive a service after they are referred to a choice provider (a CSA that specializes in working with the CFSA population). Children are screened by CFSA and then referred by CFSA to DMH. Once DMH receives a referral, it links the child to a choice provider, a process that takes an average of 6 days.¹²¹ Then it takes the choice providers an average of 15 days to complete a diagnostic interview once.¹²² After the interview, the child must wait an average of 13 additional days before actually receiving a mental health service.

RECOMMENDATIONS

5-1. Each year, DMH goes through a community service review process required by the Dixon lawsuit through which it samples cases and reviews their quality. Several years ago, DMH created a new office within its agency to focus on these reviews and other ways of assisting providers with organizational development and improving the quality of their services. Even with the recent settlement of the Dixon case, DMH should retain its commitment to the review process so as to be able to continually monitor quality of practice.¹²³ Most importantly, DMH should continue to use data from this review process to provide technical assistance to providers to improve their outcomes. There is large variability in the scores across indi-

vidual CSAs and targeted training interventions have had a positive impact on the lower performing agencies.¹²⁴

5-2. DMH should ensure that all child mental health providers are using appropriate, standardized tools to measure the functional outcomes of children they serve. These tools (such as the Child and Adolescent Functioning Assessment Scale) allow clinicians to assess a child's functioning at various points during treatment and compare how the child is doing at different points in time to evaluate individual cases and overall outcomes for subsets of children.¹²⁵ DMH should provide free training to providers on how to use these tools.

5-3. DMH should improve the percentage of children getting services in a timely manner from CSAs. At least 50% of children should begin receiving appropriate services within seven days of their enrollment and all children should be receiving appropriate services within two weeks. Currently, the time it takes to see a clinician varies widely among CSAs. DMH should work with the CSAs who are succeeding in this area to determine what makes them successful and support other CSAs in implementing these practices. DMH should also ensure that full assessments are happening in a timely manner so that this first step does not slow down the creation of a detailed treatment plan and delivery of actual services.

5-4. DMH should ensure 100% of children in a hospital have a complete and thorough discharge plan and that mental health services are being delivered in the community within seven days of discharge or sooner if the discharge plan requires it.¹²⁶ CSAs and other community providers who were involved with the child and family prior to the hospitalization must be included in these meetings. Within the next six months, a DMH representative should participate in the treatment review and discharge planning meetings of all District youth in psychiatric hospitals to ensure that discharge plans are realistic based on available services. This representative should ensure the family and child secure those services post-discharge.

5-5. DMH and CFSA should ensure that all children entering care are screened for mental health needs and, if necessary, are connected to a CSA for prompt assessments and services.¹²⁷ In FY11 only 56% of children who were deemed eligible for a screen were actually screened within 30 days.¹²⁸ By FY13, every child should be screened. The clinicians administering these screens must use clinically sound, formal screening tools which are appropriate for the age of the child.

5-6. DMH, DYRS and Court Social Services should ensure that all children involved with the juvenile justice system are screened for mental health needs and then, if necessary, are receiving the appropriate mental health services.

6. IMPROVE PSYCHIATRIC SERVICES

Lack of Child Psychiatrists

Nationwide, there is a dearth of child psychiatrists.¹²⁹ There are only an estimated 1.6 child and adolescent psychiatrists per 1,000 children and youth with severe mental health conditions.¹³⁰ It is well established that there are not enough child psychiatrists in the District. For example, RAND has documented a “particular dearth” of children’s mental health providers—including only one psychiatrist—east of the Anacostia River, where more than half of all the District’s children live.¹³¹ There are extremely long waits to see a psychiatrist at the CSAs. DMH recognized this need and created the DMH Children’s Physicians Practice Group to provide emergency services as well as evaluations and ongoing medication management for children. Early anecdotal reports are that this group’s services are high quality, but the group alone cannot fill the need for timely psychiatric services.

Increasing Use of Medication

Another major concern is the potential over-medication or improper medication of children with mental illness, particularly among youth in foster care. Use of psychotropic medications is only one of many treatment options that should be considered in treating a child with mental health problems. Children may be inappropriately medicated for a variety of reasons. One common scenario is that a psychiatrist makes a decision to prescribe medication without having all the pertinent information about a child. Another frequent situation is that medication becomes the default treatment option because non-medication services are not available.

Over the past decade, the prescription of psychotropic medication for youth has increased 200–300% and polypharmacy has increased 250–800%.¹³² National research finds that children covered by

Medicaid are prescribed antipsychotic medication at a rate four times higher than children on private insurance. Children on Medicaid are also more likely to receive drugs for less severe conditions than middle-class children.¹³³ Here in the District, the 2009 Community Service Review found that 53% of children whose cases were reviewed were prescribed one or more psychotropic medication.¹³⁴ In 31% of these cases, the person reviewing the case did not find the medication management to be acceptable.¹³⁵

Between 45% and 75% of psychotropic medications given to children and youth are prescribed off-label.¹³⁶ Off-label prescribing is often the standard of care and requires additional vigilance by physicians who understand the benefits and risks of off-label use for drugs which have often not been studied in children. Use of antipsychotic medication in children and youth is particularly alarming since these medications have an unknown effect on the developing central nervous system.¹³⁷

Over-Medication of Children in the Child Welfare System

Youth in foster care are particularly at risk of being over-medicated since they often do not have consistent caregivers monitoring their diagnoses, treatments and medications. The prevalence of psychotropic medication use among youth in foster care is much higher than in the general youth population. Estimates of psychotropic medication use by youth in foster care range from 13% to 52% compared to 4% of the general youth population.¹³⁸ Youth in foster care are prescribed psychotropic medication at rates 3.4 to 4 times greater than other youth who use Medicaid.¹³⁹

The federal government has recognized the significance of the problem in recent years. The Fostering Connections to Success and Increasing Adoptions Act of 2008 (P.L. 110-351) requires states

to amend their child welfare state plans to “plan for the ongoing oversight and coordination of health care services for any child in a foster care placement” and notes that mental health should be included in this plan.¹⁴⁰ The Child and Family Services Improvement and Innovation Act (P.L. 112-34) is even more detailed in this area and requires states to amend their child welfare state plans and create protocols for monitoring the appropriate use of psychotropic drugs prescribed to foster children.¹⁴¹

The Government Accountability Office (GAO) recently issued a report and testified to Congress about the impacts and costs of medicating foster children.¹⁴² The report raised particular concerns about the rates of children prescribed more than one psychotropic drug at a time and those prescribed doses exceeding the maximum level approved by the Food and Drug Administration. The GAO urged the Department of Health and Human Services (HHS) to issue guidance on the oversight of psychotropic prescriptions for children in care.

HHS recently sent a letter to states expressing increasing concern about “the safe, appropriate and effective” use of psychotropic medications among children in foster care.¹⁴³ In June 2012, the Administration for Children and Families will require states to submit a “comprehensive description of procedures and protocols planned or in place to ensure the safe and appropriate use of psychotropic medications.”¹⁴⁴

Many states have already begun this work and have implemented psychotropic medication oversight policies and procedures for their foster care population. A recent study of nearly every state and the District identified which states had policies or written guidelines regarding psychotropic medication oversight for youth in foster care; 54% of states had established written policies and another 27%

TANYA, 10, AND MATT, 6, entered foster care five years ago due to their mother’s substance abuse and inability to care for them. Tanya is diagnosed with, among other things, post-traumatic stress disorder and reactive attachment disorder. She is currently prescribed three antipsychotic medications (Abilify, Risperdal and Seroquel) as well as an anti-depressant (Zoloft). Matt is diagnosed with, among other things, attention deficit hyperactivity disorder (ADHD), adjustment disorder and fetal alcohol syndrome. He is currently prescribed an antipsychotic medication (Risperdal), an antidepressant (Trazodone) as well as two medications for ADHD (Concerta and Intuniv).

were developing them.¹⁴⁵ The District has not yet begun this process.¹⁴⁶

RECOMMENDATIONS

6-1. Within the next six months, DMH should assess the gap between need and availability of child psychiatric services and develop a plan to close this gap. DMH should consider:

- ▶ The need for child psychiatric services in the Medicaid population;
- ▶ The current capacity for providing these services (including doctors who speak Spanish and other languages);
- ▶ The current wait times to get an initial appointment (or reschedule an appointment if it is missed);
- ▶ The wait times between initial diagnostic appointment and actual start of services;
- ▶ Ways to bring more child psychiatrists to the District, such as:

- Higher reimbursement rates;
- Loan repayment for doctors who work in underserved areas;
- Fellowship programs.

6-2. Within the next two years, the District should create a DC Child Psychiatry Access Project (modeled after a successful Massachusetts program),¹⁴⁷ with mental health consultation teams available to assist primary care providers meet the needs of children with psychiatric problems. In this model, the consultation team—consisting of a child psychiatrist, social worker or psychologist, care coordinator and support staff—is on call to respond to primary care clinicians who need assistance with a patient’s mental health needs, including diagnosis, medication management and referrals. Often a telephone consult can occur while the patient is in the waiting room. When necessary, a subsequent face-to-face appointment is arranged. The consultations are free to the doctors and available regardless of the patients’ insurance status. In Massachusetts, where the project began as a pilot in 2003 and was rolled out statewide in 2004, the project cost only 17 cents per child in the state. The Massachusetts model is being applied in Washington and Illinois.¹⁴⁸

6-3. Within the next year, the Department of Mental Health should develop an oversight mechanism to ensure children in foster care are not being improperly medicated.

- ▶ DMH and CFSA should convene a workgroup on the psychotropic medication of children in foster care. The group should include mental health, child welfare and Medicaid experts, as well as birth parents, foster parents and child advocates.
- ▶ The workgroup, with the advice of child psychiatrists, should develop guidelines setting forth acceptable prescribing practices. The American Academy of Child and Adolescent Psychiatry has published guides which can inform this process.¹⁴⁹
- ▶ Many other states have created these medication guidelines/utilization parameters and the workgroup should review these models.
- ▶ The guidelines should set forth a set of prescribing practices which are listed as “red flags” and will require additional review from DMH. These flags can either prompt case reviews, initiate a prior review process or be used to conduct quality assurance, audits or case reviews.¹⁵⁰
- ▶ The workgroup should design a way for these “red flag” reviews to be generated and reviewed by DMH. For example, prescriptions that are outside the established guidelines could be flagged by the Medicaid system in some manner. Alternatively, CFSA’s Office of Clinical Practice could track prescriptions and automatic alerts could be sent to this office and DMH when a prescription falls outside the utilization parameters.

7. IMPROVE COMMUNITY-BASED SERVICES TO REDUCE RESIDENTIAL PLACEMENTS

Community-Based Services Must Be Available to All Children

Many children in foster care, particularly in therapeutic foster care, live with families in Maryland. While some of these children live just over the District line, others live more than an hour away. Currently, it is quite difficult to find providers who accept DC Medicaid to serve these children. This is particularly challenging for the more intensive home based services where providers are required to be in the child's home or school three to four times a week.

Institutionalization Harms Children

Hundreds of District children who have been diagnosed with mental illness live at residential treatment centers (RTCs). It is harmful for children to be unnecessarily institutionalized.¹⁵¹ Children are often placed in RTCs which are far away from the District and therefore are cut off from their communities and unable to see their families. Evidence shows that this isolation impedes youths' clinical treatment and their quality of life. Perhaps most importantly, research does not show that RTCs are effective in treating adolescents.¹⁵² RTCs are also extremely expensive, costing approximately \$300 a day. According to the DC City Administrator, the District spends approximately \$61 million per year on RTCs in local and federal funds.¹⁵³ This money could be better spent on community-based programs and services. DMH estimates the cost of a psychiatric residential treatment facility (a specific type of RTC for children with mental health needs) ranges from \$150,000 to \$250,000 per year whereas the cost of wraparound supports provided in the



community ranges from \$20,000 to \$27,000 per youth per year.¹⁵⁴

The District has made strides in reducing the number of youth in PRTFs and this good work must be the foundation of a continued effort to better serve our children.¹⁵⁵ The number of youth in PRTFs has decreased in recent months: from 153 in May 2011 to 89 in December 2011.¹⁵⁶ The number of CFSA youth in PRTFs has been greatly reduced from 112 youth in FY09 to only 24 at the end of the first quarter of FY12.¹⁵⁷ Unfortunately, there is no information about how the children diverted from PRTFs, or those discharged and returned to their homes and communities, are now faring.

Wraparound Pilot

One model DC has developed to reduce the number of children in residential placements is the High Fidelity Wraparound Pilot. Wraparound is "an approach of coordinating highly individualized, family-centered plans of care that focus on the unique needs and strengths of each youth and family."¹⁵⁸ The services that each child receives are developed through a team-planning process where individuals who are

KENDRA IS A 16-YEAR-OLD girl who was sexually assaulted by her father. After she began acting out, her mother turned her over to CFSA. She was diagnosed with PTSD and ended up at a residential treatment center (RTC) in Georgia. Although she was only supposed to be there for 6 months, she stayed there for 11 months. She made some progress while at the RTC, but her behavior quickly deteriorated when she returned to a group home closer to the District. Her mother visited her monthly, at best, while she was at the RTC and no meaningful family work could be done. While the RTC temporarily stabilized Kendra, she is not able to generalize anything she learned there. Her mental health and life have not improved since her return; she recently ran away from her foster home.

relevant to the well-being of the child (family members, services providers, teachers, agency staff) collaborate to create and implement an individualized plan.¹⁵⁹ It is an evidence-based model that requires adherence to specific principles and procedures. Nationally, the wraparound model has been touted as an effective community-based services delivery method. Wraparound services not only have better outcomes but are also less restrictive and costly than institutional and group care.¹⁶⁰ However, a wrap program cannot operate in isolation; it can only be successful if there are appropriate community-based services to which to link a child and family.

In the District, the wraparound program is currently run by DC Choices and serves children through a community program and a school program (full service schools). In FY11, of the 162 youth served by the school wrap pilot, 98% were diverted

from a PRTF. Of the 49 youth in the community wrap pilot, 69% were diverted from PRTFs.¹⁶¹ In FY12, the pilot added only 17 more slots,¹⁶² but the need is much greater than these few additional spots. There also needs to be better education about the program, its benefits and eligibility criteria. Too many CSAs and others in the system are not referring children because they are not sure how to access the program or who is eligible.

Improve Therapeutic Care

Many children in the child welfare system end up in residential placements because DC does not have an appropriate therapeutic foster care program for children with mental health issues. Although, CFSA contracts with private foster care agencies to place children in therapeutic foster homes, these foster parents are not properly trained or supported. DC's current therapeutic foster homes are very different from the evidence-based models of treatment foster care (TFC)¹⁶³ which have been successful in other parts of the country.

TFC refers to the use of a foster home as a therapeutic milieu for youth with significant emotional or behavior issues. TFC is used with children ranging in age from preschool to young adulthood and there are many forms of it used around the country. The goal of TFC is to decrease problem behavior and increase developmentally appropriate and positive behavior in children and adolescents who would otherwise be in need of out-of-home placement. TFC treatment goals are accomplished by providing the youth with close supervision; fair and consistent limits; predictable consequences for rule breaking; a supportive relationship with at least one mentoring adult; and reduced exposure to peers with similar problems.¹⁶⁴

Importantly, many TFC models work with the youth's current caregiver (often foster parents) and

his or her biological parent (or family of origin). The goal is for the child to achieve the stability and develop the competencies necessary to reunify with his or her biological parent or be placed with another permanent caregiver. A typical TFC team includes the foster parent, a program supervisor who provides intensive support and consultation the foster parent, a family therapist, an individual therapist and child skills trainer. There is also a designated person who gathers daily behavioral information from the foster parent, usually over the phone. There are weekly team meetings to review the child's progress and adjust the treatment plan. Foster parents can access program staff 24 hours a day, seven days a week and foster parents are treated as professional members of the treatment team. The foster parents must be willing and able to implement precisely tailored treatment interventions and actively participate in weekly meetings and daily phone calls. TFC parents view themselves as preparing children for success in a permanent placement via a short-term, highly intensive intervention.

The most widely disseminated model of TFC, Multidimensional Treatment Foster Care (MTFC), has been demonstrated effective by many studies.¹⁶⁵ When compared to youth placed in congregate care, MTFC youth have shown improved outcomes in numerous domains. Several states are currently using MTFC as part of their foster care program. MTFC is usually funded through a blended funding stream that includes Medicaid (EPSDT funds), Title IV-E foster care funds and a small percentage of state local dollars.¹⁶⁶

Therapeutic foster care programs are advantageous not only to children in the child welfare system, but also to children in the juvenile justice system as well as children in the community with mental health problems who are not involved with

either agency. Therapeutic foster care should be available as a voluntary mental health service when a custodial parent is having difficulty maintaining a child in the home.

RECOMMENDATIONS

- 7-1.** The District should ensure that there are appropriate community-based programs and services to support youth diverted and returning from residential placements. The District should clearly demonstrate how the money saved by not placing children in residential placements is being reinvested in community-based services.
- 7-2.** DMH must ensure that the choice providers (or another group of providers) include practices that are located in Maryland or clinicians who will partner with DC-based CSAs to offer services to DC wards living in Maryland. Currently only one out of six choice providers and only 2 out of 27 core service agencies are located in Maryland.¹⁶⁷
- 7-3.** The District should continue to improve its oversight and monitoring of children in RTCs.
 - ▶ DMH's policies regarding PRTF placement should be issued as DMH regulations.¹⁶⁸
 - ▶ The interagency committee on residential placements should collect and report data on how youth diverted from or returning from PRTFs are doing in the community (e.g., school attendance, reports from outpatient mental health clinicians and parents on the child's improved functioning, any juvenile justice involvement or hospitalizations).
 - ▶ All MCOs, including Health Services for Children with Special Needs, and District agencies should be bound by the PRTF placement guidelines;¹⁶⁹ DMH and its sister agencies must discuss what changes are necessary to ensure this occurs.
 - ▶ The District should annually report on children placed in all RTCs, not just PRTFs, and issue

a report on this topic, outlining the placing agencies and procedures through which the child was placed in the setting. The District should aim to reduce overall RTC placements by 20% each year.¹⁷⁰

7-4. The District should expand the High Fidelity Wraparound Pilot program to serve more children.¹⁷¹ The program should evaluate which services and programs are most successful in allowing children to remain in the community and how these services are funded. If this evaluation concludes that there are valuable services that children in the Wraparound Pilot Program are receiving which are not available in the larger community, DMH should create a plan for how to offer those services more broadly.

7-5. DMH should ensure that children receive community-based intervention (CBI) services in a timely manner and also that these services are high-quality. CBI services are time-limited, intensive services for youth ages 6 through 21 intended to prevent the youth from an out-of-home placement.¹⁷² The longer the family must wait for CBI to start, the more likely the child's condition will deteriorate, leading to a hospital stay or a residential placement. Encouragingly, from FY10 to FY11, there was a 37% increase in the number of youth receiving a CBI service. DMH's goal is for a child to wait no more than 72 hours from referral until he receives his first CBI service. Currently, the average wait is 15.5 days. The length of delay var-

ies greatly based on the provider.¹⁷³ The quality of CBI services also varies considerably based on the specific team that is working with a child and the experience and training level of that provider.

- ▶ DMH should work with providers to determine what interventions and processes are needed to ensure children can receive CBI services more immediately. In two years, the average number of days from referral to services should be reduced to three days.
- ▶ DMH should work with providers to capture and analyze outcome measure for CBI consumers to ensure that services are high-quality and providers are appropriately trained.

7-6. DMH should ensure that a quality therapeutic foster care model is available within two years for children in foster care as well as children involved with DYRS and other children in the community with mental health needs who are not involved with either agency. The District must develop consistent standards for licensing, training foster parents and implementing this service. The District should build off discussions that they have already begun between CFSA and DMH on how to improve the District's existing therapeutic foster care model. As the agencies consider which evidence-based treatment modalities are best suited for the District, they should also work closely with DHCF to maximize Medicaid funding for this service.

CONCLUSION

The District has made laudable progress in its children’s mental health system over the past several years. There is, however, much work to be done. It is time for children’s mental health to be a priority in the District. Many other systems the District’s children are involved with—child welfare, education and juvenile justice—are hindered by the lack of a high-quality mental health system that provides robust preventive, early intervention and treatment services.

This plan’s seven sections include a total of 32 specific recommendations for how we can improve

the District’s child mental health system. As stated earlier, some of these changes can and should happen immediately and others will take more time to plan and implement well. There is no one simple solution; but, these pages contain a blueprint for how to create a system where all children receive easily accessible, high-quality, coordinated mental health services. The Children’s Law Center looks forward to working with families, providers, advocates and government officials to implement this plan’s recommendations.



ENDNOTES

- 1 The terms “mental illness,” “mental disorder” and “mental health problems” mean specific things to mental health professionals, yet are often used interchangeably in everyday conversation. This plan is focused on the broadest definition of these terms. While some children and youth may have a diagnosis such as bipolar disorder or schizophrenia, many more are diagnosed with conditions such as anxiety disorder, attention deficit disorder, disruptive behavior disorder, post-traumatic stress disorder or depression. Office of the Surgeon General, U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General, Ch. 3 - Children and Mental Health* (1999).
- 2 Shannon Stagman & Janice L. Cooper, National Center for Children in Poverty, *Children’s Mental Health: What Every Policymaker Should Know* 3 (2010).
- 3 Ronald Kessler et al., *Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication*, Vol. 62, No. 6, Archives of General Psychiatry 593-602 (2005).
- 4 The President’s New Freedom Commission on Mental Health, *Final Report to the President* 58 (2003).
- 5 Shannon Stagman & Janice L. Cooper, National Center for Children in Poverty, *Children’s Mental Health: What Every Policymaker Should Know* 3 (2010).
- 6 The District of Columbia has the second highest child poverty rate in the nation; as of 2009, 29.4% of children in the District are poor. Children’s Defense Fund, *The State of America’s Children B-10* (2011).
- 7 Alicia F. Lieberman et al., *Zero to Three, Poverty, Trauma, and Infant Mental Health* 54 (2009).
- 8 Shannon Stagman & Janice L. Cooper, National Center for Children in Poverty, *Children’s Mental Health: What Every Policymaker Should Know* 3 (2010).
- 9 *Id.*
- 10 Embry Howell, Urban Institute, *Access to Children’s Mental Health Services Under Medicaid and SCHIP* 5 (2004).
- 11 Dennis R. Jones, Court Monitor, *Report to the Court (Dixon et al v. Gray)*, Exit Criteria 5, 7 (2011).
- 12 By comparison, Maryland reports that almost 9% of Medicaid youth under the age of 18 receive a service through its public mental health system. Christine Ferguson et al., Department of Health Policy, School of Public Health & Health Services, The George Washington University, *Mental Health Carve Out Assessment* 3 (n.d.).
- 13 DC Department of Health Care Finance, *Medicaid Annual Report FY2008* 4 (2008). The percentage of District children on Medicaid is significantly higher in 2012 than when this figure was calculated in 2008. The District has not published an updated percentage since 2008. In FY10, there were over 91,000 children (under age 21) on Medicaid, but DHCF was unable to provide the number of children (under age 21) in the District. The U.S. Census Data for 2010 breaks down the number of children under 18, making calculations difficult.
- 14 In the District, to be Medicaid eligible children under 18 must live in families whose income is below 300% of the federal poverty level (FPL); for youth age 19-20 the family’s income must be below 200% FPL. To be eligible for federally funded Medicaid an individual must be a citizen or a qualified alien. Immigrant children who do not qualify for the federal Medicaid program are enrolled in a 100% locally funded program, the Immigrant Kids Program, which is otherwise identical to the Medicaid program.
- 15 42 U.S.C. §1369(a)(43).
- 16 District of Columbia Medicaid State Plan §3.1(a)(9).
- 17 Beth A. Stroul, National Technical Assistance Center for Children’s Mental Health, Georgetown University Child Development Center, *Issue Brief: Systems of Care: A Framework for System Reform in Children’s Mental Health* 1 (2002).
- 18 *Id.* at 3-4.
- 19 DC Child and Family Services Agency and Department of Mental Health, *A Mental Health Needs Assessment of Children in Foster Care* (April 2007); Anita Chandra et al., RAND Health, *Health and Health Care Among District of Columbia Youth* (2009); Carole Roan Gresenz et al., RAND Health, *Behavioral Health in the District of Columbia: Assessing Need and Evaluating the Public System of Care* (2010).
- 20 District of Columbia Behavioral Health Association, *Towards a True System of Care: Improving Children’s Behavioral Health Services in the District of Columbia, Part 2 of 2* (2009).
- 21 RCI Counseling, Scruples, Progressive Life Center, Family Preservation Services, Green Door, Student Support Center. DC Behavioral Health Association, *Sensible Budget Choices: Increasing Access Can Save Money* 2 (2012).
- 22 Washington Hospital Center’s Outpatient Clinic and Latin American Youth Center. DC Behavioral Health Association, *Sensible Budget Choices: Increasing Access Can Save Money* 2 (2012).
- 23 DC’s Federal Medicaid Assistance Percentages (FMAP) for Fiscal Year 2013 for the Medicaid is 70.00. Fed. Reg. Vol. 76, No. 230 (2011).
- 24 District of Columbia Behavioral Health Association, *Towards a True System of Care: Improving Children’s Behavioral Health Services in the District of Columbia, Part 2 of 2* (2009).
- 25 DC Behavioral Health Association, *Memo to the DC Council Committee on Health on the South Capitol Street Memorial Tragedy Act, Section 606: Credentialing of Behavioral Health Providers* (2011).
- 26 22A D.C.M.R §1201.1.
- 27 In addition to those four services, the other MHRS services include crisis/emergency, rehabilitation/day services, intensive day treatment, community-based intervention and assertive community treatment (which is only for adults) 22A D.C.M.R. §3402.
- 28 Josie Acosta et al, RAND Health, *Working Paper: Guide to the Behavioral Health Care System in the District of Columbia* 14 (2010).

- 29 The Research and Training Center for Children’s Mental Health, The University of South Florida, *Health Care Reform Tracking Project 1* (2000).
- 30 Two of the District’s MCOs already carve out mental health services—Beacon Health Strategies is the MBHC for Chartered Health Plan and Optimum is the MBHC for United HealthCare Community Plan.
- 31 Richard Frank, *Chapter 8: The Mental Health Economy and Mental Health Economics*, National Mental Health Information Center, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.
- 32 Christine Ferguson et al., Department of Health Policy, School of Public Health & Health Services, The George Washington University, *Mental Health Carve Out Assessment 7* (n.d.).
- 33 A carve-out uses “administratively or legally separate organizations to provide health care services for particular conditions, procedures, diseases or group of patients.” Christine Ferguson et al., Department of Health Policy, School of Public Health & Health Services, The George Washington University, *Mental Health Carve Out Assessment 7* (n.d.).
- 34 U.S. Government Accountability Office, *Medicaid Managed Care: CMS’ Oversight of States’ Rate Setting Needs Improvement 2* (2010).
- 35 This list is partially based on DMH and CFSA’s 2011 review of the *2007 Children’s Mental Health Needs Assessment*. DC Council Committee on Health, FY10 Oversight Questions: DMH Responses, Question 34. It is also based on CLC’s experience representing hundreds of children each year who are seeking mental health services.
- 36 Psychotherapy includes family, group, play, art, dance and drama therapies with providers who are credentialed in that area of expertise. Currently, many CSAs cannot provide “psychotherapy” because it is not an MHRS service; they can only provide “counseling” (22A D.C.M.R. §3417). Counseling can be provided by psychiatrists, psychologists, LICSWs, APRNs, RNs, LPCs, LISWs and addiction counselors. Psychotherapy (which is also referred to simply as “therapy”) can only be provided by clinicians with a graduate degree and a license in mental health.
- 37 Intensive day treatment is a structured, intensive and coordinated acute treatment program that serves as an alternative to acute inpatient treatment or as a step-down from inpatient care. The care is short term, day programming consisting of therapeutically insensitive treatment for individuals who are not in danger but have behavioral health issues that are incapacitating and interfering with their ability to carry out daily activities. Beacon Health Strategies, LLC, *District of Columbia Level of Care Criteria*, Intensive Day Treatment 17 (2010).
- 38 Partial hospitalization or “acute partial hospitalization programs” are short-term day programs where intensive, acute treatment is provided in a therapeutic environment. A child receives daily psychiatric management and active treatment similar to that provided in an inpatient setting, but the child returns to a supportive home environment in the evenings. Partial hospitalization programs are provided by either hospital-based or freestanding facilities. Beacon Health Strategies, LLC, *District of Columbia Level of Care Criteria*, Acute Partial Hospital Programs 14 (2010).
- 39 Per the Dixon settlement agreement, the District has agreed to increase the provision of evidence-based practice for children and youth by 20% in FY2012 (baseline FY2011) and 20% in FY2013 (baseline FY2012). The evidence-based practices listed in the settlement are multi-systemic therapy and functional family therapy. *Dixon v. Gray Settlement Agreement 16* (2011).
- 40 Trauma-focused cognitive behavioral therapy (TF-CBT) is just one type of trauma-focused or trauma-informed intervention. DMH may want to also consider other interventions or models. As of December 2011, only one DMH provider offered TF-CBT. As of February 2012, four new providers are now offering this service. DC Council Committee on Health, FY11 Oversight Questions, DMH Response to Question 50.
- 41 As of February 2012, only two DMH providers offer this service. DC Council Committee on Health, FY11 Oversight Questions, DMH Response to Question 50.
- 42 As of February 2012, only two DMH providers offer this service. *Id.*
- 43 DMH plans to train providers in this model in 2012.
- 44 In June 2010, DMH launched the Parent Infant Childhood Enhancement Program (PIECE) at its Howard Road facility. This program’s goal is to provide treatment to infants, toddlers, young children who are experiencing social, emotional and behavioral difficulties and their parents. The program only has three clinicians. DMH should assess the need for these services and expand the program to meet this need.
- 45 Quality of parenting has been identified as a key factor in enabling young children to “cope adaptively with adverse environmental circumstances.” Unavailable parents, unresponsive and harsh parenting are associated with negative outcomes in young children such as high levels of stress hormones, more mental health problems, more learning difficulties and more behavioral disturbances. Alicia F. Lieberman et al., *Zero to Three, Poverty, Trauma, and Infant Mental Health 54* (2009). Examples of parenting programs include: Triple P-Positive Parenting Program, a behavioral family intervention designed to improve parenting skills and behaviors by changing how parents view and react to their children. It teaches healthy parenting practices and how to recognize negative practices. Richard Barth, *Preventing Child Abuse and Neglect with Parent Training: Evidence and Opportunities*, Future of Children, Vol. 19, No. 2, 95(2009). See also <http://www.triplep.net>; The Incredible Years, a parent training intervention focused on strengthening parenting competencies and fostering parents involvement in children’s school experiences in order to promote children’s academic, social and emotional growth and reduce conduct problems. Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice, *Juvenile Justice Bulletin: The Incredible Years Training Series* (2000). See also <http://www.incredibleyears.com>.
- 46 Axis I: Clinical Disorders including psychotic, mood, anxiety and adjustment disorders. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV-TR) 27* (2000).

- 47 DC Behavioral Health Association, *Memo to the DC Council Committee on Health on the South Capitol Street Memorial Tragedy Act, Section 606: Credentialing of Behavioral Health Providers* (2011).
- 48 *Id.*
- 49 *Id.*
- 50 RAND Health, *Health and Health Care Among District of Columbia Youth* 93 (2009). The study did not break down this data for children enrolled in the other Medicaid MCOs and this data does not seem to be otherwise publicly available.
- 51 Behavioral Health Subcommittee, Medical Care Advisory Committee, *FY2011 Year-End Report and Recommendations* 3 (2012).
- 52 *Id.*
- 53 RAND Health, *Health and Health Care Among District of Columbia Youth* 84 (2009).
- 54 Anita Chandra et al., RAND Health, *Health and Health Care Among District of Columbia Youth* (2009).
- 55 DC Departments of Health Care Finance and Mental Health, *Memorandum of Understanding for Implementation of DHCF's Solicitation Number DCHC-2007-R-5050*, (3)(b) at 3 (effective as of 1/2/09).
- 56 The DC MCOs differ significantly on their credentialing process. United/Optimum credentials providers as a practice, rather than as individuals. Chartered/Beacon not only credentials providers individually, it also verifies all submitted information and requires supplementary information in excess of the contractual minimum. Behavioral Health Subcommittee, Medical Care Advisory Committee, *FY2011 Year-End Report and Recommendations* 4 (2012).
- 57 DC Behavioral Health Association reviewed the MCOs' online provider directories based on its own member samples. Behavioral Health Subcommittee, Medical Care Advisory Committee, *FY2011 Year-End Report and Recommendations* 7 (2012).
- 58 Dawn Horner, Center for Children and Families, Georgetown University Health Policy Institute, *Program Design Snapshot: 12-Month Continuous Eligibility* (2009).
- 59 *Id.*
- 60 *Id.*
- 61 The nine MHRS services are: diagnostic/assessment; medication/somatic treatment; counseling; community support; crisis/emergency; rehabilitation/day services; intensive day treatment; community-based interventions; and assertive community treatment (for which children aren't eligible), 22A D.C.M.R. §3402.4.
- 62 These recommendations mirror those in the MCAC report. Behavioral Health Subcommittee, Medical Care Advisory Committee, *FY2011 Year-End Report and Recommendations* 8 (2012).
- 63 Kaiser Family Foundation, *State Health Facts: Has 12-Month Continuous Eligibility Under Medicaid and Separate CHIP Programs* (2011).
- 64 Dawn Horner, the Center for Children and Families, Georgetown University Health Policy Institute, *Program Design Snapshot: 12-Month Continuous Eligibility* (2009).
- 65 Research shows that even brief gaps in health insurance coverage causes people to skip or delay care while uninterrupted coverage can reduce hospitalizations for children by 25%. Children with gaps in insurance do not seek medical care, including preventive visits, and do not get prescriptions. Health care costs could decrease as acute episodes are prevented or treated at an earlier stage and chronic conditions are better managed. Dawn Horner, the Center for Children and Families, Georgetown University Health Policy Institute, *Program Design Snapshot: 12-Month Continuous Eligibility 2* (2009).
- 66 Dawn Horner, the Center for Children and Families, Georgetown University Health Policy Institute, *Program Design Snapshot: 12-Month Continuous Eligibility 2* (2009).
- 67 Many parents and others in the District have a low-literacy level and the website should strive to explain things in simple language.
- 68 The President's New Freedom Commission on Mental Health, *Final Report to the President* 60 (2003).
- 69 Anita Chandra et al., RAND Health, *Health and Health Care Among District of Columbia Youth* (2009).
- 70 *Id.*
- 71 Shirley S. Wang, *Call for Kids' Mental-Health Checks*, Wall Street Journal, June 1, 2009.
- 72 The President's New Freedom Commission on Mental Health, *Final Report to the President* 59 (2003). See also Renee Goodwin et al., *Prescription of Psychotropic Medications to Youths in Office-Based Practices*, Psychiatric Services (2001) (a study which found that 84.8% of prescriptions for psychotropic medications were provided by general practitioners or pediatricians).
- 73 John V. Lavigne et al., *Behavioral and Emotional Problems Among Preschool Children in Pediatric Primary Care: Prevalence and Pediatricians' Recognition*, *Pediatrics*, Vol. 91. No. 3, 649-655 (1993).
- 74 President's New Freedom Commission on Mental Health, *Final Report to the President* 60 (2003).
- 75 Shelia Smith et al., *Building Strong System of Support for Young Children's Mental Health: Key Strategies for States and Planning Tool*, National Center for Children in Poverty 4 (2011).
- 76 Marian F. Earls, American Academy of Pediatrics, *Clinical Report: Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice*, *Pediatrics*, Vol.126 (2010).
- 77 Olivia Golden et al., Urban Institute, *Home Visiting and Maternal Depression* 4 (2011).
- 78 Marian F. Earls, American Academy of Pediatrics, *Clinical Report: Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice*, *Pediatrics*, Vol.126 (2010).
- 79 *Id.*
- 80 *Id.*
- 81 *Id.*
- 82 Elizabeth DiLauro, ZERO to THREE Policy Network, *Supporting Parents and Child Development Through Home Visiting* (2009).
- 83 Over the past two years, DC received approximately \$1.6 million in federal dollars for home visiting through the Affordable Care Act, Maternal, Infant and Early Childhood Home

- Visiting Program. U.S. Department of Health and Human Services, Health Resources and Services Administration, <http://granteefind.hrsa.gov>. DC's FY10 funding for home visiting programs was \$750,000 which is an average of \$75 per low income child (the national average is \$171 per low income child). This funding was administered through the Department of Health to the Child and Family Services Agency. The Pew Center on the States, *States and the New Federal Home Visiting Initiative: An Assessment from the Starting Line* 32 (2011).
- 84 These are programs which best meet the definition provided by the Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program, which states: "...including programs supported by State or Federal government funds, where home visiting is a primary intervention strategy for providing services to pregnant women and/or children birth to kindergarten entry, excluding programs with few or infrequent visits or where home visiting is supplemental to other services. The number and types of individuals and families receiving these services may be reported using the units and formats used by each service provider." The seven qualifying programs serve 922 families; but only four of the programs have an early childhood focus, so it was impossible for DC to ascertain the true capacity of these programs to serve the targeted population. District of Columbia Department of Health, *Application for Affordable Care Act, Maternal, Infant & Early Childhood Home Visiting Program* 14.
- 85 District of Columbia Department of Health, *Application for Affordable Care Act, Maternal, Infant & Early Childhood Home Visiting Program* 14.
- 86 The President's New Freedom Commission on Mental Health, *Final Report to the President* 65 (2003).
- 87 Shelia Smith et al., *Building Strong System of Support for Young Children's Mental Health: Key Strategies for States and Planning Tool*, National Center for Children in Poverty 4 (2011).
- 88 *Id.* at 3.
- 89 *Id.*
- 90 The Center for Health and Health Care in Schools, School of Public Health and Health Services, Graduate School of Education and Human Development, The George Washington University, *Caring for Kids* 4 (2003).
- 91 Shannon Stagman & Janice L. Cooper, National Center for Children in Poverty, *Children's Mental Health: What Every Policymaker Should Know* 4 (2010).
- 92 Massachusetts' Medicaid program has nine approved screening tools: Ages and Stages Questionnaires: Social-Emotional; Brief Infant-Toddler Social & Emotional Assessment; Modified Checklist for Autism in Toddlers; Parents' Evaluation of Developmental Status; Pediatric Symptom Checklist; Pediatric Symptom Checklist-Youth Report; Strengths & Difficulties Questionnaires; CRAFFT (Substance Abuse); Patient Health Questionnaire 9: Depression Screener. MA Medicaid reimburses providers for the administration and scoring of these screening tools in addition to the general reimbursement for the pediatric visit. Children's Behavioral Health Initiative: Screening for Behavioral Health Conditions, Executive Office of Health and Human Service Commonwealth of Massachusetts. <http://www.mass.gov/eohhs/gov/commissions-and-initiatives/cbhi>.
- 93 The U.S. Department of Health and Human Services' Home Visiting Evidence of Effectiveness project has conducted a thorough review of home visiting research literature. They have analyzed 22 models of home visiting in various domains and provide summaries of their effectiveness by outcome domain. See <http://homvee.acf.hhs.gov>.
- 94 Olivia Golden et al., Urban Institute, *Home Visiting and Maternal Depression* 16 (2011), discussing research into two promising ways to get mental health treatment to depressed mothers in home visiting programs.
- 95 DC Council Committee on Health, FY10 Oversight Questions: DMH Responses, Question 45.
- 96 Dennis R. Jones, Court Monitor, *Report to the Court (Dixon et al. v. Gray)* 28 (2011).
- 97 A model to consider is Maryland's Early Childhood Mental Health Consultation Project which began as a pilot in 2002 and in 2006 was expanded statewide. See http://www.marylandpublicschools.org/MSDE/divisions/child_care/program/ECMH. Georgetown University's Center for Child and Human Development has a Center for Early Childhood Mental Health Consultation which also has a wealth of resources, see <http://www.ecmhc.org/about.html>.
- 98 For school year 2010-2011, the School Based Mental Health Program was in 59 schools; the District has over 200 public and public charter schools. Decisions about which schools participate in the program are made jointly by DMH and the schools. The decisions are "based largely on school readiness and the availability of other resources, e.g. school counselors and social workers." Dennis R. Jones, Court Monitor, *Report to the Court* 27 (2011).
- 99 Olga Acosta Price et al., *School Mental Health Services for the 21st Century: Lessons from the District of Columbia School Mental Health Program*, Center for Health and Health Care in Schools 40 (2008).
- 100 The schools provide their own services, separate from those provided by DMH, to special education students who have been assessed as requiring mental health services to benefit from educational services. Olga Acosta Price et al., *School Mental Health Services for the 21st Century: Lessons from the District of Columbia School Mental Health Program*, Center for Health and Health Care in Schools 34 (2008). The bureaucratic/funding problems that led to this situation must be resolved so that special education students can also access the DMH service providers if these providers are appropriate for them.
- 101 For school year 2010-2011, school-based mental health billing revenues came predominately from students who were enrolled in one of the District's MCOs; such billing was approximately 1/3 of the total services of a given clinician—the remainder of the clinician's time spent on non-billable activities (prevention, early intervention). Dennis R. Jones, Court Monitor, *Report to the Court* 28 (2011).

- 102 One model to consider is the Positive Behavioral Interventions and Supports (PBIS) which seeks to establish the social environment and behavioral supports necessary for a school to be an effective learning setting for all students. PBIS is a well-known national model that is supported by the U.S. Department of Education. PBIS' framework includes primary prevention practices (proactive support for students in all locations); secondary prevention practices (targeting students at risk for behavioral problems and educational failure); and tertiary prevention practices (providing intensive support for students with chronic patterns of problem behavior). Schools that implement that model have found improvements in attendance, among other positive changes (better classroom management, less exclusionary discipline practices, improved supports for children with behavioral health needs). Maryland law requires elementary schools with high suspension rates to implement PBIS programs or similar behavior modification programs and many middle and high schools have voluntarily implemented PBIS. National Center for Mental Health Promotion and Youth Violence Prevention, *Evidence Based Program Fact Sheets: Positive Behavioral Interventions and Supports (PBIS)*; Maryland Department of Legislative Services Office of Policy Analysis, *Approaches to Solving the Problem of Truancy 12* (2008).
- 103 DC Department of Mental Health, Children and Youth Services Division, *The Children's System of Care Plan: A Comprehensive 3-5 Year Plan for Redesign 15* (2012).
- 104 *Dixon v. Gray* is a federal class action which was filed 1974. In 1975, the Court found that the District violated plaintiffs' right to adequate community-based mental health care. For the past 38 years, the District's mental health system has been under various forms of Court monitoring and oversight. Per a 2002 consent decree, the District is required to meet 19 performance measures (Exit Criteria); its compliance with these measures is reviewed by the Court monitor and the Court in periodic status reports. In the fall of 2011, the judge preliminarily approved a settlement agreement between the parties which moves the District closer to ending this longstanding litigation. See Information – Dixon Case at www.dmh.dc.gov.
- 105 The FY11 systems performance score of 59% is an improvement over the FY10 score of 49%, but still well below the Court requirement of 80%. Dennis R. Jones, Court Monitor, *Report to the Court 11* (2011). Per the *Dixon* settlement agreement, the District has agreed to reach an overall system performance level of 70% on the CSRs for child/youth by Sept. 30, 2013.
- 106 Department of Health Care Finance, *Fee-for-Service Schedule*. See also: DC Behavioral Health Association, *The South Capitol Street Tragedy Memorial Act of 2011: Analysis & Recommendations for Title VI 3* (2011).
- 107 DC Department of Mental Health, *MHRS Provider Authorization and Billing Manual*, Section 9.3 (58), App. A (82) (2010).
- 108 Collateral contacts information is only listed in the provider billing manual under one service, community support. DC Department of Mental Health, *MHRS Provider Authorization and Billing Manual*, App. A, 82 (2010).
- 109 DC Behavioral Health Association, *The South Capitol Street Tragedy Memorial Act of 2011: Analysis & Recommendations for Title VI 3* (2011).
- 110 Congressional Research Service Report for Congress, *Medicaid Targeted Case Management Benefits 1*(2008).
- 111 Center for the Study of Social Policy, *LaShawn A. v. Gray Progress Report for the Period January 1-June 30, 2011 99* (2011).
- 112 Phone conversation between Rebecca Brink, CLC, and Melissa Harris, Acting Deputy Director, Division of Benefits and Coverage, Disabled and Elderly Health Programs Group, Centers for Medicare and Medicaid Services (May 20, 2011). Also see, Massachusetts offers TCM through its Intensive Care Coordination service to all youth enrolled in certain types of Medicaid programs with serious emotional disturbance, available at <http://www.mass.gov/eohhs/docs/masshealth/cbhi/mnc-target-case-mgt-services-icc.pdf>; Minnesota offers TCM to adults experiencing serious and persistent mental illness and child with severe emotional disturbance, http://www.dhs.state.mn.us/main/groups/publications/documents/pub/dhs16_143920.pdf; Montana provides TCM for youth with serious emotional disturbance, <http://www.mtrules.org/gateway/RuleNo.asp?RN=37%2E87%2E805>.
- 113 Dennis R. Jones, Court Monitor, *Report to the Court: Dixon v. Gray*, Exit Criteria No. 17, 8 (2011).
- 114 "Enrollment" is measured as the time when a child/youth is linked/assigned to a core service agency. "Enrollment" happens before a child's first appointment. Email between Rebecca Brink, CLC, and Denise Dunbar, CFSA Mental Health Program Manager, Child and Youth Services Division, Department of Mental Health (March 26, 2012).
- 115 DC Council Committee on Health, FY11 Oversight Questions, DMH Response to Question 48.
- 116 22A D.C.M.R. §3411.5(f).
- 117 Mary's Center had an enrollment of 50 patients and saw 80% within 7 days of enrollment; MD/DC Family Resources had an enrollment of 112 and saw 8% within 7 days of enrollment. DC Council Committee on Health, FY10 Oversight Questions: DMH Responses, Question 91 and Attachment.
- 118 Shannon Stagman & Janice L. Cooper, National Center for Children in Poverty, *Children's Mental Health: What Every Policymaker Should Know 4* (2010).
- 119 DMH screen 56% of CFSA children removed from their homes for the first time or re-entering foster care who were deemed eligible to receive a mental health screen. This is an improvement from the 35% screened in FY10. DC Council Committee on Human Services, FY12 Oversight Questions: CFSA Responses, Question 30 and Attachment.
- 120 DC Council Committee on Human Services, FY12 Oversight Questions: CFSA Responses, Question 30 and Attachment.
- 121 DC Council Committee on Human Services, FY11 Oversight Questions: CFSA Responses, Round 2, Q10, Attachment 2.
- 122 CFSA stated that in FY11 CFSA and DMH did not capture data on how long it took from linkage to the Choice Provider to actual delivery of services, but expects to have this data for FY12. DC Council Committee on Human Services, FY12 Oversight Questions: CFSA Response, Question 30(e).

- 123 Under the Dixon settlement agreement approved by the court February 16, 2012, the District must conduct CSR for children/youth during FY12 and FY13. The District must also contract with Human Systems Outcomes, Inc. to provide support for the CSR process and provide consultation regarding “targeted interventions for providers and system capacity building.” *Dixon v. Gray Settlement Agreement 15* (September 8, 2011).
- 124 Dennis R. Jones, Court Monitor, *Report to the Court: Dixon v. Gray*, Summary of Children/Youth Findings 5 (2011). Jones notes that while the child review process is encouraging, continued efforts are needed.
- 125 The Child and Adolescent Functioning Assessment Scale includes five child scales (role performance, thinking, behavior towards self and others, mood/emotion, and substance abuse) and two caregiver scales (basic needs and family/social supports). Mental Health Statistics Improvement Program, *Child and Adolescent Functional Assessment Scale*. www.mhsip.org. See also Christine M. Walrath, et al. *Reponses of Children With Different Intake Profiles to Mental Health Treatment*, *Psychiatric Services*, Vol. 52, No. 2, 196, 198 (2001).
- 126 Per the *Dixon* settlement agreement, the District has agreed that by September 30, 2013 70% of children/youth will receive at least one non-crisis service in a non-emergency setting within seven days of discharge from a psychiatric hospitalization and that 80% receive such a service within a month of discharge. The District has also agreed to develop, monitor and enforce continuity of care performance standards for CSAs. *Dixon v. Gray Settlement Agreement 21* (September 8, 2011).
- 127 DC Child and Family Services Agency, *Policy: Initial Evaluation of Children’s Health. Ch.1: Healthcare Manual 8* (2011).
- 128 DC Council Committee on Human Services, FY12 Oversight Questions: CFSA Reponses, Question 30 and Attachment.
- 129 American Academy of Child & Adolescent Psychiatry, *Resources for Primary Care*, AACAP Workforce Fact Sheet (2009). Only about 20% of emotionally disturbed children and adolescents receive mental health services and only a small fraction of them receive treatment by a child or adolescent psychiatrist. In 2009, there are only 7,000 child and adolescent psychiatrists practicing in the United States.
- 130 Children with severe mental health conditions are those children with DSM-IV diagnoses rated as “severe.” Medicaid Medical Directors Learning Network & Rutgers Center for Education and Research on Mental Health Therapeutics, *State Practices: 36 State Practices to Improve Antipsychotic Medication Safety and Quality 53-54* (2010).
- 131 Anita Chandra et al., RAND Health, *Health and Health Care Among District of Columbia Youth xvii & 21* (2009). At 119 (recommending that the District “[i]ncrease the number of . . . mental health providers who care for adolescents and children with Medicaid”). More than half of the District’s children (53%) live in Wards 7 and 8, the two wards located east of the Anacostia River. Annie E. Casey Foundation, Kids Count Data Center, available at <http://datacenter.kidscount.org/data/bystate/Default.aspx?state=DC>.
- 132 Laurel K Leslie, et al. Tufts Clinical and Translational Science Institute, *Multi-State Study on Psychotropic Medication Oversight in Foster Care 1* (2010).
- 133 Duff Wilson, *Poor Children Likelier to Get Antipsychotics*, *New York Times* (December 11, 2009).
- 134 Human Systems and Outcomes Inc., *2009 Report on Children and Youth Served by the District of Columbia Department of Mental Health 20* (2009). The cases included in the Community Service Review of Children and Youth sample are ones in which a child or youth has received services within the DMH system during the prior year.
- 135 Human Systems and Outcomes Inc., *2009 Report on Children and Youth Served by the District of Columbia Department of Mental Health 42* (2009).
- 136 Karen Worthington, *Psychotropic Medication of Our Clients: What’s To Be Done?* Written for the Georgia Supreme Court Committee on Justice for Children. Paper presented at the American Bar Association National Conference on Children and the Law (2011).
- 137 Medicaid Medical Directors Learning Network & Rutgers Center for Education and Research on Mental Health Therapeutics, *Antipsychotic Medication Use in Medicaid Children & Adolescents: Report and Resource Guide From a 16-State Study 12* (2010).
- 138 Laurel K Leslie, et al. Tufts Clinical and Translational Science Institute, *Multi-State Study on Psychotropic Medication Oversight in Foster Care 1* (2010).
- 139 Karen Worthington, *Psychotropic Medication of Our Clients: What’s To Be Done?* Written for the Georgia Supreme Court Committee on Justice for Children. Paper presented at the American Bar Association National Conference on Children and the Law (2011).
- 140 42 U.S.C. §622(b)(15), amending Title IV-B of the Social Security.
- 141 42 U.S.C. §622(b)(15)(A)(v), amending Title IV-B of the Social Security Act to require that child welfare state plans include not only the oversight of prescription medicines (already in the law) but also “protocols for the appropriate use and monitoring of psychotropic medications.”
- 142 Gregory D. Kutz, U.S. Government Accountability Office, Testimony before the Subcommittee on Federal Financial Management, Government Information, Federal Services and Informational Security, Committee on Homeland Security and Governmental Affairs, U.S. Senate, *Foster Children: HHS Guidance Could Help States Improve Oversight of Psychotropic Prescriptions* (December 1, 2011).
- 143 Donald Berwick et al., Department of Health and Human Services, letter to state child welfare, Medicaid and mental health directors (November 23, 2011).
- 144 *Id.* at 4.
- 145 Laurel K. Leslie et al., Tufts Clinical and Translational Science Institute, *Multi-State Study on Psychotropic Medication Oversight in Foster Care 5* (2010).
- 146 According to DMH, in early 2012 CFSA (with DMH’s support) submitted a grant request entitled “Quality Improvement Collaborative: Improving the Use of Psychotropic Medication among Children and Youth in Foster Care.”

- 147 See <http://www.mcmap.org>. See also Aaron Levin, *Innovative Project Makes MH Care More Accessible in Primary Care*, *Psychiatric News*, Vol. 46 No. 3, 10 (February 4, 2011).
- 148 Medicaid Medical Directors Learning Network & Rutgers Center for Education and Research on Mental Health Therapeutics, *State Practices: 36 State Practices to Improve Antipsychotic Medication Safety and Quality* 53-54 (2010).
- 149 The American Academy of Child & Adolescent Psychiatry has a variety of Clinical Practice Guidelines which are informative: Parameter on the Use of Psychotropic Medicine; Medication in Children and Adolescents; Practice Parameter for the Use of Atypical Antipsychotic Medications in Children and Adolescents; Practice Parameter on Child and Adolescent Mental Health Care in Community Systems of Care.
- 150 Laurel K. Leslie et al., Tufts Clinical and Translational Science Institute, *Multi-State Study on Psychotropic Medication Oversight in Foster Care* 7 (2010).
- 151 University Legal Services Inc., *Out of State, Out of Mind: The Hidden Lives of D.C. Youth in Residential Treatment Centers* 7, (2009).
- 152 *Id.* at 10.
- 153 *Id.* at 11.
- 154 DC Council Committee on Health, FY11 Oversight Questions: DMH Responses, Question 61.
- 155 The District has made notable progress in streamlining the process through which children are placed at Psychiatric Residential Treatment Facilities, a specific type of RTC for children with mental health needs. DMH convened an inter-agency committee on residential placements and created a uniform PRTF placement criteria form in April 2011. All child serving agencies seeking Medicaid-funded PRTF placements must now complete this referral form and submit it to the PRTF Review Committee, which is comprised of representatives from the various agencies. Even with this new protocol, the process is still complicated and it is difficult to gain a comprehensive understanding of where children are placed and by whom.
- 156 DC Council Committee on Health, FY11 Oversight Questions: DMH Responses, Question 54.
- 157 *Id.* at Question 61.
- 158 DC Choices, *Wraparound DC Report FY2009-2010* (2010).
- 159 Bazelon Center for Mental Health Law, *Wraparound Services*, <http://www.bazelon.org/Where-We-Stand/Success-for-All-Children/Mental-Health-Services-for-Children/Wrap-around-Services-.aspx>.
- 160 *Id.*
- 161 DC Council Committee on Health, FY11 Oversight Questions: DMH Responses, Question 61.
- 162 *Id.*
- 163 The most widely disseminated model is Multidimensional Treatment Foster Care. See <http://www.mftc.com>.
- 164 Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice, *Juvenile Justice Bulletin: Treatment Foster Care* 2 (1998).
- 165 Leslie D. Leve et al, Oregon Social Learning Center and Center for Research to Practice, *Multidimensional Treatment Foster Care as a Preventive Intervention to Promote Resiliency Among Youth in the Child Welfare System*, *Journal of Personality*, Vol. 77, No. 6, 1877, 1882 (2009); Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice, *Juvenile Justice Bulletin: Treatment Foster Care* 6 (1998).
- 166 Children's Law Center Staff Attorney Laura Townsend, telephone conversation with Todd Sosna, Deputy Director, California Institute for Mental Health (March 9, 2011).
- 167 For a list of 27 Core Service Providers, see www.dmh.dc.gov.
- 168 Dennis Jones, Court Monitor, has made this recommendation, noting "DMH and DHCF are participating in a workgroup that they anticipate will soon include members for CFSA, DYRS, DCPS and OSSE, to clarify the District's PRTF issues and coordinate cross-agency efforts. The agreements of this workgroup...will be memorialized in regulation as appropriate...DMH needs to move expeditiously to publish a proposed rule, receive public comment and then promulgate a final rule." Dennis R. Jones, Court Monitor, *Report to the Court (Dixon et al v. Gray)*, 33 (January 27, 2011).
- 169 School agencies (the Office of the State Superintendent of Education, District of Columbia Public Schools and public charter schools) cannot be bound by decisions made by an interagency team regarding children's special education placements. If an individualized education program (IEP) team or hearing officer has determined a child needs a specific placement, this decision cannot be altered by DMH or any other interagency team. While an interagency team may offer placement guidance or alternative community supports during the development of an IEP, all applicable special education laws and regulations govern this process.
- 170 Per the *Dixon* settlement agreement, the District has agreed to reduce the number of bed-days that child-youth with serious emotional disturbance spend in PRTFs by 30% by September 30, 2013. The baseline number of days that youth spend in PRTFs will be established by using placement data from May 1, 2011 through April 30, 2012. *Dixon v. Gray Settlement Agreement*, 15 (September 8, 2011).
- 171 Per the *Dixon* settlement agreement, the District has agreed to increase the number of child/youth who received "High Fidelity Wraparound planning and care coordination by 10% in FY12 (baseline FY11) and 20% in FY13 (baseline FY12)." *Dixon v. Gray Settlement Agreement*, 16 (September 8, 2011).
- 172 22A D.C.M.R. §3422.
- 173 Serge King, Senior Child/Youth Services Data Analyst, Department of Mental Health, *CBI Authorization and Access to Services* (FY10&FY11), Presentation to the DMH System of Care Committee September 28, 2011.



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